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“Don’t Talk about It”: Investigating the Effects of PEI’s Cultural Silence on Abortion Access and Advocacy from the Perspective of Advocates and Support People

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“DON’T TALK ABOUT IT”: INVESTIGATING THE EFFECTS OF PEI’S CULTURAL SILENCE ON ABORTION ACCESS AND ADVOCACY FROM THE PERSPECTIVE OF ADVOCATES AND SUPPORT PEOPLE

by

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Abstract

As an arm of a greater study that investigates the impacts of PEI's abortion restriction over the past two decades, "Don't talk about it" explores the situation from the perspective of support people and advocates to abortion access including; their emotional experiences of support and advocacy, the associated risks and repercussions, as well as their understandings of the barriers, facilitators and impacts of compromised access to off-Island services for PEI women and girls. Key findings show an overarching culture of silence and blame surrounding abortion on PEI, reinforced by stigma and repercussions for those speaking out. This silence serves to limit the voices of support people, advocates and those seeking the procedure, limiting awareness and stifling attempts at systemic change. However, the recent cultural and policy changes that have emerged since the time of data collection may represent a shift away from this harmful cultural silence. Recommendations for policy change include providing local and streamlined access to abortion, as well as breaking the silence at the individual, community and systemic levels.

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Acknowledgements

This thesis is dedicated to the fierce and outspoken participants of this study, and others like them who have endeavoured to help PEI women and girls in their journeys to abortion care. With deep gratitude I would like to acknowledge the collaboration of the women of the Advisory Council who made a rich and strong analysis of endless data possible. Finally, I would like to thank the lead author of the larger *Trials and Trails* study Dr. Colleen MacQuarrie, who continually manages to inspire, engage, and support myself and so many others.

"Don't Talk about It": Investigating the Effects of PEI's Cultural Silence on Abortion Access and Advocacy from the Perspective of Advocates and Support People

> Why is it that we seem to have so much more concern for unborn children than for the children already among us? There is a high incidence of poverty on the Island. This includes the so-called "working poor" as well those living on social assistance and other support programs. The effects of poverty on children are well documented. It puts them at risk in many, many ways and exacts an economic cost which we all have to bear. There are, however, few votes in poverty and addressing it any serious fashion seldom rises to the top of any political agenda. I have never understood why it is that abortion is considered by a whole lot of Christians to be a moral issue while poverty is not.
> -Reverend John Moses from his sermon in Charlottetown, PEI at United Trinity Church on April 17 2012

Recently published is a study entitled; *Trials and Trails of Accessing Abortion in PEI; Reporting on the Impact of PEI's Abortion Policies on Women* (MacQuarrie, MacDonald & Chambers, 2014). This large, qualitative, community-based study systematically explores the physical and mental health effects of PEI's abortion restriction from the perspectives of; people with lived experience of accessing an abortion from PEI, support people and advocates to abortion, and medical personnel. The study sheds light the effects of the abortion policies, with potential to inform policy aimed at facilitating access to healthcare services. The current study is a secondary analysis of the data provided by the subsection of participants that identify as support people and advocates to abortion. Support people are defined as those who have assisted access to abortion by providing emotional support, information, fundraising, accompaniment to the procedure, and advocates are those who have advocated for better provincial abortion access through organizing, educating, or acting as a media spokesperson. The majority of the participants worked as support people and advocates as part of their role at a volunteer organization or as a part of their work. Some participants have been involved in the fight for

reproductive justice over a twenty year time span and continue their work in the present, allowing for deep analysis and insight.

To ensure credibility in my findings, I also conducted my own member check meeting with a subset of the support people and advocates who participated in the original study. My project exposes the processes experienced by PEI women and girls when seeking their right to an abortion from the perspective of people who have supported them in their journey, as well as the experiences of these support people and advocates as they endeavour tofacilitate individual and systemic abortion access.

In Canada, access to abortion is guaranteed under the Canada Health Act. Despite this guarantee, access to abortion is compromised for many women. In a study by Canadians for Choice (2006), PEI ranked lowest among the provinces and territories for access to reproductive care, and exists as the only province without abortion services or a sexual health clinic. These barriers are compounded by a number of policies that limit a women’s ability to terminate a problem pregnancy. Provincial healthcare only covers abortion procedures performed at a hospital, on pregnancies before 16 weeks gestation and after women have had an ultrasound, with average wait times for the procedure often exceeding 15 weeks (Esmail, 2009). Access to health care on PEI is generally less accessible than the national averages with ultrasound wait times being no exception; the average national wait time for this test is 6 weeks, almost one third of the average Islander’s wait. These criteria may help explain why over 60% of Islanders have paid over $800 out of pocket for a basic healthcare covered procedure in the past eight years (CBC News, 2010). Further compromising women’s access is the cost of travel to the mainland and a lack of anonymity. Abortion services, previously available to women on the island, were discontinued when PEI’s Protestant and Catholic hospitals merged in 1982, at the same time that

Canada was extending women’s reproductive rights. The circumstances surrounding this decision have yet to be addressed (Clorey, 2007).

The limited access to reproductive choice for PEI women exists in tandem with an intersection of differing health, social, or economic policies and forms of oppression that exacerbate the situation for women and girls. As well as having one of the highest national rates of teenage pregnancy (Stats Can, 2006), PEI has among the highest national rates of poverty with female lone parents having by far the highest poverty rate for any family type at 47.1%, and the national child poverty rate has remained high for over two decades (Kaposy, 2010). Women in Canada are at a wage disadvantage when compared with men, earning 63% of the average male salary with the greatest wage disparities between women and men existing for younger people with lower levels of education in occupations associated with low-wage status (Conference Board of Canada, 2011). Further, women continue to be overrepresented in low-paying occupations in Canada (Conference Board of Canada, 2011). On average, Islanders earn the lowest wages in the country, with women, youth, immigrants and visible minorities being the most prevalent among those earning low-pay (CBC, 2012). Given these trends, it is conceivable that PEI’s abortion policies intersect with other economic, social and health oppressions to discriminate against Island women seeking abortion access.

Abortion is prevalent among women of all childbearing ages, SES, and geographic and ethno-racial groups. At the current rate, it is expected that one in three American women will have an abortion by the time they reach 45 years of age (Henshaw & Finer, 2003). History has shown that across the world women will undergo abortions regardless of the law and may risk their lives, well-being, health, and safety to terminate a problem pregnancy. Abortion laws that limit or restrict access to safe abortion have been recognized as a violation of the human rights

code by the UN since 2007 (WHO, 2009). Given the high prevalence of abortions and the increased risk of negative health outcomes when reproductive choice is limited, research investigating abortion access is relatively scarce.

To introduce the important topics of abortion access from the perspective of support people and advocates and their experiences as they endeavour to help women and change the policy, I first summarize all the relevant literature in a thorough literature review. In the second chapter, I explicate the proposed study, including a description of the larger study and its relationship to this study, as well as my research objectives and questions. The theoretical framework chapter describes three helpful perspectives for exploring and explaining the findings; the ecological model, liberation psychology and feminism. The fourth chapter details my methodology, including; 1) my rationale for working from the critical emancipatory paradigm, 2) reflexive writings relevant to abortion access and advocacy, 3) the suitability of the qualitative design, 4) a description of the sampling procedures used, and 5) an overview of the measures taken to ensure ethical treatment of all involved in the project.

The chapter on analysis describes interpretive phenomenological analysis and details the steps involved, and the various credibility checks used. I then outline the different ways I have begun and will continue to disseminate the findings. Chapter 7 illustrates the findings in three main themes; 1) the overarching theme of the culture of silence, 2) the experiences of support people and advocates, and 3) the obstacles and facilitators to access and their effects from the perspective of support people and advocates. The findings are followed by the discussion section (Chapter 8), which details the relevance of current literature as well as the originality of the findings. Also interpreted are the effects of cultural silence on support people, advocates, access, and, policy change. The final chapter describes the participant’s policy change recommendations,

the changing state of PEI culture, and finally sums up the conclusions of the study with its limitations and recommendations for further research.

Chapter 2: Literature Review

In the following section I first justify my method of gathering research via a system called the methodologically inclusive research synthesis. I then go over the relevant research on 1) the PEI Context, 2) the effects of abortion stigma on those supporting the women needing the procedure, 3) the research on abortion access, and 4) the effects of these barriers to access.

Methodologically Inclusive Research Synthesis

To conduct this review of literature pertaining to barriers to abortion access and the experience of abortion rights support people and advocates, I used a methodologically inclusive research synthesis (MIRS) (Suri & Clarke, 2009) as it is well suited to accommodate the diversity of perspectives, the levels of complexity found in research on the subject of abortion, as well as the scarcity and poor dispersal of subtopics in the area. In their literature review of mental health and abortion, the World Health Organization (WHO) (2009) explained the scarcity of reliable abortion research as an outcome of abortion stigma in both developed and developing countries, also noting that rates of unsafe abortion are notoriously difficult to document accurately, and that abortion research tends to show an ideological bias. While abortion has not been researched at a level that matches its prevalence or potential health effects, the body of studies found on the subject is disproportionately focused on the demographic characteristics and contraceptive history of women seeking abortion (Norris, Bessett, Steinburg, Kavanaugh, De Zordo, & Becker, 2011). These findings are generally unrelated and unhelpful to the investigation of access barriers, abortion stigma, or the experiences of abortion advocates. Also, research is focused on the health consequences of unsafe abortions, which says nothing about the

women who do not need medical attention or those wealthy enough to cross borders and pay for a private clinic. However, the flexibility inherent in the MIRS approach allows researchers to deeply investigate and synthesize research from a wide array of sources, while attending to and reflecting on their own bias. These qualities of MIRS make it appropriate for a first voice researcher investigating the disproportionate body of research that exists on the two areas examined; A) abortion stigma on support people, and B) abortion access barriers. The inclusion/exclusion criteria I used were as follows:

A. On the topic of abortion stigma and support people:

1. Research must include topic of abortion stigma.
2. Research must include topic of abortion advocates, support people, or support people to abortion.

B. On the topic of abortion access barriers

1. Research must include topic of abortion access.
2. Research must be about countries or regions where abortion access is available on demand.

Relevant Research

In this section I first explore the literature pertaining to abortion stigma and how it affects those who support women seeking the procedure. This includes 1) personal supports like family, friends and intimate partners to abortion, 2) abortion researchers, 3) the full range of abortion care providers, including physicians, nurses, and, counsellors, and 4) abortion support people and advocates. I then review the research on the effects of abortion stigma on these groups and their ways of coping.

The second section of the literature review focuses in on barriers to abortion access from regions around the world that legislate abortion on demand. I then consider the effects and outcomes of these policies. In the closing section of this literature review I present an overview of the proposed research as well as the research questions to be investigated.

The PEI Context

Demographics. The PEI population is unique in that is it mainly rurally distributed, with 70% of the land used as farm land (Weihs, 1995). The cultural demographic is predominantly white and mostly of Scottish, English, Irish and French descent, with few visible minorities (2011 National Household Survey, 2011). Close to half the population self-identifies as Roman Catholic while 43% identify as Protestant. PEI has the lowest percentage of residents identifying as non-religious among the provinces (StatsCan, 2001). The “Right to Life” groups on PEI like Birth Right and the PEI Pregnancy Centre are also a part of Christian communities, though it is important to note that some denominations, youth groups and parishioners do not identify as anti-abortion.

The Experience of Newcomers to PEI. The experience of newcomers to the island has not been adequately researched. However, a member of one of the longest PEI Chinese families has noted the difficulty and lack of acceptance into PEI culture based on assumptions that she is not a “true islander” (Islandness and PEI Foreigners, 2008). While government programs have been successful in increasing the influx of immigrants to Atlantic Canada, immigrants often leave after the prescribed time has passed (Baldacchino , Chilton , Youn Chung , Mathiang , 2009). The main impasse for newcomers to PEI has been described as systematic discrimination in the Island’s “strong cultural norm of sameness” (PEI Population Panel, 1999, p. 56) that socially supports Islanders but excludes newcomers. “Growing up in an ascribed network of

relatives and friends, most Islanders walk through life in regular company of the same social cohort, with whom they connect and thus reinforce relationships” (Baldacchino , Chilton , Youn Chung , Mathiang , 2009, p. 7). Newcomers to PEI, even those who have lived there for decades, are dubbed CFAs (come from aways) and cannot fully integrate into these intense social networks. A recent study comparing quality of life perceptions between Immigrant Islanders and those originally from the Island showed that immigrants tend to feel socially and economically excluded and are critical of the quality of education on PEI, as well as the locally available cultural opportunities (Randall, Kitchen, Muhajarine, Newbold, Williams, & Wilson, 2014).

“Islandness”. The term “Islandness” has been used to describe PEI culture and place in both positive and negative ways. In the positive sense, islandness denotes a spiritual and indescribable quality. The Island Institute’s Philip Conkling calls it “a metaphysical sensation that derives from the heightened experience that accompanies physical isolation,” which can be experienced by visitors as an “instantaneous recognition” (Conkling 2007, p. 191). PEI’s Islandness has also been critiqued as a myth (McCabe, 2003) and as an obstacle to political change (Novaschez, 2009). The Right to Life movement in Canada and the USA has lauded PEI as a “Life Sanctuary”, inaccurately lauding PEI as an abortion-free Island (McMahon, 2011).

Abortion Policy. PEI government policy has largely upheld and underscored the notion of abortion access as a sinful and disgraceful law. In response to the national decriminalization of abortion, in 1988 the PEI government passed Resolution 17 which states that "life begins at conception, and any policy that permits abortion is unacceptable" (CBC, 2013). This resolution was passed unanimously by the all-male legislative assembly at the time and remains intact. Advocates’ recent efforts calling the current government to rescind it have gone ignored (ibid). Recently, a Health PEI proposal to provide abortions locally on PEI was ordered to be halted by

Health Minister Doug Currie. However, the lead researchers continued despite the order, and the business case showed how local access would save the province money (Chapin, 2014). This finding dissolves the common economic justification of prohibiting local access. However, the abortion issue continues to be ignored by government officials.

PEI Politics. Abortion is not the only topic that reveals corruption and sexism at the government level. PEI has the distinguishing feature of being the only province where business men, government officials and policy makers are patrons of a “gentlemen’s club” where women who work in similar fields are not permitted. Also, the PEI Court of Appeals track record has been exposed as sexist and unlawful in its history of overturning rape cases; only one accused rapist in the past ten years has been convicted while the rest of the accused have been freed on a technicality (McKenna, 2014). Most recently, evidence of the close-knit and corrupt provincial government was exposed in a gaming scandal that resulted in PEI’s Conflict of Interest Commissioner stepping down over a conflict of interest (Globe and Mail, 2015). These examples suggest a tightly-knit group control and legislate policies that are often not made in the best interest of the women and girls of PEI.

Abortion Stigma

In this section I review the research that focuses on the effects of abortion stigma on those that surround people who have direct abortion experience. I first cover the different groups theorized to be impacted by abortion stigma. I then move to the known effects of abortion stigma on these groups by examining the research devoted to abortion stigma and those who provide abortion care.

Abortion “Courtesy Stigma”. Authors Kumar, Hessimi and Mitchell (2009) define abortion stigma as “a negative attribute ascribed to women who seek to terminate a pregnancy

that marks them, internally or externally, as inferior to ideals of womanhood" (p. 628). However. in an article that addresses the causes of abortion stigma, researchers Norris, Besset, Steinburg, Kavanaugh, De Zordo and Becker (2011) theorize that such stigma reaches beyond the women who have experienced abortion, suggesting that such stigma also effects abortion researchers, abortion rights advocates, service providers, supporters of women experiencing abortion, as well as intimate partners to abortion. The authors note the current lack of research on abortion supporter stigma but hypothesize that supporters may receive a "courtesy stigma" from association—a term borrowed from Goffman (1963). As abortion researchers themselves, the authors disclose their difficulty with funding abortion-related research and suggest that the pattern of rejection may be caused by abortion stigma. The authors call for more research into the effects of stigma on all potentially affected groups.

Effects of Abortion "Courtesy Stigma". Although no studies yet exist to address the effects of abortion stigma on advocates and support people, some research has been conducted to examine the effects on a few groups that surround the women that undergo the procedure, including the intimate partner to abortion and health care providers of abortion. Studies have shown that intimate partners to abortion experience similar emotions to their partners, including powerlessness, ambivalence, guilt and anxiety, which may or may not be related to abortion stigma (Shostak, Koppel, & Perkins, 2006). Stigma has different effects on abortion care providers including feeling devalued by society (Martin, Debbink, Hassinger, Youatt, Eagen-Torkko, & Harris, 2014), fear of repercussions from colleagues (Freedman, Landy, Darney, & Steinauer, 2010), fear of violence from anti-abortion terrorists (Joffe, 2009), and difficulty managing disclosure about their work with family, friends, and strangers (O'Donnell, Weitz & Freedman, 2011). Harris, Debbink, Martin and Hassinger (2011) also noted that both disclosing

and withholding one’s work with abortion led to painful interpersonal disconnections. Levels of stigma may vary according to the timing of the care, with later term abortions being more heavily stigmatized than those in the early-term (Harris, 2008). While support people and advocates accurately fit neither of the two investigated categories, these findings suggest that abortion rights advocates and supporters of women who experience abortions may also be impacted by abortion stigma, however, more research is clearly needed to address this gap in research.

Providers coping with abortion stigma. A few studies have examined the resilience of abortion providers and therapeutic measures for dealing with abortion stigma. O’Donnell, Weitz and Freedman (2011) found that abortion care providers showed different strategies for mitigating or transforming the stigma they encounter from colleagues, friends and strangers, including educating others on the work they do, taking pride in their work, and creating a safe and supportive workspace or network of professionals. Gathering in a safe space to speak about the effects of abortion stigma has also been found to be therapeutic for professionals in the field of abortion care (Harris, Debbink, Martim & Hessinger, 2011). Abortion care providers and support people and advocates contribute different facets of abortion work, yet there may be some crossover in the ways the groups cope with abortion stigma. However, more research is clearly needed in this area.

Access Barriers

In this section I provide a review of the research relevant to abortion access barriers. I begin with obstacles existing at the macro level, including economic and policy barriers such as hospital policies, facility disparity and the failure to provide a referral. Finally, I move to the barriers existing on the meso level including community norms and social disapproval.

Economic barriers. Around the world, research has verified that women without financial resources face more barriers and blockages to access while women with higher SES are able to access needed abortions by paying private clinics or through travelling to countries with more expansive access laws (WHO, 2009). The stratification of abortion fees along state policy lines in the US have been documented as exacerbating of undue burdens for vulnerable groups: younger women, women living in rural areas, immigrants and refugees, and women of lower SES (Ely & Dulmus, 2010; Hussey, 2010). Studies also show that young women's abortion decisions are shaped in part by the level of public abortion funding in their county of residence (Adamcyzk, 2008), while accessing abortions from a distance create extra fees (Canadians for Choice, 2006), making proximity to a clinic a financial as well as a geographic barrier. In the US, women of lower SES were also twice as likely to be delayed by difficulties in making arrangements to have an abortion (Finer, Frohwirth, 2006). In an investigation of the relationships between the finances associated with paying for an abortion, and the government’s level of funding for Medicaid, child care, and family leave policies in 48 states over 13 years, Hussey (2010) found that more expansive family leave policies are associated with lower rates of abortion. It stands to reason that the amount of support offered by a woman’s governing child support policies will influence termination decisions, since such decisions are complex and partially dependent upon one’s ability to support offspring. Overall, strong evidence shows that women who are of lower SES will experience more concentrated access barriers than women with higher levels of financial resources.

Policy Barriers

Hospital policies. Hospital policies refer to the limits, procedures and policies prescribed by hospitals in their routine standards of care that may act as barriers for women needing an

abortion. Examples affecting PEI women looking to use one of the two nearest clinics include a gestational limit of 16 weeks at both of the nearest facilities. If women go through the healthcare system, they lose their anonymity as their names are put on lists shared among medical and administrative personnel (CBC News, 2010). The effect of forfeiting anonymity to hospital personnel within a small, tightly knit community on accessing abortion has received little research attention. However, in Puerto Rico a study by Azize-Vargas (1998) linked the lack of confidentiality and high levels of abortion stigma to the persisting high rates of clandestine abortions since decriminalization.

The debate over confidentiality vs. parental consent surrounding abortion access in the US has been subject to study, with results illuminating how the effect of parental consent laws differ depending on the cultural context (Coles, Makine, Stanwood, Dozier & Klein, 2010). In their literature review from the Guttmacher Institute, authors Joyce, Henshaw, Dennis, Finer and Blanchard (2009) contend that confidentiality is important to improving access to reproductive options. However, the loss of anonymity for women and girls seeking healthcare is still hotly debated in articles, and research findings are unable to generate trends. More contextually specific research is required to situate and understand the effects of these hospital confidentiality procedures.

Provider refusal, objection or failure to refer. Canadian medical providers may refuse to participate in certain medical procedures, including the referral, on the basis of “conscientious objection” (Canadians for Choice, 2006). Because of this, many women in Canada still face formidable barriers such as anti-choice medical personnel, misleading information or a dearth of doctors willing to refer (Kaposy, 2010).While these blockages have been documented in

Canadian newspaper articles and reports, their effects have yet to be systematically or rigorously reviewed through empirical research.

Also, a US study shows how nurses’ refusal to attend to abortions result in delayed care (Kade et.al, 2003). Yet undetermined in Canada are the effects of other medical personnel that block access, such as nurses or counselors, adding another potential dimension of yet unexamined blockages to abortion access.

