SUBVERTING WOMEN:
ACCESS TO ABORTION SERVICES IN MANITOBA

by

Brenda Comaskey

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF ARTS

Department of Sociology
University of Manitoba
Winnipeg, Canada

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ABSTRACT

"Subverting women." The title of this project has dual meanings. On the one hand, women's lives and experiences are subverted by power inequality and by dominant discourses which claim to know the 'truth' about women's lives. The first parts of this study outline these processes from the perspective of feminist poststructuralism. On the other hand, women themselves can be 'subverting' in that they challenge patriarchal relations and strive to expand alternative discourses which better reflect their lives and experiences. The latter parts of this study describe the findings of interviews with nine women in Winnipeg about their experiences accessing abortion in Manitoba.

Three main themes emerged from the interviews: the meaning of the abortion experience to the women; barriers to access; and the stigma and silence attached to abortion. This study privileges the words of the women who participated. The women define their experiences as their own, contrary to the dominant discourses. Their stories provide us with an opportunity to challenge the way the dominant discourses frame abortion, as well as the barriers they create and sustain, and to identify areas where access can be improved.

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... the meaning and practice of abortion is central to the reproduction of the human species, to our understandings of gender, and our life ethics. (Condit, 1990:2)

What is available about women's abortion experiences has been written by providers. They are interested voices but do not show the interests of women. The medical and media literature is overwhelmingly 'loaded' with anti-abortion discourse and does not reflect the majority view about abortion ... There is a need to privilege the voices and experiences of women in order to identify the conditions for optimum service provision. The very people who have abortions are not represented in the discourse. (Ryan, Ripper, and Buttfield, 1994:1-2)

INTRODUCTION: The Research Question

> Increasing the participation of women in the creation of the discourse, adding formerly excluded voices, will cause the creation of new words and new ways of thinking. (Greschner, 1990:643)

In January 1988, the Supreme Court of Canada found section