Geographical disparity in facility availability. Although women will go to great lengths to acquire an abortion (David, Dytrych, Matejcek, 2003), distance creates sometimes insurmountable barriers for women looking to terminate. Studies from Mexico as well as Ontario show that women living in rural locations experience more barriers than those living in urban centres (Becker et. al, 2011; Sethna & Doull, 2007). Ontario abortion seekers found that 73.5% travelled more than one hour to obtain abortion services, and many rated the trip as “very difficult” (Sethna & Doull, 2007). Hospital abortion services are concentrated in urban areas, close to Canada’s southern border. Due to the poor dispersal of hospital clinics, many women living in northern and remote communities face obstacles such as unexpected costs and travel time. These barriers are increasing in severity as the amount of hospitals in Canada with accessible abortion services has lessened in the past three years. (Canadians for Choice, 2006). Young rural women in the US may be particularly affected by barriers of distance as abortion decisions are partly contingent upon proximity to an abortion clinic (Adamcyzk, 2008). More research is needed to determine the contextual and overlapping effects of geographical disparity in facility availability, and its effects on young and rural women.

Procedural barriers. Procedural barriers refer to processes required by hospitals and clinics in order to process and care for patients. Research has been done on the effects of the

mandatory wait periods in the United States, which are not part of Canadian policy, yet may be comparable to PEI’s required ultrasound for a hospital referral and the associated wait-time. Studies done in the US have shown that mandatory wait periods are associated with higher unintended pregnancy rates in teens (Coles et. al, 2010). In a literature review investigating the effects of mandatory wait periods, the strongest correlation with higher birth rates were found in states that also mandate wait periods in conjunction with in-person counselling (Joyce, et. al, 2009). While comparable, effects of PEI’s policy of mandatory ultrasounds have not been tested and these procedural barriers to access differ in several ways. For instance, the wait for an ultrasound from PEI has the potential to be far longer, and may approach or surpass the closest clinic’s gestational limit. Women obliged to wait in the US are aware of the duration of mandatory wait periods, while the duration of wait-time for an ultrasound in PEI is not fixed. Further, PEI women waiting for an ultrasound may experience additional barriers due to sporadic scheduling in appointment bookings. The effects of wait times and ultrasound appointments required in some areas of Canada have yet to be addressed by empirical research.

Stigma Barriers

Community norms and attitudes. Many studies investigate women’s reasons for choosing abortion but researchers have spent less time investigating the dynamic relationship between community norms and individuals’ abortion choices. Studies on the individual level by Finer (2005) have shown that most women give multiple reasons for their decision to terminate, and common among these are finances, dramatic life changes, and relationship problems. Women who choose to bring the pregnancy to term often count pro-life views among their reasons, however, this is an ideology that varies regionally in prevalence. For example, Hussey’s (2011) study linked welfare recipients’ decision to terminate with the types of messages about

the acceptability of abortion that a woman is more likely to receive from living in a pro-life region. Further research drawing from an ecological model (Krug et. al, 2002) suggests abortion experiences are tied to the cultural, religious and political milieu surrounding abortion (Stotland, 1996). In an article examining how ideology shapes access policy, Kulczycki (2007) describes how relatively recent access restrictions in the US has served to promote a conservative moral framework. Together, these studies denote a dynamic relationship between abortion policy and community norms.

Social disapproval. Women facing a problem pregnancy may be in consult with members of their social circle, family, and sexual partner(s) as well as others when deciding on whether or not to terminate. Few studies have investigated links between levels of social support and barriers to abortion access. However, a study from the US by Kapadia, Finer & Klukas (2011) found that women are more likely to disclose an unintended pregnancy to their partners than their friends or mothers. However, women were less likely to disclose to their partners if they predicted a judgmental or abusive reaction. Perceived negative interactions with partners were associated with later termination, whereas supportive relationships and joint decision-making were linked with abortions at earlier gestational stages. Though it is not specified from whom the lack of support was coming a recent study from Mexico on the impact of socio-demographic factors and women’s ability to access an abortion showed that divorced and separated women reported receiving the lowest levels of support in their decision (Becker et. al, 2011). These findings suggest that higher levels of social support aid in accessing abortions, however, more research is clearly needed in this area.

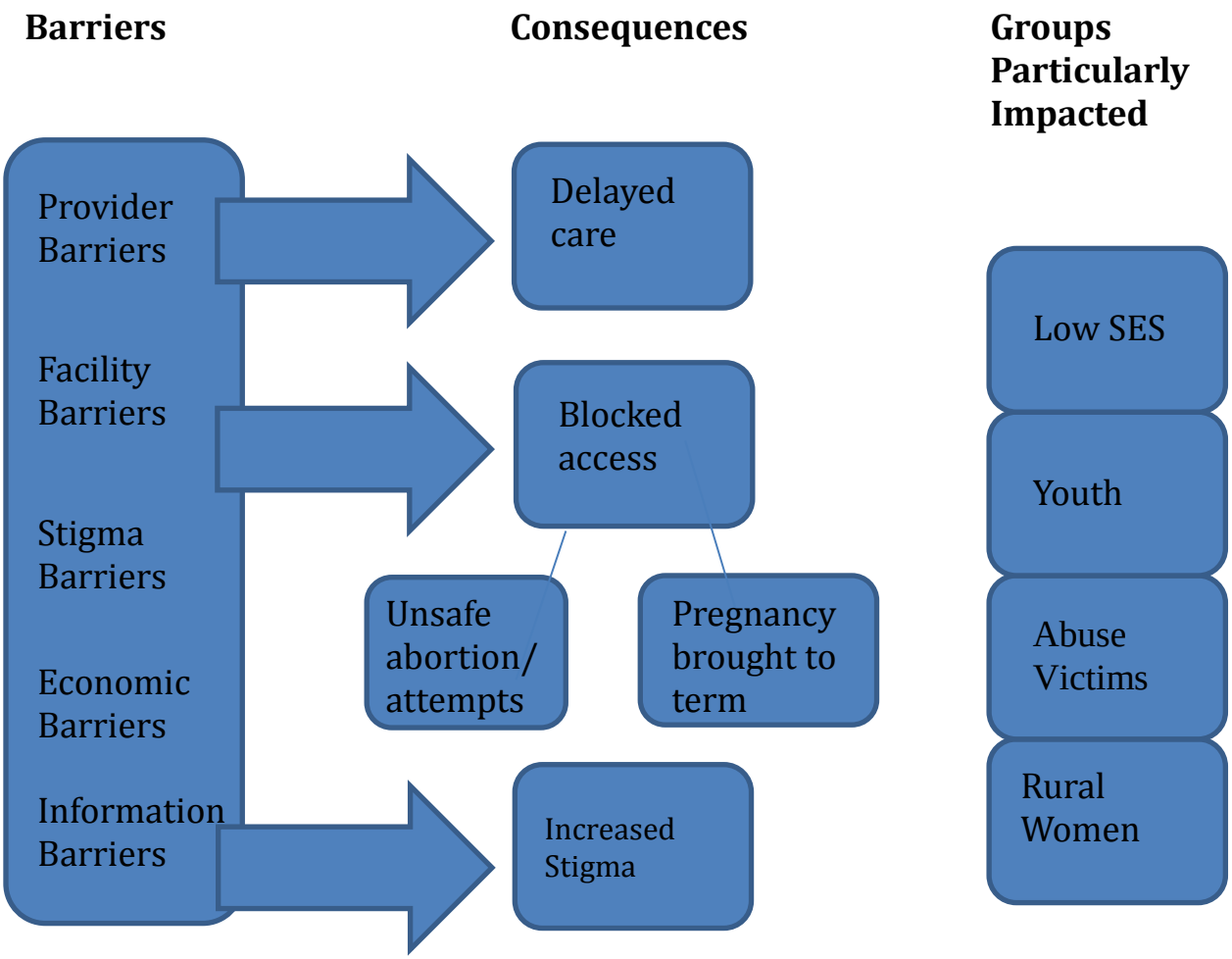
Consequences of Access Barriers

The process that a woman must go through in order to obtain an abortion varies greatly across provinces, territories, and individual hospitals, and often prevents women from being able to access reproductive healthcare (Canadians for Choice, 2006). Abortion researcher Chris Kaposy (2010) notes that a web of interconnected factors combines to delay or block access for some Canadian women despite the procedure’s legal status. This section summarizes three types of effects of such barriers: 1) long waiting periods and their subsequent consequences; 2) discrimination against certain groups of women, and; 3) unsafe or unwanted of pregnancies.

Long waiting periods. Pregnancy terminations are time-sensitive, and the experience of unwanted pregnancy is associated with higher rates of mental illness (WHO, 2009). In Canada, wait-times, gestational limits, and the availability of counselling vary drastically from one hospital to the next, and in some hospitals, wait times can be as long as 6 weeks (Canadians for Choice, 2006). It follows that the most frequently cited hand-written explanation for Ontario women turning away from a clinic was an inability to get an appointment within the necessary timeframe (Sethna & Doull, 2007). However, not all women are able to choose the speediest provider. All Island women, and many women living in remote areas have to travel distances and pay out of pocket for the associated costs.

Discrimination against vulnerable groups. The barriers examined above serve to exacerbate existing oppressions (Figure 1).

Figure 1. Barriers to abortion access and their consequences.



Blocks and delays in care may hold greater impact for certain groups of women. In a study examining reasons for delaying abortions, minors took on average a week longer to suspect pregnancy than adults did (Finer, et. al, 2005), showing that youth may experience more barriers and consequences associated with later pregnancy detection. Later detection is the most common reason given for presenting for an abortion in the second trimester, with 58% of participants being delayed in this way (Drey, Foster, Jackson , Lee, Cardenas & Darney, 2006). Surgeries reserved for later gestational stages are more complicated, sometimes more expensive, and come with more attendant health risks (Canadians for Choice, 2006). Women who exceed the closest facility’s gestational limits have to travel further in order to access the care they need,

compounding barriers related to finance and distance. Studies show that newcomers also face added language and cultural barriers in attempts at accessing abortion (Canadians for Choice, 2006). Finally, numerous studies have shown that SES is a determinant of abortion access for women around the globe (WHO, 2009). Together, these barriers privilege wealth, urbanity, legal immigration status, and age. The limited and marginalizing state of abortion access in Canada is in direct opposition to the Canada Health Act mandate of equal access for all.

Unsafe or unwanted pregnancy outcomes. Currently, no scientific research exists that examines the rates of unsafe abortions in Canada. Similarly, precise data is lacking on the amount (or experiences) of women who were sufficiently blocked from access that they brought a pregnancy to term. A longitudinal Quebec study reported the adverse mental and physical effects of being an unwanted child (Sigal, 2004), however, information about the unwilling mother is absent. In their report on access in Canada, Canadians for Choice (2006) documented two stories from women who were unable to access the abortion they were seeking. One women was refused a referral by her family doctor and instead made to feel that she would be a “horrible, unfit mother were she to abort her third child” (p. 56), and the other woman was tricked into waiting until she was past the gestational limit and subsequently could not find any physician to treat her. Women who are unsuccessful in obtaining an abortion may become unwilling mothers, a hidden or difficult to reach population due to intense stigma. Abortion and societal expectations surrounding motherhood may make research in the area of unwanted children less accessible, yet such research would be very important in illuminating the effects of barriers to reproductive choice.

Gaps in Research

Many gaps exist in the body of research on the heavily stigmatized topic of abortion and investigations into the experiences of support people and advocates are particularly thin. A few recent articles and studies have begun to draw links between the effects of stigma, ruralism, low SES, and age on women’s abilities to access abortion in areas where the procedure is legal but remains unavailable to some women. However, most psychological studies in the area generate victim blaming by focusing on individual differences. Working from a Community Psychology ethic lends a more appropriate value-base and perspective for investigating the effects of these socially and politically constructed barriers to accessing, assisting, and advocating for a human right. Such a perspective underscores the need to look at societal issues with a very wide lens; detracting from the mainstream focus on the responsibility of the individual and instead revealing the broader socio-political forces at the root of the problem.

Much more research is needed to better explore the intersecting effects of these barriers and their potential consequences of bringing problem pregnancies to term or increasing incidences of unsafe attempts at abortion in Canada. Highlighted in the review of the literature is the particular need for abortion research to examine the factors affecting access contextually, while attending to the multiplicity of factors that may serve to shape the process of abortion access from PEI. Finally, the dearth of research on the effects of abortion stigma upon the different groups who work in the field exposes many areas for further study. By examining how different groups experience abortion stigma, we bring ourselves closer to understanding its causes and antidotes.

Chapter 3: The Current Study

The present study is a qualitative and community-based study that systematically explores a small group of support people and advocates’ experiences of the barriers and facilitators associated with accessing an abortion from PEI, as well as their own experiences in assisting women and advocating for access. My role as the principal investigator on a subsection of a larger project has been outlined in the “terms of reference” section (Appendix B). I conducted a secondary analysis of a subsection of data collected by the principal investigators of the *Trials and Trails* study. The group of ten interviews of support people and advocates to abortion comprises my subsection of the data, and I examined their experiences as well as the barriers to abortion access from their perspective. I used methodological hermeneutics as my analytical approach and led the collective inquiry process with the advisory committee on the project. Finally, I facilitated a group member check process with five participants interested in being a part of reviewing our findings for credibility.

To cover all aspects of the study, I will first summarize the objectives, methods, emergent findings and community ramifications of the larger study. I then describe my own objectives and research questions in conducting this study.

The Larger Study

As discussed above, PEI’s abortion access policy has not been adequately examined in the existing literature, but a broad study of the health effects of the limited access is currently underway. Findings from the *Trials and Trails* study shows that a 14 year old ingested many substances and incurred bodily harm in an attempt to bring on her period, suggesting that for some women and girls the province’s restrictive policies may function as a blockade and a potential threat to health (MacQuarrie, MacDonald, & Chambers, 2014). The objective of the

larger study is to examine the various effects of the abortion restriction on the lives of PEI women. To understand the effects of the policy, various groups were interviewed, including women who have tried to access abortion as well as friends, family, professionals, medical personnel, and advocates who have tried to assist women. The larger study is an example of community-based research (CBR), a form of collaborative inquiry where academic and community members join efforts to identify, research and provide solutions to health inequalities or other complex problems that communities may face (Travers, Pyne, Bauer, Munro, Giambrone, Hammond, Scanlon, 2014). A community-based process of analysis was used to examine the lived experiences and outcomes of women seeking an abortion in PEI, as well as to create research dialogues with participants that fostered an engagement with the issues surrounding the topic of abortion in the community. In accordance with CBR, a project advisory council was formed to support, interpret and to help disseminate the findings of the study. The council was composed of people who have had an abortion, reproductive rights advocates, a member of each; the UPEI School of nursing, the Status of Women, and Women’s Network. I was a member of the advisory council and through my participation I became familiar with the process and benefits of the “Critical Questioner” method, where members of the project advisory council read both the raw data and the thematic summary and offer edits, additions and suggestions to the latter. Four data analysis meetings were held as a group with the advisory council to form and finalize the data analysis.

Four years have passed since the interviews with support people and advocates were conducted and much has shifted in PEI culture. The larger study helped launch several new grassroots groups working toward reproductive justice. The advisory committee to the study became an advocacy group dedicated to both repatriating local access and assisting women

individually. Over time that group has become an umbrella group for any like-minded individual or organization and is now called the Abortion Rights Network (ARN). A small group of young women also formed a group called PEI Reproductive Rights Organization (PRRO) dedicated to lobbying the government for better access at the same time; many of the founding members were participants in the larger study. Finally, in connection with the larger study the Campus Alliance for Reproductive Justice (CARJ) also emerged in 2011 with goals of activing campus and community abortion rights-related advocacy.

The work that these advocacy groups have done over the past four years since the interviews were conducted have continuously broken the silence on the subject of abortion. In turn, many of the recommendations of the present study have been enacted, happily shifting the culture of silence that is analyzed and critiqued in the present study. Although the current study did not take part in the inception of the advocacy groups, it has added to the voices calling for change and strengthened the movement; a process that will continue through the ongoing dissemination process.

Research Objectives

This thesis has four main research objectives; (1) to explore the experiences of support people and advocates to abortion access on PEI, (2) to seek a greater understanding of the barriers and facilitators to those seeking an abortion from PEI, (3) to use these findings to guide and inform healthcare policy improvements,, and, (4) to contribute evidence to the growing collaborative pro-choice movement on the Island in their efforts to reduce abortion stigma and help repatriate abortion access. *Table 1* summarizes how the strengths of qualitative research meet the research questions and aims of the current research.

Table 1

Research Questions, Objectives and Corresponding Qualitative Research Strengths

Research Questions	Research Objective	Strength of Qualitative Research
1. What are the experiences of support people as they endeavour to help women in need of an abortion? 2. What are the experiences of advocates as they endeavour to improve abortion access on PEI?	To explore the experiences of support people and advocates to abortion access on PEI	• Suitable for studying under-researched areas • A respectful and thorough approach well suited to investigating personal experiences
3. What are the barriers to abortion access for girls and women in PEI as identified by support people? 4. What are the enablers to abortion access for girls and women in PEI as identified by support people?	To seek a better understanding of the barriers and facilitators to accessing abortion from PEI from the perspective of support people.	• Suitable for exploring processes • Suited to exploring contextually located knowledge • Flexible enough to accommodate unknowns
	To use these findings to guide and inform healthcare policy improvements	• Suitable for evaluating programs and guiding improvements • Creates the rigorous and powerful findings that are important when approaching decision-makers
	To contribute to the growing collaborative pro-choice movement on the Island and help reduce abortion stigma	• Suitable for engaging participants and community members through promoting collaboration

Chapter 4: Theoretical Framework

The main theoretical framework that I draw upon in this thesis is liberation psychology, a theory that brings together mechanisms of oppression and liberation on three levels; the individual, community and structural levels. In this way liberation psychology is similar to the ecological model, which I cover first. I then move on to a detailed description of liberation psychology, starting with the Antonio Gramsci’s theory of ideological hegemony; a concept that was foundational to liberation psychology. The final theoretical framework that I draw from is feminism. Although the rights of women were not originally included as oppressed groups in liberation psychology, both feminists and liberation psychologists have noted the compatible nature of these two frameworks. The focus on dominance, oppression, and breaking the silence as a method of transformative change are integral to both theories. Critical feminist theory is helpful both for its recognition of women as an oppressed group and for the more contemporary studies on the intersections of dominance and multiply oppressed groups.

Ecological Model.

Bronfenbrenner’s (1979) ecological model presents a useful theoretical framework to engage with the effects of marginalizing policy. The model can be used as a tool for understanding and addressing structural inequalities and their individual and community effects. Summed up in the infamous phrase of the sexual revolution of the 1970s– “The personal is political”, is the idea that seemingly personal experiences like abusive relationships or troubling emotions can have systemic, political roots (Moane, 1999, p. 2). Echoing assertions made by early feminists about personal and political connections, the ecological model displays how everyday experiences of oppression are embedded in policies that promote discrimination. In a study looking at Canada’s childcare policies, Canada ranked last of the 14 countries studied for

public spending on childcare for ages 0-6, with just .2% of the nation’s GDP allotted for this category (Early Learning, 2004). While public services like healthcare and education have not kept pace with demand, minimum wage has failed to keep in line with inflation, helping to grow ‘the working poor’ (Maxwell, 2006). Canada’s lack of effective policy surrounding low-wages and childcare help to create “the everyday experiences of violence, poverty, stress, discrimination, and prejudice that are manifestations of oppression” (Moane, 2003, p.92) for young women in PEI. Adolescent women and girls in PEI face the prospect of aggravated poverty and compounded oppressions related to sexism, classism, ruralism and ageism. Canadian policies surrounding child care and minimum wage laws (government decisions made on the macro level) have the potential to deeply affect the personal lives of young women. Nelson and Prellitensky (2010) argue that psychological research too often investigates at an individual, ameliorative level rather than aiming for macro-level or transformative change. However, should collaborators in *Trials and Trails* and its off-shoot organizations reach their goal of changing policy, we will have achieved far-reaching, transformative change. Where Bronfenbrenner’s model stops short is in adequately addressing the processes by which these levels interact, or what strategies are effective in influencing social change. However, the social determinants of health and liberation psychology interface well with the ecological model, and provide further insight into the relationships that can enable social change.

Liberation Psychology

Liberation psychology (LP) takes the position that an individual’s psychology and their political environment are not only linked, but interactive. Therefore, not only can oppression have negative effects on health and well-being, but resisting oppression and instigating political change can be an act of liberation, producing positive psychological effects. The model of LP

involves two cycles; the cycle of liberation (otherwise known as the conscientization cycle), and the cycle of oppression. In theory, the two cycles work in opposition to each other, with liberation and oppression being at opposing ends of the spectrum. Oppression works through four systemic mechanisms of control: “powerlessness”, “isolation”, “internalized oppression” and “lack of awareness”. The antidotes to these mechanisms of control are through “awareness”, “building strengths”, “making connections” and “taking action”, which make up this conscientization cycle. Each of these stages can be activated on an individual or personal level, an interpersonal or community level, or at a political level.

> Liberation is a process entailing a social rupture in the sense of transforming both the conditions of inequality and oppression and the institutions and practices producing them… It is also a political process in the sense that its point of departure is the conscientization of the participants, who become aware of their rights and duties within their society, developing their citizenship and critical capacities, while strengthening democracy and civil society. (Montero & Sonn, 2009, p. 1).

LP research maintains the purpose of overcoming the psychological effects of oppressions on intrapersonal, interpersonal and political levels. However, LP originated from revolutionary ideals of Latin American social sciences and the Roman Catholic Church when the region was enduring a number of brutal dictatorships and it was common for groups of oppressed people to naturally come together in protest (Montero & Sonn, 2009). LP research has gone global, is no longer affiliated with the Church and has a scope widened from class oppression to include to multiple oppressions, acknowledging that oppressions may also be intersecting. One example of the transferability of the premises of LP to contexts outside of historical Latin America is evidenced in a Spanish study involving a group of women from a marginalized neighbourhood who found that through participating in the study, the participants “identified the social injustices that affect them, responded to oppression by prioritizing problems and defining actions, and

developed action capacity by identifying barriers to participation” (Luque-Ribelles, Garcia-Ramirez, & Portillo, cited in Montero & Sonn, 2009, p. 279). While LP posits change as the key to accessing liberation, individuals in the study will not be expected to participate in any collaboration or organizing outside of the study. However, LP is a suitable praxis to engage community-based research with such a community because it problematizes the existing structural barriers and social systems, and creates the potential for collaborative partnerships.

Antonio Gramsci

Marxist philosopher Gramsci’s critical theory of the nature of dominance by the ruling elite was very influential to the originators of LP theory, and his insights into the characteristics of oppressed and silenced societies are helpful to deconstructing PEI’s abortion-related cultural repression. His theory of class rule and the basis of dominance include the powerful concept of ideological hegemony; where “subtle but pervasive forms of ideological control serve to perpetuate oppressive structures” (Boggs, 1976, p. 38). Both cultural attitudes and political structures are shaped by hegemony, which in turn perpetuates a “natural order” that serves to maintain the status quo and power of the ruling class. The extent this ideology is internalized by local culture allows for what Gramsci termed “common sense” to prevail, a condition that is the basis for oppression in LP theory. Gramsci’s theory explicates how a pervasive cultural common sense creates a docile, self-deprived and exploitable public that is unconscious of the dominant power relations or their own capacity for change (Boggs, 1976).

Feminism

Regardless of its legal status, women around the world have used abortion to control their reproduction at every point in history, and in every known society. However, certain eras showed heightened advocacy around abortion and birth control rights. Feminists have been the striving

force in the fight for reproductive rights from its inception. Autonomy and equality for women were at the forefront of the second wave of feminism in North America with theory that made famous the link between personal experiences and political powers. In the 1960s, the US women’s liberation movement formed and became very active in the fight for abortion rights. Through marching, lobbying and speaking out about their personal experiences the women that made up the movement “raised consciousness” about abortion and formed allies with medical professionals – eventually witnessing limited and then expanded abortion access. Canadian advocates organized similarly and doctor Henry Morgentaler spearheaded. The third wave extended the analysis of oppressed groups to include diverse classes, cultures, sexes, genders, and sexualities; recognizing the intersectional nature of these oppressions. Both waves of feminism apply to the current situation of restrictive abortion policies for Island women. A woman’s autonomy is at stake should control of her reproduction be taken from her. Women, and particularly mothers, in western culture are expected to be responsible for a disproportionate amount of childcare and housework, without recognition for these time-consuming tasks (Moane, 1999). Women also generally have lower paid jobs with less security than men. While women account for almost half of the labour force in Canadian society, this percentage drastically drops with each step up the corporate ladder: “After years of flooding into the work place, women now account for 47 per cent of the labour force and 37 per cent of management” (Globe and Mail, 2010). Despite these gains, they remain a small minority at the top of Canada’s top 500 companies and the small presence of female corporate officers has barely budged in the past decade.” This financial insecurity fosters dependence and insecurity, two psychological effects of oppression.

Further, women typically live in fear of sexual violence or harassment, and with reason. While it is difficult to have an adequate estimate of how widespread sexual violence like rape is (due to under-reporting because of fear), studies from Europe and the USA have shown that "up to 80 percent of women worry about sexual assault, and restrict their behaviours out of fear of sexual assault (Gordon and Riger, 1989; Stanko, 1993) Statistics Canada has shown that half of all women have experienced at least one incidence of violence since the age of 16, and 60% of women feel afraid walking alone in their own area after dark (Violence Against Women Survey, 1993). However, this on-going oppression is particularly relevant within the home. Spousal violence makes up the single largest category of convictions involving violent offences in non-specialized adult courts in Canada over the five-year period 1997/98 to 2001/02. Over 90% of offenders were male (Stats Can, 2006). Among the groups most susceptible to violence are geographically-isolated women and young women. Fear of violence is institutionally reinforced through "depictions of high levels of violence against women, and of women as victims, in mass media, popular culture and pornography" (Ussher, 1997, in Moane 1999, p. 41). Women in our culture who are sexually objectified are most commonly young women and girls, also with negative psychological effects (Grabe & Hyde, 2009) and our legal system is not geared in favour of those under the age of majority. Although women in PEI are more susceptible to poverty, class lines are not divided between the genders. As noted earlier, poverty is a major concern for Islanders, and barriers to abortion access disproportionately affect women and girls living under the poverty line. Youth, rurality, and women living with abuse are also more vulnerable to the provinces restrictive policies.

Intersectionality. Second wave feminist Petchesky argues that a woman's freedom to choose is integral so long as conception, pregnancy and child-rearing are more the responsibility

of the woman. However, third wave feminism took issue with the focus on “choice” of previous abortion rights movements citing the exclusion of women who felt they would have made different decisions should their social, political, or economic situations have been different. Instead of “pro-choice” the relatively new term “reproductive justice” emerged late in the 1980’s, coined by organizations promoting the rights of Native Women and Women of Colour. Such a perspective is intersectional because it shifts the debate from individual choice and autonomy to the greater structural sources of inequalities that contribute to social injustices, while also echoing the need for access to birth control. As Hankivsky and Cormier (2009, p. 3) writes, intersectionality

> promotes an understanding of human beings as shaped by the interaction of different social locations (e.g., ‘race’/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created.

A perspective that views inequities as the result of interactions between different social and power relations is very helpful to understanding the effects of PEI’s abortion restriction on women needing care and those who assisting them or advocating for better access. By adhering to an intersectional framework, individual experiences can be linked to the broader cultural context and its maintaining policies and structures -- allowing for research that works toward social justice.

Chapter 5: Methodology

In this chapter I first give my rationale for adhering to the critical emancipatory paradigm. In accordance with this stance, the following section gives my personal reflections on

the central topics to this thesis such as my path to intersectional feminism and my experiences with advocacy and abortion. Thirdly, I show how qualitative design and particularly the method of interpretive phenomenological analysis are suitable to the aims of this research. I then go over the sampling and procedures and finally end the chapter by explicating how these methods are in accordance with the ethical standards of Wilfrid Laurier University.

Paradigm - Critical Emancipatory

The critical emancipatory paradigm focuses on the lives and experiences of historically marginalized people, how and why inequities are reflected in asymmetrical power relations, and how findings of inequity from social inquiry are linked to political and social action (Mertens, 2009). Emancipation from oppression is the ultimate goal of critical emancipatory research, which uses social science as a platform for social change. The values of equality for women and other marginalized groups align well with my broader goal of contributing to the creation of a more equal and just society through research. The emancipatory paradigm values the unique perspectives of those with lived experience and situates this group as essential guides for understanding, querying and deconstructing structures of oppression. Knowledge then must incorporate multiple ways of knowing and be contingent upon the situation of the knower. In this study, I work from these assumptions as they guide the way I collect and analyze my data.

One branch of this paradigm is critical feminist theory, a perspective that assumes a socially constructed hierarchy of privilege that favours men--known as the patriarchy. Unequal distributions of power are not limited to the gender binary but extend to other dominant and marginalized social relationships, with examples not limited to but including; class, age, sexuality and race. This assumption falls in line with the way I see the world and the lens I will be using to frame my research.

Such a perspective is also well suited to investigating the issues of access and advocacy as its overarching aim is that of transforming existing oppressions. The guiding principle of critical research is “an emancipatory interest in knowledge” (Alyesson & Skoldberg, 2000. p.110). Using the results of social enquiry to deconstruct asymmetrical power relations allows for knowledge of the mechanisms of oppressions - knowledge that increases the potential for social and political action. The aim of this framework is well suited to an investigation into the effects of an oppressive policy and the experiences of those working to change it. It also holds potential to provide key insights to help guide advocacy efforts and policy recommendations.

Reflexivity

“Reflexivity as reflection on and critical examination of the research process is central to feminist inquiry” (Kushner & Morrow, 2003, p.36). The qualitative approach demands that its researchers examine their reasons, goals and desires for studying a given topic as well as their motives behind their choice of methodology (Maxwell, 2005). My interest in increasing the understanding of the barriers and facilitators to abortion access in PEI stems from my personal experience and the feminist and social justice values that I ascribe to. Accordingly, my interest in conducting qualitative and community-based research is linked to my desire to practice research as an ally and a collaborator.

I started viewing the world with a feminist lens early on in life. I noted that typical lists of chores were far more extensive for girls than for boys, who simply had to carry a pre-tied bag of garbage the few metres to the garage. This double-standard frustrated me and I began to also see gendered expectations of teenagers in the areas of care, co-operation and prudence. Eventually I extended my critique of these “double-standards” to society, and beyond the gender line to many other constructed categories. Over time and through critical coursework I developed an anti-

oppression sensibility, and values of social justice that align well with those of community psychology.

My undergraduate training in psychology was also unique in its amount of critical courses. The history course explored statistics’ history of eugenics, the developmental course introduced me to the demographic legacy of native people’s cultural genocide, and in the cognitive course’s reader was a critique of mainstream psychology as a mechanism of neoliberalism. However, it was my liberation psychology and social justice course that allowed me to see how my values of social justice and social sciences could finally be brought together. By connecting the personal, interpersonal and political psychological levels, both liberation psychology and community psychology demonstrate how each person is impacted by structural issues, and how individuals can also be influential in the bigger picture.

I also acted as a support person to a close friend seeking an abortion at a very young age by providing her emotional support, a safe place to stay and accompanying her to her procedure. This formative experience showed me the crucial role of support people in accessing abortion s, and deepened my analysis of the need for accessible care. My friend’s care was financially and logistically accessible. When I moved to PEI and learned about the access restrictions, and I could not imagine how much more difficult that would make an already difficult, stigma-ridden and time-sensitive situation.

Also crucial to authentic feminist inquiry is the reflection of one’s insights as situated knowledge (Haraway, 1988). To place myself, I am a white, urban woman and abortion-rights advocate living in PEI. I am also pregnant with plans to become a mother. I am an educated woman holding one masters, one pending, with a lot of debt who is looking for work. I live in a place notoriously difficult to find stable work and a living wage. I also have parents that would

take me in to their middle class home in Toronto if I was desperate, so I consider myself broke but not poor. As an advocate for reproductive rights in PEI I have gone public with my beliefs. By doing so I have possibly made my struggle to find work here more difficult; a situation that is exacerbated by my status as someone not originally from the Island.

My role as a PEI abortion rights advocate holds potential to foster trusting relationships between myself as a researcher and participants that are integral to producing candid conversations and rich data sets (Patton, 2002). The development of rapport is essential for accessing more accurate data; however, the goals of my study go beyond reaching experimental rigour. Built into the design of this study is the aim to counter some of the internalized feelings of blame and powerlessness brought on by the silence and secrecy surrounding abortion, and also to foster relationships that continue to fight the effects of stigma, an objective that community-based research is suited to.

Qualitative Design

Emerging from a perspective that values the voice of lived experience is the conception and development of qualitative research methods. Exploring the factors that facilitate, delay or block timely reproductive care in PEI is best approached by seeking to understand such journeys via those who have lived them. Within the larger study, *Trials and Trials*, the lived experience of abortion access from PEI is interrogated from many perspectives. The sub-section of the study that I analyze is from the perspective of those who have supported access to abortion from PEI by advocates, support people, support workers, fundraisers, and those who accompanied someone to their abortion. The perspective of support people and advocates has been relatively unexplored in research, yet the support of many individuals is needed, especially when the

procedure is difficult to access. As the identification of barriers and facilitators by such support people is hitherto unexamined, this subset of data may hold unique and surprising findings.

Given that PEI’s access policy is not well understood and is shrouded in secrecy, an approach that is flexible enough to allow for unanticipated factors is suitable. A strength of qualitative research is its ability to uncover the processes behind events (Maxwell, 2003), and since accessing an abortion from PEI is not straightforward, research that uncovers processes is favoured. A thorough understanding of the processes behind this area of the healthcare system helps inform and guide improvements, which is one of the broader goals of this research program. See *Table 1* for a summary of how the strengths of qualitative research meet the aims of this research project.

Interpretive phenomenological analysis. Qualitative research is also applicable to the investigation of people’s experiences from within their contexts (Patton, 2002). The proposed study is phenomenological in nature, and will use interpretive phenomenological analysis (IPA) as its analytical method. IPA grounds the understanding of a particular phenomenon on the perceptions of individuals who have lived experience, as well as the meanings and interpretations they attribute to their experience (Creswell, 1998). In the context of my study, the phenomenon of interest would be abortion rights advocacy and personal support in PEI, and the interpretation of interest is abortion access from the standpoint of support people and advocates. The data acquired from the larger study is appropriate for IPA analysis because the interviews used open-ended questions to acquire personally salient results. The identification of barriers and facilitators will be left to each individual interview participant rather than by previous research or my own understanding. The ten interviews of support people and advocates collected from the larger study were the sole source of data for this project. Transcripts were coded in detail, and

did not use a predetermined codebook, instead allowing each participant to have unique codes and themes. My focus was on meaning-making of these codes by suspending my own interpretation and inquiring into the participant’s experience. Limiting the influence of preconceived ideas about the phenomenon being studied is a characteristic of phenomenology known as “bracketing” (Baker, Wuest & Noerager Stern, 1992) that is used to ensure that responses from the participants are respected and that their meanings are preserved. Also in line with IPA analysis is the lengthy process of triangulation undertaken with the advisory committee for each interview. Each participant’s transcript was first examined individually, in detail, with the codes emerging from the data. Only after each transcript was thoroughly analyzed, recurring patterns of importance to the participants that emerged from the body of transcripts were then taken as main themes and an organizing, overarching theme emerged.

Research that is community-based and utilizes IPA involves its participants in ways that are not only meaningful but allow for collaborations between participants, with research programs, as well as related organizations. Qualitative findings are also generated and verified by the examined group through consensus coding and member checking, so it follows that these results are meaningful to the participants and understandable to the broader community (Maxwell, 2003). When findings of such studies are formatted for policy-makers, they tend to constitute powerful policy briefs due to the high level of rigour achieved and the number of researchers involved.

Sampling and Samples

Two sets of participants were involved in this study with qualitative methods employed for each group; 1) ten semi-structured interviews with support people and advocates to abortion

access from PEI and, 2) a subset of five participants from the ten original interviewees interested in participating in a member checking group.

Participants. Support people and advocates are defined as those who have accompanied someone to an abortion, advocated for better abortion access in the province, as well as those who provided financial or emotional support. Although the recruitment advertisement for the study asked for both male and female support people and advocates to participate, only women came forward to participate so both samples in this study are entirely made up of women. The majority of the participants worked as support people and advocates as part of their role at a volunteer organization or as a part of their work. Participants worked or volunteered for the following organizations: CARAL, Women's Network, Child and Family Services, PEI Rape and Crisis Centre, Women's Shelters, PEI Government, PEI Planned Parenthood, Native Affairs, as well as other non-identifiable agencies or organizations. This pool of participants offers a wide of knowledge and experience that spans from the early 1980s to the present, contributing a rich and full scope of data for this project. Often the advocacy and personal support that the interviewees spoke of were from an earlier decade or an organization that is no longer in existence, such as Planned Parenthood or CARAL. Some participants have been involved in the fight for reproductive justice over a twenty year time span and continue their work in the present, allowing for deep analysis and insight.

Semi-structured interviews. Ten semi-structured interviews from support people and advocates have been collected by the principal investigators of *Trials and Trails*. These semi-structured interviews have been digitally recorded with the participants' permission and the approval from the ethics board at the University of Prince Edward Island.

Member check. Approval from the ethics board of Wilfrid Laurier University was granted for this section of my study (Appendix C). Information-rich (Sterwig & Stead, 2001) participants were recruited from the support people and advocates subsection of the *Understanding for a Change* study, and a subset of five of the support person and advocate interviewees participated in member checking of the findings. The conversation was recorded by note-taking with the group’s permission. The group of five participants was small enough to foster candid dialogue, but large enough to give voice to a variety of perspectives.

Procedures

Interviews with support people and advocates. The larger study used a semi-structured interview guide for the interviews with support people. These ten interviews focused on the experience of supporting people in assisting access abortion from PEI. The interviews ranged from one hour to an hour and a half in length and were conducted in a private, comfortable location by the two principal investigators of the larger study. Analyzed in the current study, the findings from these key informants gave the larger perspective to the phenomenon explored, which helped identify overarching trends. The common themes identified by this set of interviews assisted in the development of the member check group guide, and ensured noted experiences, barriers and facilitators to access did not go unobserved.

Member check group for consensus coding. In order to ensure an analysis of quality and rigour, the principal investigator of the current study conducted a member check group with a subset of five of the support person and advocates interviewees. A semi-structured conversation guide was used for the member check group (see Appendix A member check guide). The member check meeting attended to the barriers participants observed when assisting abortion access as well as their own experiences of advocacy and personal support. The member

check meeting took two hours and was located at a private and comfortable space in the community. As recommended by Miles and Huberman (1994), the meeting was used to check that the meanings of the participant’s words were accurately interpreted and to verify that the investigator’s emerging theories were sound.

Ethics

Risks to both researchers and participants included emotional harm. Due to the sensitive nature of abortion, the phone number of a counsellor from the PEI Rape and Crisis Centre was given to participants at the beginning of the member check group and she was available for counselling at all times. I made sure that a trusted friend was available for my own debriefing.

By the nature of member check groups, confidentiality could not be guaranteed, so there existed a slight possibility that anonymity of the participants would not be protected. However, these risks are quite small and in the opening to the meeting participants were asked to verbally agree to confidentiality, as well as being reminded that confidentiality could not be guaranteed. A reminder of the researcher’s duty to report child abuse or suspected child abuse was also given before the meeting began.

Chapter 6: Analysis

In this chapter I review my means of data analysis, beginning with my rationale for using a phenomenological style of analysis. I then go over the various means of credibility checks employed in this thesis, including a process of consensus coding and the member checking of findings.

Data Analysis

To analyze the data I used interpretive phenomenological analysis. (Baker, Wuest & Norager, 1992; Smith, Flowers & Larkin, 2009,). This analytic approach allows for a feminist

social analysis and is “especially useful when one is concerned with complexity, process or novelty” (Smith & Osborne, 2007, p. 55). IPA posits that an experience can be understood through examination of the meanings which people impress upon it making it an appropriate tool for examining human lived experience (Shinebourne, 2012). In order to respect the experience of each participant, a careful and thorough analysis of each case is conducted before moving to a general, nuanced account of themes across participants.

All transcripts were recorded verbatim. Using the qualitative data analysis software NVivo, all interview transcripts were coded. At the coding stage, the initial step was to become familiar with each transcript at a time by repeatedly reading the text and recording margin notes on points of interest (Smith & Osborne, 2007). The primary focus in interpreting the interview data was to identify the forms of barriers and facilitators the participants have found or witnessed in their experience as support people and advocates, the effects of these barriers and facilitators, and each participants’ personal experiences of personal support and advocacy. Coding did not follow a predetermined codebook, but instead codes emerged through meticulous attention to each transcript. Codes were determined via thorough examination of participants’ experiences and the meaning-making attributed to such experiences. For instance, should a participant express their anger over the lack of information about abortion provided by doctors, the codes of “anger”, “lack of information” and “physician” would be created. As the number of codes grew, organizing themes become more apparent for each interview. For instance, the code “barriers” was an umbrella code for many types of obstacles to access, such as stigma, poverty, hospital policies, travel, etc., and the umbrella code “facilitators” included emotional support and accessible transportation, among others. Similarly, the code “effects of barriers” included stress, financial effects, delayed care, etc.

In accordance with the critical questioner process put in place from the larger study, a summary of codes and analysis for each individual interview was securely forwarded to a member of the advisory committee, along with a copy of the original transcript, who then edited or added to the analysis of the themes. In this way, the data was collaboratively interpreted and categorized by the researchers. After this stage of coding was complete, the entire body of data was evaluated to determine commonalities, irregularities, over-arching themes, linkages and the like (Coffee & Atkinson, 1996). The “culture of silence” emerged as the constitutive theme that served to organize the data. The main themes of participant’s experiences and the barriers and facilitators to abortion access emerged as the two main themes to which many subthemes belonged. This step by step process of coding and finding themes served to not only categorize the data but more importantly to help identify the characteristics, dimensions and relationships (Coffee & Atkinson, 1996) of abortion access, effects, and the experiences of support people and advocates. At this time the analysis was compared with previous research and theory, and serves to contribute to our current understanding on the subject as “basic research” (Struwig & Stead, 2001).

Credibility Checks

Triangulation was used in a few different ways to ensure credibility in the proposed study (Patton, 1999). The viewpoints of support people and advocates sometimes differ: support people are defined as those who helped someone access an abortion by giving information, fundraising or accompanying someone to their termination, while advocates have embarked in educating, organizing and speaking out for reproductive rights. While many participants identified with both roles, a few were exclusive to one or the other. Therefore, a range of perspectives came together to yield common themes in the findings (Shenton, 2003). As well, by using the system

of consensus coding in place in the larger study, triangulation took place between myself and the advisory council. After coding each transcript I shared the bare transcripts and a summary of my themes with two members of the advisory council. Each member then also interpreted the data independently, as well as adding to, confirming, critiquing or editing my themes. Finally, triangulation of all participating members was reached at an in-person meeting where the themes were finalized. This process of consensus coding has set a precedent in generating succinct and meaningful themes for *Trials and Trials,* and the advisory council participated in this format for my subsection of the data.

I also sought out the opinion of our interpretations from the participants through member checking (Miles & Huberman, 1994). As discussed earlier, this meeting was recorded through note-taking for key decisions by a member of the advisory council, and notes were interpreted for verification of the findings. No new data from the member check was added to the findings, however, I used the member check as an opportunity to verify any thin or unexpected themes to check the accuracy of my interpretation of the participant’s words, and to ensure the quality and rigour of my analysis.

Chapter 7: Findings

The data from the ten interviews of support people and advocates covered a very wide scope of material, subject matter, and opinions. However, two very clear main themes emerged from the data under a third, constitutive that organizes and brings together each theme and subtheme. The overarching theme is the culture of silence, and is addressed last. The two main themes that spring from the overarching theme are: 1) The effects of cultural silence on the experiences of support people and advocates, and, 2) The effects of cultural silence on abortion

access. Each main theme and the overarching theme are comprised of several subthemes. Table 1 summarizes the themes and sub-themes that emerged from the interview data.

Table 1

Emergent themes

Theme	Description	Exemplary quote
Theme 1: Effects of Cultural Silence on the Experiences of Support people and Advocates	This theme describes how PEI's current cultural silence on the subject of abortion personally effects support people and advocates as they endeavour to help secure access for individuals, and advocate for access on community and structural levels.	"There's an awful lot of people on campus in this situation who are scared to say anything about much of anything. .. So there's this, I think, in a culture like PEI, to some extent it's inherently silencing."
Theme 1: Subtheme A: Support Roles	This theme describes the roles the participants filled in supporting women needing access, including: giving information, fundraising, counselling and emotional support, as well as education and advocacy	
Theme 1: Subtheme B: Emotional Effects of Support Work	This theme shows the range of emotions felt by the participants in their work supporting women, including shock, anger, stress, burn-out, fear, isolation, pride, and fulfillment.	
Theme 1: Subtheme C: Risks and Repercussions of Support Work	This theme demonstrates the risks and repercussions of supporting women and advocating for access, including judgment, hostility, being cut-off from the community and job insecurity.	
Theme 2: Effects of Cultural Silence on Abortion Access	This theme describes how PEI's current cultural silence on the subject of abortion effects the various aspects of accessing an abortion, including: finding information, the doctor's referral, the ultrasound, privacy, travel, and expenses.	"the system saw it as justifiable, because they're saying the fetus isn't viable. "It's not going to survive, why put the mother through a full term pregnancy. Let's give her the option of aborting. And then there was all kinds of supports".
Theme 2: Subtheme A: Facilitators to Access	This theme provides a description of the facilitators to abortion access from the perspective of support people. Facilitators identified are: financial resources, the "justifiability" of the	

	need for abortion, and connections.	
Theme 2: Subtheme B: Obstacles to Access	This theme provides a description of the obstacles to abortion access from the perspective of support people. Obstacles identified are: Lack of information, lack of financial support, obtaining the doctor's referral and test appointments, "justifiability" of abortion, stigma, travel, lack of confidentiality, youth, lack of connections, and timing.	
Theme 2: Subtheme D: The Effects of the Facilitators and Obstacles to Access	This theme shows the effects of the facilitators and obstacles to access from the perspective of support people, including delayed care, blocked care and compounded oppressions. • Delayed care had further effects including stress, later term abortions and their health risks • Blocked care was shown to result in stress, self-induced abortions and their and higher levels of FAS in children • Compounded oppression was shown to heighten inequality based on age, gender and SES	
Theme 3: Effects of Cultural Silence on Policy Change	This theme describes how PEI's current cultural silence on the subject of abortion effects the movement to change provincial policy from restricting access, to providing facilitated and/or local access.	"I re-posted [Study Advertisement] to my Facebook profile: No comments whatsoever. I thought that was really interesting. So people are again, really afraid to come out about this in any way. Like, even to "Like" or say "This looks like a good project," people were just: "Shhhht."
Theme 3: Subtheme A: Cultural Silence	This subtheme demonstrates the different ways that the cultural silence on PEI results in internalized stigma, secret abortions, and a blanket of silence from press, politicians, first—voicers and support people.	
Theme 3: Subtheme B: "Pro-life" vs. "pro-	This subtheme shows how the anti-choice movement endeavours to maintain the status quo on abortion	

choice"	access on PEI, including strategies as labelling the Island as a "life sanctuary", using hostility, and upholding a misogynistic culture. This theme also shows how the "pro-life" vs. "pro-choice" divide encourages silence on the topic.
Theme 4: Subtheme C: Policy Change Strategy	This theme provides a discussion of the policy change strategies suggested by the participants, including: breaking the silence by encouraging dialogue, depolarizing the two stances, expanding education, sharing stories and engaging government.

Theme 1: Effects of Cultural Silence on the Experiences of Support people and Advocates

This theme describes how PEI's current cultural silence about abortion personally affects support people and advocates as they endeavour to help secure access for individuals, and advocate for access on community and structural levels. Theme 1 includes three subthemes:

1. Subtheme A: Support roles
2. Subtheme B: Emotional effects of support work
3. Subtheme C: Risks and repercussions of support work

Theme 1: Subtheme A: Support roles. The participants cover a wide variety of experiences and roles through their advocacy efforts and personal support. Most often, these roles are a part of their work for an organization that supports reproductive justice, or through volunteering with a (now defunct) regional chapter of the Canadian Abortion Rights Action League (CARAL). The names of the organizations that participants worked for have been omitted to protect their privacy. As people that have direct contact with a number of women going through the sometimes arduous process of accessing an abortion in PEI, they have a rare

vantage point. Many participants were able to point out patterns, often with high levels of insight and analysis into the structural causes of these difficulties, as well as the effects for Island women. In many interviews the participants' experiences covered a plurality of roles and their collective experience spanned multiple decades, from the 1980s to the present. Support roles included giving information, emotional support, advocacy and educational work, accompaniment to the abortion, organizing the logistics related to abortion referrals and travel care, as well as fundraising. One participant who also advocated for local access and helped run an information line summarizes the different roles she took in helping women access abortion, including providing financial aid, emotional support, and being a confidant for women in need.

> *I answered a lot of phone calls for many years, one of the things that we did was to have an information line that women could call and get information about abortion services and ask for help if they needed it financially. So CARAL actually raised money and supported women, gave them a little bit of money to travel off-Island or pay for their abortions if they needed it. That became a really important function of our group. I talked to a lot of women on that information line over the years who just felt like they couldn't talk about this with anybody else. So even when I wasn't promising to get money for women, it was still an important conversation, because they had—they didn't want to talk about it with their families, they didn't want to talk about it with their friends.*

Giving Information. Giving information about how to access abortion emerged as the most common area of support provided by support people and advocates, a role that was not limited to the directly affected women themselves, but also to their family and friends. For example, one advocate relays explaining the process of accessing an abortion to a family member of the anti-choice movement when he had no information about how one might obtain an abortion from PEI:

> *The mother was very active in the Catholic Church, and in fact active in the anti-choice movement, and very much against abortion in every possible way. And I remember that this man called me and he told me, "My (teenage) daughter is pregnant… and I've been soul-searching about this for several days and I'm calling you to ask you, if she wants to get an abortion, how do I do that?"*

This dearth of available information on this procedure is evident in many interviews, which is revealing of the silence surrounding abortion in PEI.

Emotional Support. Being a purveyor of information about this heavily stigmatized topic would naturally overlap with acting as a confidant by giving emotional support to both the women and those connected with them through open listening and validation. Several participants also reported that women they gave access information to would say that she has kept her pregnancy or abortion a secret from everyone else in her life. This participant describes acting as the only confidant to a client who had extreme difficulty letting out her secret:

> *I just remember her pain, and I remember her fear, telling me, and it just broke my heart that she was so afraid to tell someone, and it all had connected to other things in her life, that she really felt that she needed to share that in order for people to get the bigger—you know, for me to understand her bigger picture.*

The above excerpt speaks to the fear of judgment and isolation felt by some women who have experienced an abortion and are unable to share their experience. It was very common for the participants to be the first to person to hear of the problem pregnancy. By listening and validating women in their choices, the advocates and support people often provided a safe space for women to share their abortion decision, showing women that breaking their silence can be judgment-free and restorative. Sometimes lending a supportive ear gave the affected woman enough confidence to then tell some of her established and trusted connections like family or friends, broadening the bubble of resistance to the cultural silence.

Activist and advocate. Although the participants were varied in their levels of disclosure about being pro-choice and vocally advocating for change, most were comfortable with some level of speaking in favour of reproductive rights. Most had their own ways of advocating for change, including protesting, writing letters, television and radio appearances, and sharing

personal stories on a one on one basis. The following advocate speaks of how she uses her anger about the issue to fuel her work as a public educator:

> *I am angry about this issue, but I have to use my intelligence and my compassion and my insight to be a teacher in this field, is what I think, and an educator. So that’s how I see myself currently.*

Fundraiser. The women calling CARAL often needed financial help to access their abortions. Confidential and efficiently processed abortion services could be found at the Morgentaler clinic, a service that costs upwards of seven hundred dollars. However, the travel, child care, overnight stay and bridge add up to, at minimum, two hundred dollars and are in addition to that fee. For women who succeed in booking an abortion that is covered by health care, the time and money needed to travel to Halifax and back may be out of reach. Support people and advocates sometimes play the role of financial provider to these women in need, often through their own pocket and a casual network of abortion rights supporters willing to pitch in to help. One participant explains the informal process of fundraising for a woman in need:

> *We would fundraise. And it was literally our friends, right? So you would get on the phone, and you would call your four or five friends, and hope that they’d all give you fifty bucks, and we would do that kind of very basic grass-roots fundraising to raise money, because sometimes the women would say, “Well, I have two hundred dollars, but I need x.” I can’t remember how much it cost at that time, but it was quite a bit of money. And then you, of course, would need to pay for transportation, and potentially accommodations, and that kind of thing. So yeah, we would try to find money, usually out of our own pockets and other people’s pockets.*

Some participants who worked for different government and non-government organizations would fundraise for the women by applying to these agencies for financial help on behalf of these women. Here a participant explains how she would approach a variety of different agencies for financial help in order to assist women in need of abortion care but without the funds:

> *I also sat on the board. Community legal information, AIDS PEI, the Rape and Sexual Assault Centre. It was just understood that I had resources, that I would fight hard and that I had no concern. If somebody needed something … I just kept pushing on the door until someone gave me what I wanted.*

Organizer and Accompaniment. Participants also acted as an organizer for women in need; sometimes arranging appointments, affordable places to stay, and occasionally accompanying women to their abortion

> *I helped secure them a place to stay that was cheap and then getting transportation helped out with and that kind of thing and then I went (to the abortion clinic) with them again.*

Theme 1: Subtheme B: Emotional Effects of Support Work. The effects of abortion stigma on abortion rights support people and advocates not yet been addressed by research. However, findings show that support people and advocates may also be affected by the same stigma that the women they endeavour to help experience. Several strong emotions and themes emerged when investigating the experiences of support people and advocates to abortion in PEI. These emotional effects of advocacy work in this heavily stigmatized area included shock, anger, stress, burn-out, fear, fear, risk, fulfillment and community belonging.

Shock. The majority of the participants were not originally from the Island, all of these whom described a very strong sense of shock upon discovery of the lack of abortion access on the Island and how difficult it was for women to attain one.

> *Coming here and seeing what people go through was shocking to me. [laughs] Like, totally shocking to me. You know, I couldn’t believe that a person did not have the right to access abortion here.*

For the participants not originally from the Island, this realization and subsequent shock sprouted the need to advocate for change in this area where they had not considered such an endeavour before moving to PEI.

Anger. Frustration and anger are the most prevalent emotions that emerged from the data, with most participants clearly stating that they feel angered by the present situation on PEI, and that their anger is rooted in their dealings with women who are failed by PEI’s present health care system and the Island’s cultural silence and blame surrounding the issue.

> *I get information from everywhere and so the fact that we’re a women’s organization, I hear about people wanting to access services and not being able to or it being prohibitively difficult which fuels my personal outrage (laughs), which I’ve always had, and now I have the professional layer on top of that which just makes it just more developed rage. It really upsets me. It’s really upsetting, you know?*
>
> -
>
> *I just really believe so passionately that no one should have to have a child they don’t want to have. So I just—and it just makes me mad. I’m whispering, sorry. This whole thing just makes me mad. I’m whispering. [laughs]*

Anger emerged as a reaction to the injustice of PEI’s abortion restrictions and obstacles and particularly the effects on those living in poverty or otherwise marginalized. However, anger was also strong when participants spoke of the lack of control they face as they assist women in a system that appears to be designed against them. Support people and advocates often worked to help women through the referral system, which was fraught with many obstacles and delays.

Stress. Many participants spoke about the stress and frustration involved in supporting, advocating, organizing or accompanying women in a system that seemed to create obstacles instead of facilitating the medical procedure. A participant speaks about the stress accompanying the uncertainty of whether the woman she is trying to help will receive the support she needs:

> *I found it extremely stressful as an advocate, to be trying to get her service in this time-frame that—I mean, you had no control over it. It’s just, that’s what it was. It had to be done within that time-frame or it wasn’t going to happen. And then what does that mean for her?*

Further, the participants sometimes accompanied women through these heavily stigmatized, under-cover and sometimes emotionally painful procedures. Here a participant expresses how helping women in this situation without systemic obstacles would ease the stress involved in this work:

> *As a women’s advocate, as a woman who works with women all the time, I just—what a comfort that would be as a support to women, to know that I could make that referral and it would be smooth for her.*

Burnout. Support people and advocates often worked to help women through the referral system, which was fraught with the difficulties including; finding a supportive doctor and referral, getting a timely ultrasound, as well as travel, expenses and childcare. Of all the red tape encountered by helping over ten women access an abortion, one participant expresses her feelings of exasperation:

> *They just give you the run-around so long that you just go “screw this I can’t do it anymore”.*

Further, the participants often encountered difficulty navigating open expression of their abortion stance and related work. Those who did speak out for abortion rights sometimes felt hostility from the community or experienced other repercussions. The judgement that support people and advocates experience also added to the feelings of lack of support, stress and burnout:

> *[being a women’s rights advocate] just becomes synonymous with being malcontent and going against the grain and it’s like, I don’t know, it feels futile.*

The hopelessness in this statement is another indicator of burn-out and compassion fatigue often associated with the helping professions. The participant also speaks of being perceived in PEI society as underappreciated and maligned for her contributions.

Fear/Risk of Speaking Out. The decisions that the participants face related to the issue of disclosure about their work and their stance on abortion showed a strong tension in the individual interviews as well as across participants. For a variety of reasons, some decided to privately support women and girls in need of an abortion, while some decide to speak out. Although she is

openly pro-choice, one participant believes that many are not vocal about their beliefs because they assume that expressing one's pro-choice view carries great personal risk:

> *I just think that there's a perception out there that the personal risk is too great in standing up and speaking out about this issue, probably more than any other issue.*

Another participant recalls a young abortion rights advocate speaking publicly about her own abortion experience and reveals her fear about repercussions on her behalf:

> *I was thinking of that young woman that went on CBC radio and talked about her [abortion] experience, I was thinking "Oh my God she's so brave" I could hear the nervousness in her voice, but wow. I wonder if she knows, obviously she knows what she's opening herself up to.*

These statements show that being a public advocate for abortion rights, speaking about one's abortion or being openly pro-choice are commonly perceived in PEI as putting oneself at risk.

Fulfilment. Those who publicly advocated for abortion rights on PEI experienced a range of community reactions. A few advocates spoke about being surprised about the lack of negative feedback and hostility as a result of their advocacy work. Some also experienced positive feedback from the community. One participant recalls one such example with surprise and pride:

> *I picked up the phone, and I heard this elderly man on the other end asking for me by name, and I thought, "Oh, boy." And I said, "Well, this is she." At the time I think he would have been in his seventies. And he said, "I just wanted to tell you how pleased I was to see you on television tonight, and I think that's really important what you're doing." And I remember just kind of staring at the phone and going, "Wow, thank you." [laughs] So that was the only phone call I ever got at home—from an elderly man, but to tell me that he thought I was doing a good thing.*

In this narrative it is clear that the participant was expecting negative feedback about her advocacy, but was shocked to find an offer of support in its place. The experience of advocacy without negative repercussions and some examples of positive community reactions was rare in the group.

Community Belonging. Another benefit to advocacy and personal support to abortion rights in PEI was membership in a progressive community. In particular, participants spoke of

making friends with people with like-minded, feminist views beyond abortion. One participant speaks about being quickly accepted into one such group through her advocacy work:

> *It was actually a wonderful way of meeting really great like-minded women (laughs). Because you know how they say it can be hard to um sort of get… that islanders are friendly to a point but they don’t really take you into a community. And I didn’t have that experience at all, in any aspect of me being here, but it was certainly a great way to meet like-minded women and some men, in a short period of time. So that actually was great.*

Theme 1: Subtheme C: Risks and Repercussions of Support Work. While some participants spoke about the lack of anti-choice backlash and were surprised to receive support in their efforts from the community, many spoke of self-silencing and limiting their advocacy because of hostility, judgment, and risks to their work and job. Some participants link the backlash to a discontinued job, financial support being withheld, and being shunned by powerful community members.

Hostility and Judgement. A very common theme that emerged was the hostility and judgment advocates and support people felt related to speaking about or advocating for abortion rights. One participant recalls her fear and the hostility at the historic meeting about abortion when the two Hospitals were merging:

> *I remember actually being terrified when I was there, because the hatred in the room towards anybody that was pro-choice, and the anger and the hostility, and the evil jeers and looks, and that’s probably when I really realized the bigness of the political issue of abortion on PEI. I really believe it’s a political issue as well as a human-rights, women’s-rights issue. It was a very frightening experience. I remember feeling like I had to be brave to identify myself as a pro-choice person in PEI at that time. And there’s still times when I feel that it could be a dangerous thing to be associated with very vocally, speaking out as pro-choice. It’s not a friendly place to be a pro-choice person, politically.*

The participant’s description of being vocal denotes a dynamic tension related to disclosure of one’s views, with the more public display of one’s views being the more personally dangerous. In this excerpt, she goes on to say that being “very vocal” about one’s pro-choice stance on PEI may still be dangerous.

Organizational Funding Insecurity. Few organizations on the Island are openly pro-choice. One reason for this silence may be that some organizers perceive a risk to their local funding. One participant who works for a non-profit organization supporting survivors of sexual assault recalls how a regular contributor threatened to withhold funds because of the organization’s pro-choice policy:

> *Recently I had someone come to my work and say, “My group may not be comfortable to make a donation here because we’ve heard that you—” how did they say it— “we heard that you support abortion”*

Job Insecurity. Some participants expressed concerns about speaking out as a risk to their employment. Here a public advocate for abortion rights speaks of a time where her boss received a complaint and lost a client because of her extra-curricular advocacy work. Shortly after that, she and her boss decided it was a good time for her to take a break from work:

> *There was one instance where my employer was contacted and told by a client that , if she had someone working for her with so little respect for human life, then the client [couldn’t trust her with her business] (edited for privacy). My employer was supportive of my speaking out [re access], but at that point we came to a mutual decision that I would stay home with my toddler for a while longer...*

Work Insecurity. Advocates who were open about their views sometimes experienced impediments to important work tasks.. One participant explains how organizing events can be negatively affected by her advocacy:

> *[A community leader] has refused to participate at events that I’ve hosted, where I would want a group to come and do an opening… one of my youth was coordinating the AIDS walk. She wanted a group to [perform] an opening for the AIDS walk. When this person found out that I was associated with it he refused to have anything to do with it.*

A few other support people kept quiet about their stance on abortion expressed regret about not being able to do more open, pro-choice advocacy. Often, these advocates attributed their lack of speaking out to the potential work-related ramifications.

> *This is terrible to say. I didn’t go to the rally, I made a choice not to go to the rally, as part of a [organization with a religious affiliation] (edited for privacy). So I have to kind of pick and choose, so I thought, OK, I can’t be at the rally, I can’t do public support, because I can’t do, but that’s why I’m doing this interview, because I see it as an issue of social justice*

Cut off From Community. Another fear among advocates is that they may be cut off from various communities, including their workplace, neighbourhood, or extended family. Here a participant speaks of how she was shunned by important community members because of her pro-choice views.

> *There are important members of the community that won’t speak to me because I do this type of work.. I mean just by speaking to me, you’re acknowledging that you support reproductive justice. Because that’s sort of what you get known for. You get known for what you’re willing to go out on a limb for.*

Theme 2: Effects of Cultural Silence on Abortion Access

This theme describes how PEI’s current cultural silence on the subject of abortion affects the various aspects of accessing an abortion, including: financial resources, privacy, finding information, the doctor’s referral, the ultrasound, travel, and expenses, as well as the effects of these barriers and facilitators. This theme includes three subthemes:

1. Subtheme A: Facilitators to Access
2. Subtheme B: Obstacles to Access
3. Subtheme C: Effects of the Facilitators and Obstacles to Access

Theme 2: Subtheme A: Facilitators to Access. Facilitators to abortion access identified by support people and advocates are: financial resources, privacy, the “justifiability” of the need for abortion, and secret, local access. It is clear that financial resources and privacy are the main facilitators to abortion access and that these two themes are deeply connected, with money being able to buy you a more timely abortion and confidential care. Further, if you have a need for an abortion that is deemed more moral, such as the case where the fetus had abnormalities, the

referral procedure can be very well supported. Finally, in one instance, secrecy and connections were found to be the key to local, surgical access.

Privacy and financial resources. The system in place at the time of this study included two main routes to abortion care: 1) The private but costly Fredericton clinic, and 2) The Halifax Hospital that requires a referral, blood work and an ultrasound before booking an abortion appointment. This system division is relatively kinder to those with the financial backing. The majority of the participants spoke about how people with access to money had little trouble accessing their abortion care. In tandem with timely and accessible care, women in the higher SES bracket encountered little risk to their confidentiality. One participant explains:

> *They just say they’re going away for the weekend. “Going to Moncton, shopping!” [laughs] And they head off and have a procedure and come back, and nobody’s really any the wiser. Right?*

Here another participant points out how finances allow women in need of an abortion to circumvent all the wasted time waiting for an appointment with an Island doctor, obtaining the referral, accessing the blood work and ultrasound tests.

> *It’s really not as big an issue—except that it’s not accessible and it should be—for people who could afford to just take the money out of the bank and go over and have whatever done that they need done, right? And there’s generally not the whole waiting thing that would need to be happening with somebody who doesn’t have the access to the money, right?*

For women that did not have the money to access the services they needed without help, participants drew attention to the disclosures of private information that were inherent in the systems that were there to assist them, including in abortion help groups like CARAL, as well as the health care system, social assistance, and native affairs. While these services are often facilitators to access, they are also a barrier by requiring compromised privacy for a woman seeking an abortion. A participant speaks to the double bind women are in seeking assistance when they came to her at CARAL:

> *There was an actual form they had to fill out, we had to fill out with them asking questions about their income and stuff like that. So it was a little bit intrusive, I thought.*

Although CARAL and subsequent abortion rights organizations have made efforts to protect the identity of the women seeking help from the majority of the group, the women would sometimes need to work with a few different people and as described above, give personal information about their circumstances or financial situation in order to obtain the help they needed. This was in place to protect the organizations from providing funds under false pretenses (personal communication with ARN, 2012).

The pattern of breaches in confidentiality through the Island's organizations underline the connection between financial resources and privacy, where applying for financial assistance often means forfeiting one's anonymity.

Doctor's referral. Another facilitator to access was provision of a referral by a local physician. A participant explains an instance of where a doctor was supportive, ensured a woman's privacy and facilitated her progress through the system:

> *Her family physician treated her quite well, and jumped on getting treatment and doing whatever right away. And the obstetrician-gynecologist was extremely professional and took care of things, and sort of told her what it might mean for her in the future, and gave information in that way, was very conscious of protecting her privacy, right? Because I know I was there at one point when the doctor came in and wanted to talk, and said, um, "Could you leave the room while I talk?" And the person said, "Oh, she can stay." So they were not going to disclose any personal information or, you know, talk about why she was actually there, and what was going on, in front of anybody.*

Advocates and support people played a part in supporting this process by giving information to what doctors were willing to refer for the procedure. It follows that those with access to the right information or the right people would be able to access a pro-choice physician and referral more easily.

"Justifiable" abortion. The only participant in the study who does not identify as an advocate (and who does not identify as "pro-choice"), but who acted as an ally was privy to a referral process that went beyond simply offering a referral to abortion care, but also supported the process organizing funding and accompaniment support through social services. Here she explains the support she witnessed for a woman who was referred to Halifax for an abortion by her physician because the fetus was not likely to survive outside the womb. She explains how the referral was taken care of by the system, how the hospital staff were extremely supportive and how the abortion was treated in a medical manner. The ally describes the procedure she supported as a "justifiable" abortion, for both her and the PEI hospital staff:

> *The referral process and everything was really good because people thought it was a justifiable abortion, right? So I think they're situation would've been different than a lot of other women that were requesting one. In this case it was being recommended by the system. I think people were so much more supportive, she got a referral right from her obstetrician gynecologist, there was no question, no giving two doctor's names and all that kind of stuff. And it was like getting results, like you might have cancer so we're sending you so Halifax to get a second opinion kind of thing… I think that's how the system saw it as a justifiable one, because they're saying "The fetus isn't viable. It's not going to survive, why put the mother through a full term pregnancy. Let's give her the option of aborting". And then there were all kinds of supports. They were just, they were really lovely at the hospital and supportive.*

Her explanation implies a lack of moral judgement for all those who were involved in this woman's care. She also points out that should the woman have been requesting an abortion, her care may have been more hands-off, judgmental and less streamlined.

Secrecy and local access. Secrecy was shown to be a facilitator to local, Island access to abortion. In one instance a participant spoke about how one may be able to receive a surgical abortion on the Island if it is done in secrecy, holding the culture of silence in place. Medical abortions are also available to women on the Island if they know the right doctor and are sworn to secrecy, as the doctor performing these does so anonymously. Also, Island women have

resorted to clandestine and self-abortions through physical harm or ingesting dangerous amounts of chemicals (MacQuarrie, 2013), all of which function under the veil of secrecy.

> *Interviewer (I): that's interesting you're saying that um in some instances you've heard of, or gotten word that maybe abortions are being performed here but they're being performed under the guise of D and C.*
> *Participant (P): Oh I know they are.*
> *I: They are.*
> *P: Yup.*
> *I: Oh interesting. Very interesting. I hadn't heard that yet.*
> *P: Yeah. I know of at least one… And that physician is my physician. She didn't do it for me but she didn't tell me. This person, we have the same physician. And I would label that physician as a very empathetic person… So to me when they did this for that person that was, that person doesn't always make the best life choices but had four children already and is living in poverty so, she did her a great favour for that person's mental and physical health and for that of her family.*

Overall, it is clear from the findings that the ultimate facilitator to surgical abortion access is money. Financial resources facilitate a timely and private abortion, although travel is still a barrier. Should one enlist the help of a support organization, or to go through the public health route, one risks losing their confidentiality. Being connected to the right people or being privy to secret information like who may perform medical abortions or a local D and C are also facilitators to local access. The effects of these facilitators are that wealthy and connected women are able to get timely access, while women with lower SES are left to pay out of pocket, risking their anonymity and humiliation, as well as a host of other barriers described in the next section.

Theme 2: Subtheme B: Obstacles to access. This theme provides a description of the obstacles to abortion access from the perspective of support people and advocates. In accordance with the facilitators to access, the strongest obstacles to abortion access that emerged were a lack of financial resources, followed by privacy. Obtaining a doctor's referral, lack of information, unnecessary tests, abuse, and red tape were also cited as common obstacles to access.

Lack of financial resources. Obtaining an abortion from the private clinic in Fredericton is often the only way for women to access abortion care, as the health care covered route requires jumping a series of obstacles in a very tight time frame. For one, obtaining a doctor's referral is a mysterious system to navigate, as there are no guarantees that one's doctor will be supportive. Abortion surgery is time-based, with earlier care being the least involved and least expensive. However, an embryo must be at least seven weeks in order for the surgery to be possible. Also, both the Halifax and Fredericton clinic have a 14 week gestational limit for the procedure, leaving less than two months open for a surgery date. Delays in detecting the pregnancy or delays in the process of obtaining a health-care covered appointment may mean that a private and costly appointment is the only route. In the following example, a participant recalls a difficult time financially supporting a woman in need:

> *I had a client who wanted to get an abortion and, I mean, we just had to jump hoops for this woman in order to— we had to get money from somewhere else. She went to her physician but there was nothing happening there. Income Support: they couldn't help her with funding to go somewhere to get one, and we eventually ended up calling CARAL, and there was sort of a—I don't know if they collect money from people, or if they had a little bit of money at the time, but they were able to give a little bit of money towards it, and the woman ended up having to borrow it from somebody in order to go across.*

In addition to the stress involved with having to appeal to a number of different sources, applying for funds takes time that moved the woman along in her gestational period, putting her at greater risk of being denied abortion care.

Concerns with privacy. Privacy and financial resources again show a deep connection as those who go through the public health system have their name put on a hospital list that is accessible to medical staff., Those who have to go through agencies like Child and Family Services, Social Services, Native Affairs and other organizations have the potential to suffer humiliation through a privacy breach, confrontation, or public shaming. In the following

example, a participant recalls accessing funding for abortion care through one such organization, a process that required compromising the anonymity of the woman she was assisting:

> *I: So what was involved in getting those resources?*
> *P: Well it completely blew this woman's anonymity. So I had to apply for non-issued health benefits. Which paid a portion of it, but I had to go through the community leader. There's history between this woman and the the community leader. So I really didn't want to have to but you have to give their name.*

Another participant recalls the story of a woman who had been sexually assaulted who would have been required to disclose private and disturbing information about her life in order to access a health care covered procedure:

> *And not only did she feel then she had to explain to people that she'd been sexually assaulted, which she didn't want to do—how was that going to be? She was going to have to tell people about the sexual assault in order to see if she could get the province to pay for her access to abortion, so she chose to go another route and borrow money and try to get the money raised so that she could go away to have it done without the whole world having to know everything about her whole story in order for her to access an abortion.*

It is clear from both examples that privacy and financial resources are intertwined, again with accessing financial supports or a health care covered procedure requiring a compromise of one's anonymity.

Lack of supportive doctors. Finding a supportive doctor that would provide a referral for a health care covered abortion was reported as a problem by many participants. Island doctors do not publicize whether or not they are pro-choice, or whether they would refuse to refer. Although by law physicians are required to refer to another doctor that will be helpful to the patient, many refuse. Further, as the following excerpt illustrates, women may fear a breach of their confidentiality should they confide in their family doctor. Participants spoke of young women who were afraid their families would find out as well as women with abusive partners:

> *Another woman saying she didn't feel she could even talk to her family doctor, because her family doctor was also the doctor of her partner, she didn't know what the doctor's opinion would be on her asking for information on abortion, so she didn't feel—whether or not he would tell her*

> *partner. The partner was violent. She knew that if the partner knew that she was planning on having an abortion that he would have taken her to court injunction, if he had to, to prevent her from having an abortion, so again she didn't feel that she could use her own family physician, because she just didn't know what her family physician's position would be. And feeling very afraid to find out, like that the consequences could be too great for her*

Another effect of having very few known supportive doctors on the Island is that those who do help are overburdened and as such are prone to burn out. One participant explains:

> *I know there's at least one doctor here who has been very supportive. Something that angered me was that it always took so much effort to find you know one or two doctors that were willing to help women. But then of course when the burden of abortion falls on their shoulders then they get worn out you know, of course, like anybody. And it should be that everybody every doctor's office has the information*

Unnecessary tests. An extremely common difficulty relayed by participants accessing an abortion covered by health care is the provincial requirement of having an ultrasound before booking the appointment in Halifax. Because PEI's average ultrasound wait time is beyond the fourteen week gestational limit, women need to be put on an emergency ultrasound waitlist at the hospital, a list that also compromises confidentiality as a number of medical staff have access to it. Further, women on the list have to drop whatever they may be doing when the hospital calls with an opening. Finally, as the participant below explains, travel to the hospital is challenging for rural women, and women without their own vehicle or license:

> *It was challenging to get them out there, too. Because you know there's never transportation. I would be trying to do my other stuff, but trying to get them to their ultrasound was difficult… you could wait for a long time. You could have an ultrasound appointment, but that doesn't mean it's going to happen.*

The burden of travel. Even for the women that are able to overcome all the preceding barriers and book a covered abortion in Halifax, the cost and time that it takes to travel can be too difficult to overcome. Off-Island abortion care requires a vehicle, gas and bridge fare or shuttle tickets for two because accompaniment is required. On top of these travel costs, food and lodging for the night is also imperative, as well as the time off of work and/or childcare for those

who need it. Lower SES women are particularly affected by travel barriers, and as the following excerpt shows these difficulties may block women from the care they need:

> *P: That person doesn't always make the best life choices but had four children already and living in poverty so, she did her a great favour [by providing a local, secret, surgical abortion] for that person's mental and physical health and for that of her family.*
> *I: Fo someone like that it may have been quite difficult to get to Halifax*
> *P: Oh yeah, the barriers would have been huge. Huge.*

Theme 2: Subtheme C: Effects of barriers and facilitators. This theme shows the effects of the facilitators and obstacles to access from the perspective of support people and advocates, including delayed care, blocked care and compounded oppressions. Delayed care had further effects including stress, later term abortions and their health risks. Blocked care was shown to result in distress, self-induced abortions and higher levels of FAS in children. Compounded oppressions were shown to heighten inequality based on age, gender and SES.

Delayed care. One very clear impact of the interconnectedness of the barriers is the contortion of the process of accessing a simple procedure into a maze of increasingly difficult and stressful obstacles to overcome. The tension underpinning this escalation of difficulty is the matter of timing. Should a woman go too long into her pregnancy, her chances of getting the care she needs becomes slimmer. Each week that her care is delayed increases the potential for more distress, delays, health risks, expense and travel. One participant explains how someone she was assisting was delayed in her care as she appealed to different sources for funds, and how that affected the timing of her abortion:

> *Finding funds takes time. Time is an important piece in all of that. You know, the further along she gets, the more risk there is to her. So, I believe originally she had planned on going to Fredericton maybe, or something. And then I think she ended up going to Montreal because they had a little bit wider window.*

Distress. As the chances of obtaining an abortion become more tenuous, anxieties and distress are raised for the women needing the care. A few participants spoke of the distress

women experience as their time is running out, their bodies are changing and they risk exposing their pregnancy to the people they are trying to hide it from. Here the participant tells of an extremely stressful experience of accompanying a woman to Halifax to her abortion where she was denied the procedure because her blood alcohol level was too high, and she became very unstable. The woman was from a very rural area of PEI, very low income, and was suffering being publicly shamed over social media for having an abortion. The obstacles that she had overcome to finally arrive in Halifax were extraordinary, and the prospect of going back to PEI without having the procedure done was unbearable for her.

> *P: I know it was just… she was hysterical, could not get her to leave with me. Took, you know, and I’m phoning people back on the Island “somebody help me because this woman, she had totally lost it at this point.*
> *I: She wouldn’t leave Halifax.*
> *P: She wouldn’t leave Halifax. I really, I was at that point where I would have to leave her there, really really didn’t want to. It was one of those incredible, you know, how did I end up in this situation. You know this woman I just, it was, I just couldn’t imagine how it could have been any worse.*

Though the participant was able to secure her an appointment a week later, the participant found it very difficult to find the funds required for the travel the second time.

Self-induced abortion/self-harm. A few participants noted that women who encountered obstacles to abortion care may turn to self-harm in an attempt to self-induce abortion. Participants noted that women may use a variety of measures to self-induce, including using herbs, excessive alcohol or physical injury. One participant recalls seeing all of these methods used in the community she worked with:

> *I: When you were in PEI, did you ever come across a woman who had tried to self-induce abortion?*
> *P: Oh yes I saw that frequently.*
> *I: Oh. Can I hear more about that please?*
> *P: Self-induced through drinking so much that you think that’s going to do it. Um throwing themselves downstairs, I’ve seen that. I’ve heard of women taking herbs like herbal tisanes I guess you’d call them, that are meant to make you bleed. But I don’t know that any of them have been successful, to my knowledge none of them were successful.*

Blocked from termination. Some participants spoke about a few women who were blocked from having an abortion and ended up carrying the pregnancy to term who are now parenting a child against their will. None of the women spoken of considered adoption an option. Each of them cited the domino effect of one barrier leading to another barrier, and eventually the woman in question would end up being blocked from the procedure by a coalition of delays and obstacles. In the following excerpt a participant tells the story of how a woman was denied an abortion because she was trying to find funding from different sources, faced repeated denials, waited for an ultrasound and then eventually ended up a parent:

> *P: She came looking for information on abortion and obviously she had already decided in her mind that it wasn't a good time for her to be having a baby. There was a whole lot of legal stuff going on in her life at the time so we went to Income Support. She was denied the money there. And then we called CARAL to see if we could get some funds through them. And then we had gotten the information from the clinic to find out what she would need to do in order to be able to get the abortion over there, and then it was trying to set up for her to get an ultrasound, and things just drug out and drug out and drug out to the point where she really couldn't have it done anymore. So she had a baby.*
> *I: And do you know, she decided to then…*
> *P: She kept the baby. Yeah, she kept the baby.*
> *I: Did she ever think about adoption, do you know?*
> *P: Never, it was not something that she considered, no*

Compounded oppressions. A common pattern noted by the participants was how those who were more disadvantaged in some way were more likely to be delayed or blocked by the system's barriers. The impact of this pattern is one of compounded oppressions, where those who are have suffered or continue to suffer from physical abuse, sexual abuse, substance abuse, are at the mercy of the province's red tape and restrictions. Other groups profoundly impacted are girls too young to drive, women too poor to travel or too rural to access doctor's appointments. Those who could easily afford to pay the private clinic and travel fees, accessed their care with fewer hassles and much less wait time. Though all of these groups were noted by the participants,

women of lower SES were cited most frequently by the participants as those who bear the brunt of an unfair system:

> *It was really clear at the beginning, and it still is, to me, that it’s an issue of income and the lack of access to services has a more profound impact on women who are disadvantaged in some way, and especially women who don’t have a lot of money.*
>
> *…*
>
> *You shouldn’t have to try to come up with a thousand dollars and somebody to drive you there, and somebody to look after your children, and you shouldn’t have to talk to a social worker to see if you can get the money, and have to disclose to maybe somebody who you’re not really wanting to have a long-term relationship with, and having to tell people so that you can raise money, and — women who have means can be a lot more discreet that women without means, and it’s not fair. It’s just not fair, and it’s really at the heart of a woman’s life, and what she wants for herself, and the choices that she makes for the rest of her life. It impacts the rest of her life.*

One striking impact for those without financial resources was a clear pattern of breach of anonymity, sometimes with humiliating results. As noted above, women who need to have a health care covered procedure risk compromising their anonymity through the hospital list for an emergency ultrasound. Those women who apply to various services for help with funding face another possible privacy breach from the within the organization to which they have applied for help. A participant accompanied a couple to an abortion in Halifax, a process that was financially supported by an organization. Here she explains how individuals who worked within that organization breached confidentiality and the couple suffered being unexpectedly confronted about their choice to have an abortion. An anti-choice board member from the helping organization visited the couple’s home and suggested they reconsider their choice; a humiliating experience that angered the couple.

> *The part that was difficult, or what I viewed as difficult was the organization that was assisting this couple, there was some broken confidentiality. And so, the boss told somebody within the organization well this is what’s going as a volunteer sign a confidentiality agreement, and that went to somebody, and then to somebody else and then to somebody else, all within the organization, and they’re all in it technically I guess, but with those kinds of things, they’re really delicate. And I feel that the only person that needed to know was the person that asked me to go and myself. And the couple, or the woman involved. After we got back from Halifax the first time, one of the staff members went to their house and told them that they didn’t have to have an abortion.*

The participant points to the number of people that were informed of the couple’s situation as partially to blame for the compromise in anonymity. She also requested that the individual who paid the couple a visit be fired for his transgression. However, the individual was a board member, and it was implied to the participant that he was not fired because of his position. This scenario is an example of how this individual’s powerful position allowed him to transgress his organization’s ethics by breaching confidentiality, embarrassing and imposing his views on a client, and was able to do so without consequence. It is also another strong example of how those who are more marginalized bearing the brunt of PEI’s lack of accessible abortion services.

Ostracized from the community. The humiliation of being shamed for one’s choice to have an abortion is not the only negative consequence of a breach in confidentiality. In a few instances, participants spoke about women being shunned from their communities for having had an abortion. Here a participant speaks of a mother and daughter who were shunned from their home community because they had both had an abortion at some point in their lives and their grandfather had found out:

> *Her mom was saying her grandfather won’t speak to her anymore because of something that [her daughter] did. And she didn’t elaborate it right then, so I sort of let her know that it was OK to talk about it, and then she went on to say that [her daughter] had had an abortion. The mom herself had had an abortion, and now the grandfather wasn’t speaking to them so they were cut off from the rest of the family.*

Long-term individual effects. Long-term effects of the barriers to abortion access on PEI are difficult to measure. However, several clear examples were touched on by the participants. One example is the advocate’s difficulty in financially assisting the mother and daughter who had been shunned by their community. Another participant spoke of a young woman who was planning to go to University but was blocked from abortion care and ended up parenting against her will. Although the participant was not sure whether or not the woman eventually attained her

educational goals, she knew that her plan of attending school was delayed as a result of being blocked from abortion care:

> *Well I do know it did have some effect, I do know that. Because she was planning on attending school, and things, which didn’t happen. So she, you know, maybe it did a couple of years down the road, after I was no longer in touch with her, but for the September it did not happen.*

Another participant spoke of a woman in an abusive relationship having to co-parent with her abuser for the next few decades:

> *One participant she ends up having a baby with this person who she might have even left like long before the baby born, and now this person has equal right to that baby, and the law even supports that. It’s very very rare that sole custody is even given anymore. There’s a lot of orders on visitation and whatnot. And so this woman will have to cooperate with her abuser for the rest of that child’s child life*

Being shunned by one’s community, putting off educational goals or parenting in an abusive situation are clear examples of negative long-term effects of the barriers to abortion care from PEI.

Community effects. The long-term effects that impact individual women who are denied care may impact the woman’s family as well as her community. A participant goes on to explain those obstacles to access and the culture of blame and silence surrounding reproductive choice is harmful to the health of women in general and to the health of communities:

> When their ability to make that choice is impeded in any way, whether it’s a really [laughs through words] deplorable health system that doesn’t pay for—that makes it really hard for a woman to have it—or whether it’s a church that preaches that it’s a sin, or whether it’s not having a sexual health clinic, not having the information available to students in schools, not having—you know, just that sort of suppression of the information, that has a huge impact on the health—*really* on the health of women. And the health of their families. I think there’s a direct line there.

Higher levels of FAS. One participant linked the high levels of Fetal Alcohol Syndrome in the community with the lack of abortion on PEI:

> *Now it took… you know just incredible amounts of going to different sources to get this money from a community that already doesn’t have anything. You know there is so much FAS in the community as a result of this kind of thing because they don’t have access to abortion.*

These findings begin to show some of the far reaching and long-term effects of the barriers and facilitators to abortion from PEI. It is also clear that financial resources allow privileged women to far more easily access timely and confidential care, while those without face a complex maze of barriers that interplay with each other and escalate in difficulty over time. This division in care along financial lines deepens an existing inequality between marginalized and privileged women and girls in PEI.

Theme 3: The Constitutive Theme: The Culture of Silence

Theme 3 is the overarching theme that serves to organize each theme and subtheme within it. PEI Culture and attitudes was the largest and most nuanced theme that emerged from the interviews, with cultural silence being at the core of this theme. Emergent from each interview and reiterated by the member check meeting was how the experiences of advocates and the process of accessing an abortion all hinge on PEI’s culture of silence and blame surrounding the topic of abortion. Underpinning each participant’s stories and insights was the pervasive silence on the subject; inhibiting doctor’s referrals, limiting general knowledge about abortion in the community, complicating voicing one’s stance on abortion and increasing judgement, blame and stigma.

In theme 3, the culture of silence describes how PEI’s current cultural silence on the subject of abortion effects the movement to change provincial policy from restricting access, to providing facilitated and/or local access.The overarching ideology of blame and judgment on PEI influences the reproductive justice movement here as all participants spoke about the difficulties of speaking about abortion, advocating for access and the lack of dialogue about related subjects like trans rights, sexual pleasure or miscarriages, for example. Participants posited that the silence had a plurality of origins like: the religious right, misogyny, generational

knowledge, lack of sexual education, and the lack of anonymity that comes with small communities. This silence is also reinforced in many ways; black and white morality, judgment, blame and stigma, women keeping their abortions a secret, the government ignoring the issue, the lack of coverage by the press, the alienation and divide from the pro-life and pro-choice factions making it difficult to have open dialogue. Theme 3 consists of three subthemes and each are comprised of several smaller themes:

1) Subtheme A: Cultural Silence
2) Subtheme B: Pro-life vs. Pro-choice
3) Subtheme C: Change Strategy

Theme 3: Subtheme A: Cultural silence. In a multitude of ways, PEI's cultural silence is addressed by all of the participants. A smaller group of advocates who have a long history of supporting access showed high levels of insight and analysis into the origins and effects of cultural silence.

Here an advocate explains how her willingness to speak about certain subjects is moderated by her cultural context. She goes on to point out that it may not be a conscious editing, but that she notices her range of available topics to be much more limited in PEI:

> *A culture like PEI, to some extent it's inherently silencing. I know there are things that I self-censor here, much more than I would if I was living even in Halifax. So I watch what I say, depending on how well I know the people that are in the room. Depending on the situation. And I don't even really do it consciously, but I know I do it. So in a way I'm a different person here than I might be if I lived somewhere else. I guess you could say that about anybody, but I do think because of the parochial nature of the society here, people are really nervous about saying what they really think about anything that's even a little bit controversial.*

In the above excerpt, the participants points out that it may not be a conscious editing, but that she notices her range of available topics to be much more limited in PEI, alluding to a very pervasive but hardly noticeable aspect of her new culture. Another advocate noted how most of

her Facebook posts will get attention, yet her re-posting of the study advertisement went completely ignored:

> *I re-posted[the ad for the study] to my [Facebook] profile: no comments whatsoever. I thought that was really interesting. So people are, again, I think, really afraid to come out about this in any way. Like, even to say, "Like," you know, or "This looks like a good project," or—like, people were just, "Shhhht."*

Many participants echoed the sentiment that the topic of abortion was particularly silenced; that although many topics on PEI are taboo, there is significantly more pressure to keep abortion experiences under wraps. In the following excerpt, a participant also speaks to the repressive nature of the silence for those with personal experience.

> *Some of the women I know who've had abortions can't talk about it outside the circles they know are safe because they know there's going to be judgement, and people they know will think that that is a wrong choice. And that's silencing, not being able to talk about that choice with a parent or a best friend or a grandparent or someone. Someone who might ordinarily be really close to you. That is really silencing. So I think it's that moral structure around it that makes people feel like they have to justify it.*

***PEI compared to other cultural contexts*.** Participants frequently noted the abortion-related cultural differences between PEI and various other places in Canada. Here, a participant tells of a young woman not originally from the Island, who had to go into the PEI hospital as a result of complications from an abortion, and felt a huge reaction from staff, nursing staff, and even some doctors that she dealt with:

> *One (medical staff person) said to her "It's probably better if you don't tell people why you're here." This is a woman who wasn't raised here, where she came from it was quite OK to share that kind of information. [Where she was from] abortion was accessible to women, it was a choice that women had, and she felt very comfortable until she was shut-down—she said she refused to feel shame but she felt [the hospital staff] were trying to put shame on her.*

Another participant cited a major difference in the level of comfort in disclosing a personal abortion experience depending on their cultural context—with PEI being a place where abortions are seldom spoken of:

> *Everybody that I know who has left PEI to access an abortion has felt they had to be very very secret. When people come from off-Island who’ve had access to abortion, they’re very open about it—they talk about their struggles, as just part of their own history when they’re sharing and talking. And there isn’t that same sense of “I can’t talk about this”.*

Secret abortions. Out of fear of repercussions for breaking silence about their abortion, advocates very frequently noted how women who had undergone an abortion would keep their abortion(s) a secret in a variety of ways. In the passage below, an advocate describes how it is common for women to call their elective abortion a miscarriage. Advocates and support people keep quiet about their work supporting abortion access out of fear of judgment and repercussions. This social silencing helps maintain the status quo and echoes the effects of shaming experienced by women with direct abortion experience.

> *I don’t know anyone who has accessed an abortion on PEI who didn’t feel that they needed to keep it a very big secret… I remember one woman telling me for months that she had this big secret that she needed to tell me, that she had this huge big secret, and that it was going to change how I felt about her when I found out this big secret. And what the big secret was that she’d had an abortion. And I just felt horrible that she would think that relationships would dissolve because she had chosen to terminate a pregnancy which she had no regret about.*

The participant’s narrative notes that while the woman with the secret wanted to share it,she feared it would negatively alter their connection. Another participant speaks about women who refer to their abortions as “miscarriages”.

> *A lot of women will say when they get back from [their abortion] that they miscarried. So that’s a very common scenario to say “I miscarried” because you know as soon as they find out they’re pregnant they’re ecstatic and then, the dad doesn’t come forward and there’s no support. You know as they’re starting to realize how dire the circumstance is, and the first thing is self-induced and when that doesn’t work…*

Renaming abortion a miscarriage is another way of keeping secret a procedure that may otherwise be quite obvious. As in the above excerpt, women who find that their support systems dissolve or their circumstances change may unexpectedly find themselves with a problem pregnancy. In a culture where “abortion” is unspeakable and may provoke repercussions, evading ownership of the act becomes a common solution.

Internalized stigma. Participants who repeatedly acted as confidants for women who were seeking an abortion, such as those advocates who worked on CARAL’s telephone line, or counsellors who worked closely with women through helping organizations such as Anderson House or the Rape and Sexual Assault Centre showed a high level of analysis and were able to recognize internalized oppression of abortion stigma in their clientele. The following excerpt illustrates a participant’s understanding of how societal messages were making her client extremely fearful that her secret had the potential to taint her close relationships. She goes on to note the oppression of being forced to keep a secret that is a part of her life experiences and that the abortion-related societal hatred becomes an internalized part women who have undergone a termination:

> *I’ve seen it affect them physically, depending on what kind of conversation is happening around them. I’ve known somebody who’s had to leave work because the hatred was so big that she went to the bathroom and was throwing up, so she had to leave work. That sort of thing. Feeling—like anything, if someone has to suppress something about their life, including their experience of having an abortion, or having to make that choice—it’s just one more way that women are told to be quiet and shut up and keep it to themselves, and then if you hear all this negativity and all this hatred and all this judgment against women, then you personalize that and it becomes that they’re talking about you. And the women that I have talked to, that’s how it feels to them. That hatred that people are spewing, they’re not saying about women, they’re saying you, you are this. You are that.*

Theme 3: Subtheme B: Prolife vs. prochoice. This theme shows how the anti-choice movement endeavours to maintain the status quo on abortion access on PEI, including strategies

as labeling the Island as a “life sanctuary”, using hostility, and upholding a misogynistic culture. This theme also shows how the “pro-life” vs. “pro-choice” divide encourages silence on the topic.

Powerful religious right. The religious right is a powerful movement on PEI. Many participants noted the extremely high proportion of the population belonging to the Christian right, or being connected by family, workplace or through their church community. Like the advocate quoted below, a few participants rightly linked the culture of silence to the predominance of the Christian right.

> *I think PEI’s still very much a Catholic province, a lot of my students still go to church, they’re young people, I think a higher percentage than maybe you would see in other parts of the country are still actively involved with church and religious activities. I think that there’s still an awful lot of religious, political pressure put on women, and men too, to not even talk about this*
> *I just think that because they’re so closely connected, frankly, to the Catholic Church, there’s an awful lot of people who would be pro-choice but would never say it out loud, because maybe they’re Catholic. Because they’re nervous to come out and say—to speak out against the Church in any way.*

A tension emerged between one advocate an ally who grew up in a household that she describes as seemingly anti-choice but with more room for nuance and discussion on the interior, and many of the advocates who did not identify as Christian. This particular participant offers insight into the range of stances within PEI’s church community. Also, as an insider to Catholic and anti-choice groups, her analysis of how black and white ideas of right and wrong produce a culture of silence is valuable and informative.

> *Messages that are based on morality, on black and white morality I think are a real silencing factor. Also assumptions that particular groups are going to have a particular morality. Because I was raised in a really Catholic household but the social justice group that I was involved in and that was really prochoice was also a Christian group. So it was also the Christian left, not just the social justice left that I developed my analysis.*

Her clear division between the Christian right and left show that a range of opinions are available and allow for more respectful and inclusive terminology when speaking about the influences of faith on abortion beliefs.

The international anti-choice movement has dubbed PEI a “life sanctuary” because of its lack of local abortion in a country with a national policy demanding access (LifeSiteNews, 2011). A few participants noted that the broader anti-choice movement that is very powerful in the United States has some stake in PEI remaining “abortion free”.

> *I think [PEI]’s valuable to the anti-choice movement by virtue of being the last stronghold.*

A couple of participants stated that the broader anti-choice movement may be financially backing many local anti-choice projects. More research is needed to determine the influence of broader anti-choice groups on the PEI context.

Misogyny. Several participants saw PEI culture as unjust toward women who find themselves with a problem pregnancy. The shaming rhetoric about women who find themselves in such a situation was cited as misogynistic in nature, ignoring the role of the male partner in conception while blaming women and labelling them as promiscuous and deserving of the removal of their reproductive rights. Here a participant expresses her view of the anti-abortion propaganda as rooted in misogynist and anti-sexual freedom ideals:

> *I really feel it’s this, um, this murder is wrong kind of philosophy that kinds of fuels a lot of people, like, “abortion is murder”. But really, like deeper beneath that, is just the idea that (Sighs) my sense would be that other people would think “well, you were promiscuous and now lay in your bed you promiscuous women”, you know. “You made this situation for yourself so now you just have to deal with it, and you don’t just get to take the easy road out and just have an abortion and not follow through with the bed you made for yourself.*

Theme 3: Subtheme C: Change strategy

Open Dialogue. A very strong theme was the wish that conversation could be more open, personal, and inclusive on the Island. Participants believed that open dialogues about personal hardship, sexuality and other frequently silenced topics on PEI could bring about a cultural revolution.

> *I wish I could talk to people one on one, because I think one on one conversations are really powerful. And peer to peer adult conversations about the issue are really powerful*

Education. Sexual health education in schools, as well as education about abortion in the general public were seen as central to reducing cultural silence. Some participants alluded to the idea that many people in the anti-choice camp are not fully aware of the circumstances most women face when deciding to terminate, a product of the heavy anti-woman rhetoric on the Island.

> *I felt that they were given a one-sided story. They weren't really educated—I'm not saying everybody, but that was my feeling at the time. And I still feel that way. I still feel that if people really understood the issues and the dilemmas and the rights that women, if we could really talk about it, that people would be more open-minded about a woman's right to choose for herself what's right for her.*

Other participants spoke of the need to address and accept the plurality of cultures and heritages that exist on the Island, instead of the prevailing view of PEI from one mainstream and dominant perspective:

> *We need to talk about a lot of things. If we could learn about our culture, what is that? Cultures, but in general Island culture. I think learning about our history in a different sense. Not from the general heterosexual Anglophone male, able bodied male sense. From different gender, ability and also ethnic cultures, because that will help us understand things.*

Depolarizing Views. As many participants pointed out, the polarization of the "pro-choice" vs. "pro-life" conversation about abortion leaves out a lot of people and also serves to halt open dialogue:

> *I think one of the unfortunate results of what we've been calling the old conversation about abortion is the polarization of the sides. I think there's a lot more moderate people out there than strictly anti-choice people, and I think if you were able to frame it from*

> *more of a health perspective, you might get more of those moderate people into the conversation. There are people who are never going to come into the conversation. That's okay. There are always going to be thorns in the side of this particular issue, but I think if you could—and I'm not in favour of compromising, but if there's a way to moderate the way we talk about this, I think it would probably help bring some of the people with moderate views into the conversation—into a place where you could actually talk about it instead of, you know, cross your arms and zip your lip, and that's that*

While remaining pro-woman, the participants viewed open, patient and compassionate conversations as key to a cultural shift away from abortion stigma.

Sharing Stories. One common strategy for opening up caring and communicative conversation on PEI was sharing personal stories on a one-on-one basis: An advocate who grew up in a predominantly anti-choice household views the sharing of personal stories as foundational to her abortion-related conscientization writes:

> *I really think that what's going to make a difference on Prince Edward Island, like in terms of a cultural shift, as well as changes to the policy and access, is going to be sharing stories. What's been my experience is that people's willingness to share stories has been what made it possible for me to see the issue from all sides, and see the issue in a new light, and that is why I've been interested in looking for reproductive justice now, you know, today. So, I think that that's really powerful, and, um, you can't see things in black and white when you talk to a person, or when you hear a person's experience.*

This passage also echoes the need to depolarize the abortion issue on PEI through patience and understanding.

Building Bridges. Many participants saw the need to include abortion in the gamut of progressive health issues that are frequently avoided on PEI to help build a supportive network working towards reproductive justice.

> *I do think reframing it as part of the gamut of women's health is probably part of what needs to happen. Instead of looking at it as this monolithic thing. [Adopts 'scary' voice] Abortion. You know: "Well, we have contraception, and we have healthy sexuality, and we have, LGBT stuff, and we have this and that, and the morning-after [pill], and we have abortion.*

Bridging the subject of abortion with other gender, health and sexuality issues would soften the harsh abortion-related stigma, and grow support people with like-minded groups and

organizations. By connecting a network of supporters, participants saw the potential to reduce stigma and achieve a critical mass of people working together toward change.

Chapter 8: Discussion

The key purpose of the following chapter is to contextualize the key findings of this study with previous research, theory and analysis, as well as to offer my own analysis and conclusions about the findings. I begin the first section of the discussion by considering the overarching and first key finding of PEI’s abortion-related cultural silence as one example in the trend to meet feminist advocacy with silence from a variety of socio-political contexts. I then focus on this trend specifically in PEI and explore theory that links such silence with cultural patterns that reinforce systemic inequalities. Next, I demonstrate how support people and advocates are facilitators to abortion access in a fragmented and hostile system. I also explore the effects of cultural silence on the participants’ experiences, their roles as support people and advocates and the repercussions they faced by exploring the previous literature, and how their social silencing mirrors those with lived abortion experience. I follow this section with an exploration of the effects of silence on the barriers, facilitators and effects of PEI’s abortion policy as witnessed and confirmed by support people and advocates. I then link the intersectional oppressions surrounding abortion to a strong patriarchal culture in PEI. Finally, in the dissemination section of this chapter, I show how support people and advocates have shifted culture and health policy and give my plans for dissemination of the key findings of this study.

Key Finding 1: PEI’s Abortion-Related Cultural Silence

Feminist advocacy met with silence. “The sin of omission is just as telling as a sin of commission” argues author Nick Cohen (2015) in a recent article about the massive silence faced by the Swedish Foreign Minister in her efforts to address Saudi Arabia’s harmful and sexist

policies. A thick layer of silence also encourages stigma and blame related to HIV/AIDS in South African schools, a silence around sex and illness that is more strictly and violently enforced in women and girls (Morrell, 2003). In PEI, advocates and support people have been trying to change the abortion policy since the procedure was locally banished in the early 1980s—efforts that have fallen on deaf ears of government and health officials, referring advocates to a non-existent health policy for over two decades. Feminist writer Jane Bennet (2001) calls the lack of response to gender-based violence as ‘deafness’, noting that it compounds the violence through “the erasure of the victim’s identity, her access to self-hood, her meaning…” (Bennet, 2001, p. 92). It is not coincidental that the women’s rights movement declared “Breaking the Silence” as the strategy of choice for addressing the patriarchy’s systemic oppression of women and girls, as silence, inaction and omission often characterize the responses to feminists’ calls for change. It is also the deafening silence that has historically immobilized the movement and continued to prevent abortion-related culture and policy change from taking place on PEI for decades.

The term “Culture of Silence” originates from liberation psychologist Paulo Friere in his study of the poor and marginalized. Author Richard Shaull (1989) explains how Friere connected a lack of political will with oppression:

> His early study of the life of the poor also led him to the discovery of what he describes as ‘the Culture of Silence’ of the dispossessed. He came to realize that their ignorance and lethargy were the direct product of the whole situation of economic, social and political domination – and of the paternalism—of which they were victims” (p. 45)

The observations and insight from the participants underscored this culture of silence as being upheld by economic, social and political domination on the Island. Silence is a result of prohibition and policing; a result of unequal power (Foucault, 1976). Although feminists from various times and cultures have noted the deadened reaction to their advocating for change,

misogyny and sexism vary in intensity and composition according to the cultural context. Of abortion stigma, Kumar et al (2009) disputes "any universality of abortion stigma… understanding stigma as created across all levels of human interaction: Between individuals, in communities, in institutions, in law and government structures, and in framing discourses" (p.628). The perspective of abortion stigma as a contextual phenomenon related to power and oppression is a view echoed in the findings of this study.

Abortion stigma in PEI. The cultural scope of Canada is varied when it comes to abortion stigma, and as many participants noted, the climate is particularly oppressive in PEI when compared to many other Canadian regions. The majority of the participants in the study were not originally from the Island, and each advocate from this group was shocked and moved to political action by the lack of reproductive justice on PEI. In this way, the culture of silence and blame on PEI prompted reproductive justice advocates out of people that were not so inclined when living in areas of lesser abortion stigma.

The low proportion of participants in the study that were originally from the Island compared to those "from away" is also indicative of a broadly silenced culture. One Island-raised participant grew up in what was perceived as a "pro-life" family and found her way to the movement gradually, through social justice and hearing first-hand accounts of friends' abortion experiences. Another does not claim a pro-choice stance, and the last "Islander" participant believes that abortion access should continue to be located off-Island, for the protection of women's confidentiality. The tension between those participants from the Island with those from elsewhere in Canada is revealing of a particularly strong local abortion stigma.

***PEI's Ideological Hegemony*.** To interpret the effects of cultural silence I draw on feminist theory, liberation psychology and Gramci's critical theory of ideological hegemony.

According to Gramsci, cultural hegemony is symptom of domination where the subjugation of the masses includes internalized oppression of values and ideals that are “supportive of the established order and class interests that dominate them” (Boggs, 1976, p. 38). Dominance is replicated and maintained through beliefs, attitudes and religion as well as structures like education, policy and the expected family formation. Likewise, the policies and cultural norms that frame abortion as unspeakable is underpinned by a moral ideology of abortion as sinful and akin to murder. Participants cite this ideology as originating from the dominant Christian and Catholic tradition and faith on the Island, specifically the Christian right. This harsh judgment of an extremely common procedure relegates it to a morally reprehensible act; something to be very ashamed of. Under such hegemony, admitting to wanting, needing, assisting or performing an abortion becomes unspeakable. Stigma researchers Parker and Aggleton (2003) use the concept of hegemony to link stigma to cultural power and domination. They argue that stigma is a form of ideological hegemony that causes some groups to be devalued while others feel superior - a social process that both enhances and reproduces the existing imbalances of power.

Hegemony varies greatly across societies; however the tension between those originally from the Island and those from elsewhere is telling of an attitudinal disparity. Unlike those originally from the Island, the few participants from elsewhere each experienced shock when learning of the abortion policy. Opinions of locally-raised participants ranged from acceptance to a conscientization of the injustice of the policy. This tension suggests that the “common sense” of abortion-as-wrong has a stronghold in PEI. In addition, those most vocal and comfortable in their advocacy at the time of the interviews were also originally from elsewhere, and were each spurned into political action upon becoming a part of PEI society. In this way, women ‘from away’ were made into advocates by the abortion-related culture of silence and blame, a trend

telling of a repressive ideological hegemony when compared to the participants’ previous contexts.

Internalized oppression. Both Gramsci and liberation psychology (LP) theorists speak about internalized oppression as a mechanism of ideological control on an individual level. As Moane (1999) points out, the distribution of political influence is not distributed equally in hierarchical systems. Extended here is the argument that one’s capacity for change and political influence are similarly distributed in such systems, with those at the bottom distanced from this capacity for change that we all (theoretically) hold. According to LP theory, internalized oppression is a psychological impact from the cycle of oppression, which emerges as self-blame in the oppressed. “The psychological result of sustained dominance and subjugation is that the person who is oppressed eventually internalizes a demeaning view of her or himself; as someone who is not worthy of resources and rights. Hence, the person becomes transformed into her or his own oppressor” (Ribelles, Garcia-Ramirez & Portillo, 2009, p. 278). Emergent from many of the participants’ accounts was the internalized idea that because one has had an abortion, others would view them negatively if their secret were discovered. Several participants noted that women would be deeply personally and physically affected when hearing anti-choice rhetoric, showing an internalization of the stigma.

Similar to those with lived experience of abortion, some support people and advocates interviewed were secretive about their contributions and avoided rsupport people. Some also feared for other advocates who were more vocal about their beliefs. Like abortion providers, most of the support people and advocates interviewed struggled with their level of disclosure about their abortion stance and work. Therefore, support people and advocates are clearly subject to abortion stigma, with some similarities to those with direct abortion experience while sharing

other aspects of the courtesy stigma shown to affect abortion providers (Freedman, Landy, Darney, & Steinauer, 2010). Consequently, PEI’s abortion stigma also works as social silencing against those who support women as they attempt to access care.

Key Finding 2: Support People and Advocates Facilitate Access

The restrictions, hostility, and silence related to the issue of abortion on PEI leave many voids and pitfalls on the road to accessing the procedure. Support people and advocates take on the roles that are needed in such a fragmented system, often making possible what would have been blocked in their absence. By volunteering or working beyond the scope of their jobs, support people and advocates use their compassion, networking, and leadership skills to create the social capital that is needed to bring women and girls in need to their procedures. Support people contribute humanity in a hostile environment, providing a space for women and girls to speak of their need for an abortion without shame, and by providing the information, connections, and funding needed to arrange the various appointments and navigate out of province access. Advocates speak out, educate, and demand women’s reproductive rights where doing so may risk repercussions. Although the consequences of personal support and advocacy at the time of the interviews seemed great, the movement has grown and its message has become more commonplace, showing also that the work done by the participants confirm that change is possible, and that advocacy and personal support are integral to shifting cultural norms.

Participant roles shaped by silence. A large portion of the roles taken on by support people and advocates are shaped by the oppressive culture of silence and blame that surrounds the topic. Creating spaces, however small, to break the silence on the topic and offer support in a culture that dictates the opposite is central to each of the roles played by the participants.

Advocates and support people often feared what repercussions they would risk by being open and supportive of reproductive choice in such a cultural context. The findings show that while some acts of breaking the silence go unaddressed or are occasionally applauded, some have lasting repercussions. A culture of silence is kept in place through adverse social reactions such as hostility, victim blaming and negative repercussions when the silence is broken. In a culture where silence on the topic reigns most social interactions, women needing access face a greater set of barriers, and the roles of support people and advocates are primarily shaped by these resulting needs. Vocally advocating for access to abortion was often avoided or done with trepidation, while giving information and emotional support emerged as the most universal themes among participants. Even for advocates and support people, the topic of abortion is not easily spoken of in PEI so information about accessing the procedure is not readily available and misinformation is common (MacQuarrie, 2014), and the role of giving accurate and confidential information is a crucial to assisting women in need.

Providing information often worked in tandem with the second strongest role of giving emotional support. This finding is also shaped by the abortion-related cultural silence, as women who are in need of an abortion feel that they have no safe space to voice their secret in their usual support circles. Many of the women calling CARAL or speaking with the participants had not spoken with anyone else about their situation, and hence were in a more isolated and emotionally fragile state. Being a confidant to these women allowed for a small, safe way to break their silence, avoid judgment or hostility, and sometimes would act as a catalyst for women to open up with a trusted friend or family member. Therefore, one of the most needed and important role of support people and advocates is to help foster very small cultural exceptions to PEI’s culture of silence and blame. More literature is needed to address whether or not this role is as important in

other cultures, however, one study has shown that non-judgmental counselling after the abortion is a common provision of a women’s health hotline. This commonality suggests that supportive and non-judgmental spaces for women to talk about their abortion decisions and experiences may be an essential role for support people and advocates in cultures beyond the PEI context.

Repercussions for breaking the silence. A tension emerged from the polarized reactions participants experienced when breaking the cultural silence on abortion, with some participants’ acts going unaddressed or rewarded by the community and others experiencing lasting repercussions. The hostility commonly experienced by participants advocating for reproductive rights is further evidence of a prevalent “common sense” of abortion as morally reprehensible, or in LP terms, the jeers, narrowed eyes and cold shoulders experienced by participants when opening up the subject of abortion is indicative of a widespread internalized oppression of women. This shows that abortion stigma affects support people and advocates in similar ways to those who have first-hand experience of abortion. Although the participants were not subject to the same rhetoric and shaming that one with lived experience may be, many feared or experienced threats to one’s career and livelihood. The outcome of this threat was that support people and advocates were careful about when, where and if they felt comfortable voicing their opinions, showing again that support people and advocates experience the same sanctioning of rights and similar repercussions to the women they are supporting.

Repercussions to one’s work-life were a strong theme in the findings when advocating for abortion rights. Threats to cut organizational funding, job insecurity and barriers to work-related tasks speak of more intense and organized reactions; similar to the backlash to feminist advocacy by men’s rights groups. For example, a sizeable proportion of men’s rights organizing efforts are concentrated on defunding women’s organizations like shelters and the Status of

Women in an attempt to stifle the Canadian Violence against Women campaigns (Gerard, 2009; Man, 2008). These organizations have been found to seek the discrediting of advocates and actions that fight for change in an attempt to keep the status quo.

Key findings showed that social exclusion and threats to employment were the two main sources of repercussions. Strategies that threaten job security fall into what LP psychologist Geraldine Moane calls “economic control and exploitation”, a category of several mechanisms of control found in colonialism and patriarchy. PEI’s rate of unemployment is extremely high with that of women being particularly so, therefore, threats to one’s working life and compensation are of significant gravity for many Island women. It follows that participants reported the disclosure of one’s pro-choice stance as contingent upon one’s work context, with several participants attributing the limitations to their advocacy to the stability or support of their work situation. In this way, abortion advocacy often threatens one’s livelihood on PEI.

Key Finding 3: Support People and Advocates Confirm Barriers

Barriers and silence. One form of resistance to the dominant ideology of abortion in PEI is of course to electively seek out and undergo the procedure itself. However, this act of cultural resistance is also strongly shaped by the cultural silence on the topic. Women seeking an abortion must contend with a host of intersecting barriers that are put in place and further strengthened by the pervasive cultural silence on the topic. The barriers created by the culture of silence include; 1) a dire lack of information on the topic, 2) difficulties related to finding a doctor’s referral, 3) privacy concerns, and 4) Facility disparities and policies. Although previous studies have shown that women with lived abortion experience cite similar barriers as infringements to accessible care, the findings of this study effectively confirm the obstacles cited in other studies from a new vantage point - the perspective of support people and advocates.

Because the participants in this study are often witness to a large number of women and girls seeking abortion care, their insight and analysis into the patterns of obstacles and their consequences are of significant value to research on this topic. As repeat witnesses, the voices of the participants amplify and strengthen what we have heard from those who are the primary target of abortion barriers, stigma and shaming. Consequently, support people and advocates can be more strident and speak powerfully of the cost of abortion access barriers.

Lack of information. Barriers to the health care covered procedure are again determined by the Island’s pervasive silence. Obstacles such as the doctor’s referral, the tests required, and the timing of the procedure each functions to delay access to a time-sensitive procedure, resulting in women in need at risk of being unable to terminate. The lack of information on how to access an abortion is a barrier in itself, also underpinned by PEI’s culture of silence. At the time of the interviews, nowhere was there an information page on the internet, or a number where one could find information about the process of access. The lack of common knowledge about abortion and the unwillingness of medical personnel to address it are both reinforced and maintained by the general taboo on the subject. At the time of this study, the result was an information desert on how one might terminate a problem pregnancy from PEI.

A mysterious referral process. Doctors do not advertise their stance on abortion, making accessing a doctor’s referral the first step in a long chain of procedures rendered inaccessible by silence and judgment. Participants often reported that women are unable to ask their doctors for a referral because they fear being outed to an abusive partner or an anti-choice family member. A participant relates her own experience of how asking for a referral can also be silenced within the doctor’s office itself: “There were many ways in which choice could be impaired, and that was one of them. It was a doctor just not saying ‘you should not have an

abortion.’ It was like, ‘I don’t want to talk about this and, you know, I don’t like the idea’”. Refusing to speak about abortion in the context of a medical relationship where the patient’s needs come first is a clear example of silence and power creating a formidable access barrier.

Existing policy that names doctors as the only people able to refer or perform abortions greatly effects PEI’s access situation. Physicians are in short supply on the Island, and both previous research and the findings show that those who are known to provide abortion referrals are can be difficult to find in Canada (Kaposy, 2010). The current study shows that the underlying problem is that such doctors in PEI are little known and extremely overworked. If the range of medical personnel able to refer were widened to nurses and midwives the unnavigable and often anti-choice stronghold of the medical community on PEI would have much less of a monopoly on local abortion access. Further, allowing nurses and midwives to administer the simple procedure could possibly open the door to local access (Jackson, 2011).

Privacy concerns. Hidden abortions are more easily permitted in a culture that deems the topic unspeakable. However, findings align with previous research in that absolute confidentiality is only a luxury permitted to those of wealth and privilege. In PEI, the abortion health care system at the time of this study was two tiered, cleaving women who undergo the procedure into two groups: those who encountered relatively few obstacles, received more timely care, and had the option of keeping their abortion a secret. The second group of women is those who navigated the health care covered procedure. Each barrier they encountered required a potential loss of confidentiality. At the doctor’s office, women feared their doctor may relay their pregnancy to others. Should they have acquired a referral, they also required an emergency Island ultrasound, for which their name was put on a list accessible to hospital staff. The interplay between privacy and financial resources is again revealed when examining the barriers

faced by women who cannot afford the travel and associated costs and may apply to various organizations, each of which hold potential for privacy breeches.

Findings aligned with the Guttmacher Institute's conclusion that confidentiality is important to improving abortion services (Joyce, Henshaw, Dennis, Finer & Blanchard, 2009), also emerged as a significant determinant of accessibility. Unfortunately, privacy in PEI is only afforded to those with the financial means, with others forced to forfeit guaranteed confidentiality via a health care covered abortion and through helping organizations. Emerging from both were evidence of the potential for privacy infringements and subsequent shaming and humiliation, the effects of which can be quite devastating in a small population with a strong anti-choice presence and societal pressure to hide abortion experiences. These disturbing findings demand further investigation into the effects of a lack of privacy in abortion care.

A study on the non-confidential abortion care in Puerto-Rico showed that many women opt for harmful, clandestine abortions instead of the legal but open-air waiting rooms where women lined up to terminate are easily and publicly identified. The study shows the importance of confidentiality, but the open risk of confidentiality loss does not directly compare to PEI's situation where breaches in privacy are less transparent or expected. Clearly more research is needed to investigate the effects of organizational and systemic breaches in privacy on abortion care.

Facility disparities and policies. In keeping with the research, the findings showed that all women were negatively affected by the lack of local access to some degree, with economically disadvantaged women particularly hindered (Adamcyzk, 2008). Young women and those of lover SES had more difficulty finding a means to travel to the mainland and the associated costs, with effects including stress, long delays in care, self-harm or self-induced

abortions, occasionally being blocked from termination, or a loss of confidentiality. In addition to the difficulties associated with travel to the mainland, rural women of lower SES status experienced additional barriers when attempting to reach the mandatory ultrasound for a health care covered procedure. In private clinics and in provinces where access is streamlined, women are able to self-refer for an abortion with an ultrasound as part and parcel of the termination procedure. These facility provisions erase many of the time consuming delays and confidentiality barriers of the PEI health care system. Small reformations to the hospital policies such as allowing women to self-refer and including the ultrasound as a part of the abortion procedure have the potential to dramatically improve access.

While streamlining off-Island access lessens these injustices, repatriating local abortion services in PEI is essential to providing truly accessible and equitable reproductive care. Local access would remove the costly barriers of travel, accommodation and an overnight stay. Further, keeping access off-Island reinforces the stigma of abortion as locally unacceptable. Providing local access to abortion would be effectively disrupt the culture of silence on PEI by showing that termination of a pregnancy belongs on Island soil. Beyond any other measure, such an action speaks to the acceptance and support of the procedure. Local access would demonstrate to the PEI community that woman’s health is a priority to government and health officials.

Effects of barriers and facilitators. Because obstacles to abortion access affect the bodies and lives of women and girls directly, the issue of reproductive justice is gendered. Any barriers to timely and accessible care are an infringement on a basic right to one’s autonomy as well as a violation to the Canada Health Act that stipulates accessible and equitable care for all Canadians. The fact that abortion care remains off-Island when local care is possible and would be economically beneficial to PEI (Chapman, 2014) is a clear injustice to Island women and

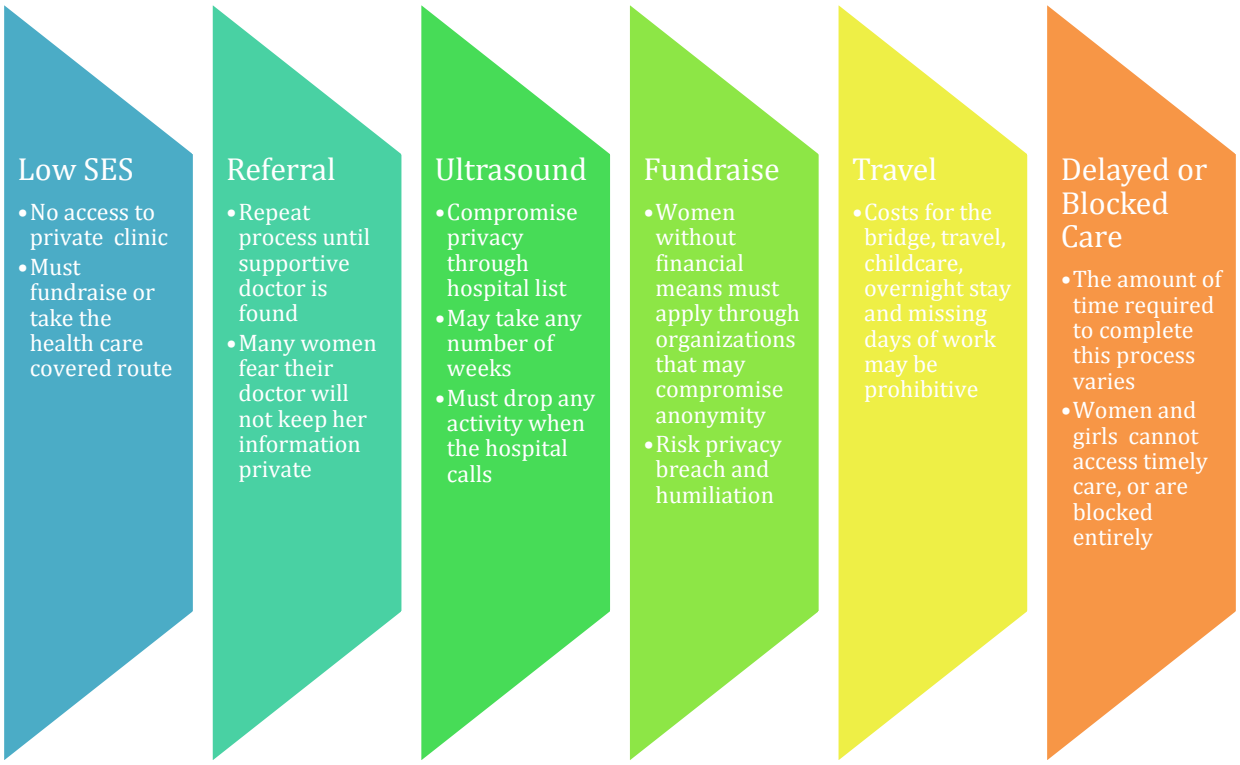
girls. Women privileged by wealth, age and connection are still forced to travel off-Island for care with an overnight, out of province stay. A procedure at a private clinic is more timely and does not require a referral or an ultrasound, however, this route requires upwards of $800 out of pocket. Therefore, the private clinic route cannot be considered accessible as it requires someone needing an abortion at the very least to schedule an appointment out of province with a minimum 8 hours of travel time, gas, bridge, lodging, accompaniment, and the cost of the procedure. Additional obstacles like the possibility of loss of work and arranging extended childcare may also be required of this comparatively more accessible route to abortion care from PEI.

Canadian women are already at a wage disadvantage when compared with men and PEI has the second lowest minimum wage in the country, one of the highest provincial rates of poverty, and women are among the most prevalent groups of those earning low-pay (Canadian Centre, 2006). Also, PEI has one of the highest national rates of teenage pregnancy (Stats Can, 2006) and female lone parents have the highest rating of poverty out of all the different family types at 47.1% (Kaposy, 2010). Taken together, these statistics suggest that the cost of the private clinic may be prohibitive to a large margin of women and girls on PEI. Finally, a recent study of infants exposed to high levels of alcohol in the womb suggests that 1.3% of PEI infants will develop fetal alcohol syndrome disorder (Brayanton, Gareri, Boswall, MacCarthy, Fraser, Walsh, Freeman & Bigsby, 2014), a rate roughly 30% higher than the estimated national average (Health Canada, 2006). Although more research is needed to investigate the relationships between lack of access to abortion and the high rates of teenage pregnancy, child poverty, and fetal alcohol syndrome on the Island, the current study indicates that the lack of accessible services may be a factor in each of these concerning provincial trends. As the support people and advocates have indicated throughout the findings of this study, PEI’s abortion policies intersect

with other economic, social and health oppressions to exacerbate the oppression of Island women seeking abortion access. Further, women and girls who choose or have no choice but to seek an abortion through the health care covered route can forgo the cost of the procedure, but are forced to overcome several other barriers including delayed care and loss of confidentiality. *Diagram 1* charts the effects of PEI’s abortion policy on those who attempt to acquire a health care covered procedure.

Diagram 1.

Access obstacles faced by women and girls seeking a health care covered abortion



Previous studies, theory and the findings shown here demonstrate that obstacles and delays to abortion care exacerbate existing oppressions. The barriers and facilitators were found to form a web of intersecting oppressions that further marginalize those of lower SES, rural populations, victims of abuse, and youth to extreme levels. The following section shows how the

intersecting oppressions served to; a) delay care, b) exacerbate existing oppressions, and c) effectively block abortion care for some.

Delayed Care and Mandatory Wait Times. As previously noted, PEI’s long wait times for an ultrasound are somewhat comparable to the mandatory wait times in some US states. Studies of mandatory wait times showed that the imposed 24 hour wait time was not a major deterrent to abortion care or the decision to terminate, but were associated with higher unintended pregnancy rates in teens (Coles, Makino, Stanwood, Dozier, & Klein, 2010). However, PEI women have the potential to wait far longer than the standard US delay and for indeterminate amounts of time. It stands to reason that the noted effect of imposed wait times may be much greater in the PEI context. The most common reason that women are turned away from abortion care is because they are beyond the gestational limit for the procedure (Canadians for Choice, 2006), a situation echoed in the findings of the present study. In addition, the findings establish that delayed care in PEI increased stress and erected many more barriers that had the potential to act as a block to termination.

Economic Barriers. In accordance with the WHO research on the effects of SES on abortion access, PEI women join those around the world who have experienced further marginalization because of their lower SES. Matching the findings of the present study, undue burdens have also been shown to increase for vulnerable groups such as younger women and girls, rural women, as well as women living with addictions or abuse (Ely & Dalmus, 2010). The authors also found immigrants and refugees to be particularly affected. While these groups were not represented in the current study, it serves to introduce many more important research questions about the harmful effects systemically imposed on marginalized groups by the current policy.

Lack of support, abuse and privacy. Studies have shown that women with problem pregnancies most commonly share their situation with their intimate partners, unless their partner is abusive. Further, negative interactions with partners were associated with later terminations while supportive relationships were linked to earlier abortions than average (Kapadia, Finer & Klukas, 2011). Similarly, this study also concluded that support is a facilitator to access and that women in abusive relationships were noted to have experienced further delays. The current study offers some insight into how social approval/disapproval functions to either facilitate or block timely care. Confidentiality barriers were associated with an abusive intimate relationship, with women being vigilant to avoid privacy breaches such as consulting with their support system or family doctor; a process that often resulted in delayed care. Social support was shown to expedite care for women in need of information, a confidant, financial assistance, and help with travel and accompaniment to the procedure.

Blocked care. Unfortunately, no scientific research has investigated the number of unsafe abortions in Canada, or those of women effectively blocked from termination. Canadians for Choice (2006) has documented a few cases of women who were blocked and the larger study (MacQuarrie, 2014) showed that PEI women have been blocked from abortions and self-induced through self-harm. Adding to the few documented cases, the participants in the present study witnessed several more similar stories; of women who had ingested tisanes or excessive alcohol, or physically harmed themselves in order to bring on their period as well as women who were forced to parent against their will. These cases are few in number, however, the stigma surrounding abortion, being an unwilling parent and self-harm to self-abort are all tremendous barriers to accessible research on this important topic. Such research would be crucial to a better understanding of the long-term effects of barriers to abortion access.

Key Finding 4: Intersectional Oppressions Replicate the Status Quo

Effects of intersectional oppressions. Reflecting on the teachings of liberation psychologist Paulo Friere, bell hooks shares how this theory spoke to her on an individual level about the intersectionality of her oppressions growing up a lower SES black woman, where feminist theory at the time did not relate to her experience: “Since so many of the early feminist books really reflected a certain type of white bourgeois sensibility, this work did not touch many black women deeply; not because we did not recognize the common experiences women shared, but because those commonalities were mediated by profound differences in our realities by the politics of race and class” (hooks, 1994, p. 52). Apparent from the findings is the massive disparity of the effects of barriers on those with financial resources and those without.

The PEI context. The pattern of exacerbated discrimination against women and girls in vulnerable situations was clear to many of the participants, all of whom showed a high level of analysis and were angered by the injustice of the situations they relayed. Findings also showed a trend of multiple oppressions erecting further barriers; constellations of marginalization that left those living in the most difficult circumstances with less reproductive choice. Of abortion access in Canada, Kaposi (2008) writes

> Autonomy is at stake in the effort to improve access to abortion. Autonomy over this aspect of our lives is crucial because of the transformative power of reproduction. Bringing a child into the world can be one of the most life-changing events that someone can experience. But autonomy is not guaranteed by the decriminalization of abortion. Autonomy can be imperiled (or supported) by a myriad of interlocking social, psychological, institutional and other factors beyond the reach of women seeking to control their reproduction (p. 22).

Those further marginalized and needing to apply for financial assistance for travel costs are more at risk of delays and being blocked from care, as well as being at the mercy of breaches of confidentiality and potential humiliation.

Humiliation through privacy breaches. The unfortunate trend of humiliation through confidentiality breaches by helping organizations is significant and deserving of further attention. In a culture that silences and shames reproductive choice, most women access their care in secret. Those who are not able to do so risk being publicly outed, shamed and shunned. Each example of a privacy breach had distressing consequences for the families and women. Some endured being cut off from their community and resources, while others were publicly shamed over social media and by members of the anti-choice.

These powerful and often public acts scapegoat the most marginalized individuals seeking care, which serves as an example for others who may consider an abortion in the future. Scapegoating the less powerful upholds the culture of silence and blame, and works in tandem with internalized oppression and the invisible and redundant abortion access system.

Culture of silence underpinned by patriarchy. These significant forces help maintain the status quo at the individual, community and structural levels. Control of women’s reproduction is another mechanism of patriarchal and colonial control (Moane, 2007). The cultural silence that so permeated the findings of this study is rooted in a cultural and systemic sexism where women are expected to exist in a fixed, subordinate position in the nuclear family structure.

Critiques of the power dynamics inherent in the nuclear family structure date back to its popularization in the 1950s. Gramsci saw the fixed and expected formation as oppressive and serving of capitalist powers. Although his critique mainly focused on the role of the father, he predicted that the women’s rights movement would undermine elitist hegemonic rule by creating new ideas about patriarchal oppression (Boggs, 1976). Postmodern and feminist concepts of a family as diverse, fluid and multi-dimensional threaten the fixed and universal institution that

proponents of the nuclear family or the “pro-family” movement uphold. Where traditionally the man takes the top of the familial hierarchy as ‘head of the household’, women traditionally take on the role as subordinate. Stereotypical attributes assigned to subordinates include “submissiveness, passivity, docility, dependency, lack of initiative, inability to act, to decide, to think” (Miller, 1986, p. 7). Women in a traditional heterosexual relationship are more likely to be in a subordinate position to their partner’s dominant status. This hierarchy may show itself as restricting the female partner even further from access to time, resources, privacy and freedom. In the feminist uprising of the 1970s, there is was a strong pro-family presence, a crusade that is currently experiencing resurgence the United States. In her article examining the pro-family rhetoric, Adams (2007) exposes the anti-women’s rights bias inherent to the men’s rights movement. She shows how this movement operates to create ambivalence in women through a discourse that: “dwells on family decline, reinforces traditional gender hierarchy in the home, and demonizes feminism for promoting women’s individualism and “destroying” family life” (p. 502). Participants with a high level of analysis and rich history of advocacy repeatedly cited the anti-abortion rhetoric as being rooted in misogyny.

The reaction to feminist movements throughout history and in the current study not only show the risk associated with being an advocate, but also indicate the influence of such progressive movements and their capacity to create social change. Although at the time of data collection there had been few successes in this regard, the risks and commitment demonstrated by the participants and their movement has since made great cultural and political strides.

Abortion rights as threat to patriarchy. Abortion exists at a nexus of threatening topics to the Christian right, pro-family movement, and is therefore heavily silenced in PEI. In fact, the act of choosing an abortion subverts the traditional family role expected of a woman through

rejection of the subservient family position. Many participants also linked the pressure to keep the cultural silence in place as originating from the strong Christian right presence on the Island.

The need for an abortion could not exist without sex, a subject participants often pointed out as shameful and taboo, particularly sex before marriage, sex for pleasure, non-heterosexual sex, sexual assault, and incest. The final decision to terminate is most often decided by a woman, allowing agency and autonomy to a ‘subordinate’ in pro-family rhetoric. Also, as Kumar writes (2009) abortion stigma is “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood” (p. 628). The stigma of abortion also stems from women’s resistance to the feminine ideal as fixedly focused and eager to be a wife and a mother.

Not only are women and girls who choose to have an abortion subverting their supposed feminine ideal, the participants of this study and the group they represent are similarly reversing the roles upheld by the patriarchy and the pro-family movement. Importantly, the entire sample of participants were women despite the recruitment advertisement for the study calling on both men and women to participate. No statistical evidence of the gender divide of reproductive justice advocates currently exist, however, the obvious trend is that this group is predominantly female and in PEI there is hardly an exception to this rule. Abortion rights support people work together, mostly with other women, for the sake of women and their rights and autonomy. To a similar end, advocates take on roles that require them to be outspoken and fearless educators and leaders. These ideologies and positions clash with the feminine ideal that outlines a person who serves mainly the demands of her husband and family.

Epilogue: Support people and advocates shift culture and health policy

Although there is more work to be done, many of the recommendations laid out by the participants that are addressed in the next chapter have come to fruition in the years since the emergence of the larger study. The PEI abortion rights movement saw a resurgence as a result of the larger project in 2011 and the newly emergent groups have succeeded in making formidable shifts to PEI culture through persistent use of local and international media, social media, lobbying, speak outs, a gender and sexual health expo, press conferences, documentary screenings and many more instances of breaking the silence. As many of the participants interviewed in this study have finally seen shifts in culture and policy that they have been working towards for many years, the ambivalence and hopelessness expressed by many of the advocates and support people at the time of the interviews may not be as strong were they interviewed again today. In fact, the difficulties explored in this study on the individual level may be a part of the process of eventual, structural-level change. Advocates, new and old, have seen much more success in recent years by lightening the heavy abortion stigma through rupturing the culture of silence. Long years of hard work, compassion, and dedication have succeeded in shifting both the oppressive abortion-related stigma and most recently improved structural access to abortion. The campaigns executed by advocates have spread the idea that addressing PEI’s lack of abortion is an important issue, and actions unrelated to the study have recently cropped up. For example, a group of health care workers and academics conducted a study on how local access would affect the province’s economy, with results that demonstrated that many thousands of dollars would be saved with local services (Chapin, 2014). Recently, a poll indicated that pro-choice Islanders are in the majority (Wright, 2015).

While policy change is much slower, some formidable changes have recently occurred. Information on how to access abortion is now online on a government website and the information is available in some doctor’s offices. Just a few weeks ago, politicians were reluctant to address the issue, claiming that the status quo is still working for Island women (Guardian, 2015). However, following the advice of abortion rights advocates, PEI has removed some major obstacles to abortion access by eliminating the need for a doctor’s referral or an ultrasound by working with the Moncton Hospital to offer more streamlined access for Island women and girls. Since the change in policy is so recent, the reality of this new system and its level of accessibility are still unfolding. For instance, government officials have promised to address the travelling and overnight costs for low-income women, though no policy has yet been laid out. Another important aspect of this new development is the frankness with which it was announced. A press conference was held specifically around the abortion access issue and the word “abortion” was spoken publicly by politicians for this first time in the history of the movement. The procedure was also categorized under the banner of “women’s reproductive health”, as opposed to “status quo” or the “controversial issue” terminology that has been used up until this point. The change in semantics by government officials represents a powerful rift in the culture of silence on the meso level - a shift that support people and advocates have been working towards for over two decades.

The successes that have emerged since the time of data collection show that support people and advocates are capable of influencing first order change. No new data has been collected on this powerful group of people since these structural changes have taken place. More research is needed to assess how these gains affect the emotional outlook and change strategy of those involved in this important movement. While this progress is a major improvement to both

access policy and the culture of silence, only local access will secure the equitable and accessible care as mandated by the Canada Health Act.

Altogether, the unique findings of this study show that reproductive justice support people and advocates suffer from abortion stigma and silence on PEI in a way that mimics those that have direct experience with abortion. Findings also show that support people and advocates powerfully underscore the same barriers that are sighted by those with lived experience, and are essential to improving access for all women and girls, and particularly so for marginalized women and those of lower SES. Finally, although not yet acknowledged at the time of data collection, time has shown that the advocacy work done by the participants and others in the movement have been instrumental to both formidable cultural and policy change.

Chapter 9: Conclusions and Recommendations

To conclude, I will first describe the change recommendations relayed by the participants. The first set of recommendations deal with changes to policy that would bring PEI closer to the Canada Health Act that mandates accessible and equitable health care for all citizens. The second set of recommendations cover strategies to alter the oppressive culture of silence and blame that surrounds the topic of abortion on PEI. The next section covers the dissemination strategy for the findings of this study as well as reflection on my own involvement. Finally, gaps in research, limitations of this study and future directions conclude this thesis.

Breaking the Silence Change Strategy

The strong theme of policy and cultural change described the various changes desired by the participants; ranging from facilitation of access and expanded support to local and

comprehensive care. Specific improvements to the system like streamlining the system to avoid delays in care, or removing the local ultrasound requirement were also recommended by many, some of which have since been implemented by the PEI government.

Policy Change Recommendations

1. **Local Abortion Access within a PEI Hospital.** A few people questioned the need for local access or full choice, but most want to see local, health care covered access on PEI within the hospitals. A free-standing clinic was not recommended as it would be an easy target for picketers and a way to take away confidentiality from women using the service. Finally, local abortion care would help to create more equitable access for Island women.
2. **Confidential Care.** Confidential abortion care was seen as paramount to improving abortion access by each participant. Privacy infractions are inherent in the current health care system and have been seen to be extremely disruptive to the lives and livelihood of PEI who need abortion care. Non-confidentiality has also been linked to self-harm and self-induced abortions.
3. **Self-Referral for Abortion Care.** Most of the time-delay to abortion care is due to finding a doctor’s referral and waiting to access an emergency ultrasound on the Island. Such steps are avoidable by allowing women and girls to self-refer, and including the ultrasound as a part of the abortion procedure as is standard in many other clinics in Canada.
4. **Update Sexual Health and Rights Education.** Participants noted a lack of comprehensive education of sexual health or their rights to services. Education in local schools that include reproductive choice and speaking openly about sexuality as well as

one’s rights within schools, religious institutions and the health care system would be protective of Islander’s overall health and the health of communities.

An interesting tension emerged over the policy change recommendations in the themes of local or off-Island services for abortion care, where the vast majority of participants agreed that local access was imperative to improving reproductive choice for Island women. However, two support people expressed the opinion that abortion care would be best left to other provinces. One support person did not consider herself an advocate for reproductive justice and only felt the procedure was justified in situations that arose from need rather than choice. The other advocate lacked an awareness of the way marginalized women were more intensely affected by access barriers and was active at a time in the 1980s when access was more efficient than it was at the time of the interviews.

Cultural Change Strategy

PEI cultural silence has had a stronghold over the topic of abortion which served to limit access and obstruct progressive views. At the time of data collection, PEI culture could be viewed as existing at the bottom of the cycle of oppression in a state of “limited awareness” (Moane, 2009). The cycle of liberation according to LP theory involves gaining awareness, building strengths, making connections, and taking action. Although support people and advocates also laid out some policy change recommendations, most of their wishes for change were concentrated on reforming PEI culture, recognizing that a shift to a more openly communicative, progressive and woman-friendly society is integral to shifting structures and policy. It follows that the change strategy of support people and advocates focuses on breaking the silence through open dialogue, education, de-polarizing views, building networks and sharing personal stories.

De-polarizing views. Many participants took issue with the very polarized PEI public on the subject of abortion, perceiving this dualism as an obstacle to open dialogue and changing attitudes. Freire also views this polarization of the left and right as a block to revolution. In his book "Education for a Critical Consciousness" (1969), he refers to a closed position on either side as "sectarianism" and writes: "Sectarianism is predominantly emotional and uncritical. It is arrogant, antidiological and thus anticommunicative" (p. 11). Such a stance helps to then underpin cultural silence, a pattern recognized by many participants. While remaining pro-woman, the participants viewed open, patient and compassionate conversations as key to an abortion stigma-related cultural shift.

Sharing Stories. Many participants viewed sharing personal stories about abortion as integral to shifting the surrounding stigma and lifting the cultural silence. Feminist author bell hooks (1994) elucidates how sharing personal stories breaks the silence productively, creating opportunity for others to gain awareness and acceptance of differing perspectives:

> These narrative moments usually are the space where the assumption that we share a common class background and perspective is disrupted. While students may be open to the idea that they do not all come from a common class background, they may still expect that the values of materially privileged groups will be the class's norm. (p. 186)

According to hooks, sharing stories grows a critical awareness that allows listeners to question a hegemonic ideology that was previously assumed.

Building Bridges. Several participants saw opportunities for cultural change through banding together with other progressively-minded individuals and organizations. Building a community of resistance is the cornerstone from which the process of liberation and reversing the negative effects of oppression emerge in LP theory. Many participants saw the need to include abortion in the gamut of progressive health issues that are frequently avoided on PEI. Bridging the subject of abortion with other gender, health and sexuality issues would soften the

harsh stigma around the subject of abortion, and grow support people with like-minded groups and organizations. By connecting a network of supporters, participants saw the potential to reduce stigma and achieve a critical mass of people working together toward change.

Dissemination

The current research has already begun its community dissemination. The larger project has roots embedded in the community and many channels of communication have been built that I will also be using to disseminate my research findings. As a member of the advisory council, one of my roles is assisting in the dissemination of the research. I am in league with a number of different community voices: people with lived experience; researchers and students; support people and advocates; and representatives from non-government organizations. A number of effects have already been made on the community through media publicity of the initial findings by way of television, internet and radio news articles. Also, interviewees have bound together as an abortion rights lobby group, just as the advisory council has united under a second purpose—to move the government and community toward the goal of abortion access on the Island. These emergent organizations work in tandem supporting each other’s mission and strategies, as they continue to help disseminate the information gleaned from the study to the larger community.

In 2014 I helped organize and presented the findings shown here at the international conference “Abortion: The Unfinished Revolution”. Appropriately, this inaugural international conference on abortion in Canada took place in Charlottetown, PEI. My work highlighted the effects of PEI’s cultural silence on both access and advocates. Earlier this year, I participated with other abortion advocates in a fishbowl-style forum about what it would take to bring local access to PEI. This forum continued the important but mostly overlooked conversation about the difficulties of being an abortion rights advocate. The fishbowl was recorded with future research

and publishing potential on this often overlooked topic. Also, the current findings will become a chapter comparing PEI’s abortion situation with that of Ireland in a book set for publication later this year. Finally, I will also be producing a policy brief of the recommendations set out by the participants that will be addressed to the provincial government and the PEI Human Rights Commission.

My own abortion rights advocacy in PEI has only grown stronger through the process and praxis of writing this thesis. I have been and am continually active in the struggle for local access. As someone who will be looking for work in PEI and is therefore susceptible to the ramifications that advocacy may have on my fragile working status, I am more aware that my fear is rooted in a systemic oppression that affects all pro-choice Islanders. This awareness helps me accept my limitations while also strengthening my will to continue in this work and grow more comfortable breaking the silence with my own voice. As this was being written I was responding to press about the reluctance of party leaders to promote local access, and I took the opportunity to include some of the repercussions that support people and advocates face when going public (McKenna, 2015). However, since the recent policy changes, a shift in cultural silence has become more evident. As abortion-related stigma and policies shift, so lighten my fears of repercussions on my work-life. This dynamic reinforces the important work of advocacy, personal support and the ability of dedicated groups to instigate powerful changes. Although more work is needed, the cycle of liberation is well summed up in the words of feminist Margaret Mead: “Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has”.

Gaps in Research, Limitations and Future Directions

Research that looks into abortion is generally limited, and the bulk of studies on the subject tend to dwell on the demographics and characteristics of those who undergo the procedure. However, this area of study is not helpful to inquiries about access and advocacy. The limited research on abortion access is in accord with the findings of this study, strengthening the conclusions that policy barriers, economic limitations, geographic disparities, stigma and a lack of social support are all obstacles to abortion care that further marginalize women and girls. The current study exposed some new barriers that may be particular to PEI, including the long wait for an “emergency” ultrasound and the systemic breaches of confidentiality for women of lower SES status.

The effects of these barriers can have dire and lasting consequences, and are therefore deserving of further research both in PEI and worldwide. Effects of the barriers again align with the limited research on the subject, showing that those of lower SES status are particularly vulnerable to the barriers and their consequences, and that other marginalized groups are suffer more concentrated effects. While abortion access from PEI discriminates against all women and girls, the trend of exacerbating the obstacles to access for marginalized women to extreme levels may have long-term effects on disadvantaged individuals and communities in terms of poverty, women’s agency, and independence. More information is clearly needed to address the long-term outcomes of these restrictive policies.

Some research has shown that immigrants, refugees and ethnically diverse women are subjected to more barriers, also with devastating outcomes. Unfortunately, the current study with its small sample size either did not include such groups, or the racial categorization was not addressed by the participants. Because the ethnicities of the women and girls assisted by the

participants were not mentioned, it is plausible that the barriers, facilitators and outcomes represented here may be indicative of a dominant narrative, to the exclusion of immigrants, refugees, and ethnic minorities. Since PEI’s tight-knit social culture is a barrier to inclusive relationships for those who are “from away”, it is also conceivable that abortion access may be particularly difficult to groups viewed as outsiders. In addition to connections and financial resources, legal status and fluency in the dominant language may be facilitators to access that such groups are excluded from. It follows that racially diverse groups in PEI may be further marginalized by the policy restrictions and investigations into these matters would be a crucial addition to research that aims to address the local inequality of abortion access.

The recent changes in the abortion policy and stigma on PEI call for further research to build and extend on the findings from the current study. In light of the new abortion policy, barriers and facilitators to access and their effects ought to be addressed by research with a view to improving the health care system. The currently unfolding cultural shift also deserves scholarly attention. As support people and advocates to access are finally seeing the fruits of their labour on political and social levels, their experiences, perspectives, and involvement in the movement may shift as well. Also, because many of the participants’ recommendations have been put into action with palpable results, reflections on their successes and future change strategies may be beneficial to the reproductive justice movement locally as well as more broadly.

Finally, the current study has shed some light on a significantly under-researched area; the experiences of abortion support people and advocates. With virtually no research existing previously in this area, these findings can be considered both exploratory and primary research on this topic. Since significant findings show that speaking out for abortion rights may hold

powerful repercussions including work insecurity and community alienation, more research is clearly needed to follow up this important gap in abortion research. Investigating the effects of advocacy may help supporters to understand abortion stigma as well as to further change strategies for the reproductive justice movement. Insights may serve to assist the movement by helping advocates understand the effects of courtesy stigma and therefore be informed as they choose their roles. Knowledge in this area may also spurn further conversation and change in the areas of the injustices faced by advocates as they endeavour to help women in need. Finally, the eventual cultural and policy changes that have emerged since the data collection stage of this study substantiate the influence of research that involves its community, the incredible capacity for structural change held by dedicated support people and advocates, and a call for more research in these areas.

Appendix A - Interview Guide for Support people and Advocates Member Check Group

Thank you so much for coming today. The purpose of this study is to understand what barriers and facilitators women face when trying to access an abortion from PEI so that we can try to improve abortion access for Islanders, as well as what the experiences of support people and advocates to abortion rights in PEI. Before we begin I would like to remind you that your participation in this study is completely voluntary, and you are able to pass on any questions or leave at any time without penalty, no questions asked.

I will not use any quotes in my final report from this member check so your identity will be protected. I will be taking notes on our conversation, but feel free to let me know if you would like to say something off the record. You can ask me questions at any time. Because laws require me to report any instances of suspected child abuse, I ask you to consider this when disclosing information about anything that would suggest child abuse to yourself or anyone else has taken place. As you know these groups cannot guarantee anonymity, but if we can all agree that what we learn from each other today remains confidential, we can help create a safe space for talking about our experiences. Can we agree to say what is said in this room stays in this room? Any questions before we begin?

1. What part of the Island are you from?

2. What does the word “abortion” mean to people in your community?

    -Were there any negative messages about abortion that had an impact on you?

    -What were they?

    -How did they affect you?

3. I’m going to present the findings from the research that we did on accessing abortion from PEI using a flip chart. After each finding I’d like to have a discussion about what you think about those findings.

   –How do these findings resonate with you?

   – Is there anything you’d like to add or change?

4. Do you think there are any other things I should know about what it’s like to get an abortion from PEI?
5. Do you think there are any other things I should know about what it’s like to be abortion rights support person or advocate?

Do you have any questions?

Thank you very much

Appendix B - Terms of Reference

This Terms of Reference refers to the nature of collaboration between myself and the team of researchers and advisory council that makes up *Trials and Trials* in regard to decision-making and authorship.

All thesis-related decisions regarding project development will be made by myself in consultation with Dr. Colleen MacQuarrie, with input from the advisory council. Members of the advisory council or broader pro-choice community who express interest in collaborating on any publications or articles will be involved in writing, editing and approving final products on which they are authors.

Those on the advisory council interested in being given credit will be named in the acknowledgments section of any publications resulting from the proposed thesis work. To meet the requirements of my academic program, I will be completing a solo-authored thesis manuscript to be submitted to Wilfrid Laurier University in fulfillment of my degree. Dr. Colleen MacQuarrie will be listed as second author on all publications arising from my thesis. In the event that I am unable to finish developing a manuscript, Dr. Colleen MacQuarrie will take over the responsibility and thus secure first authorship.

Appendix C – Ethical Approval

July 08, 2013

Dear Emily Anne,

REB # 3662

Project, "Understanding for a Change: Exploring the Factors that Facilitate and Block Access to Abortion in PEI from the perspective of support people"

Expiry Date: August 31, 2013

The Research Ethics Board of Wilfrid Laurier University has reviewed the above proposal and determined that the proposal is ethically sound If the research plan and methods should change in a way that may bring into question the project's adherence to acceptable ethical norms, please submit a "Request for Ethics Clearance of a Revision or Modification" form for approval before the changes are put into place This form can also be used to extend protocols past their expiry date, except in cases where the project is more than four years old. Those projects require a new REB application.

Please note that you are responsible for obtaining any further approvals that might be required to complete your project.

If any participants in your research project have a negative experience (either physical, psychological or emotional) you are required to submit an "Adverse Events Form" to the Research Office within 24 hours of the event.

According to the Tri-Council Policy Statement, you must complete the "Annual/Final Progress Report on Human Research Projects" form annually and upon completion of your project all forms, policies and procedures are available via
the REB website http://www.wlu.ca/research/reb.

All the best for the successful completion of your project.

Yours sincerely,

Robert Basso, PhD

Chair, University Research Ethics Board

Wilfrid Laurier University

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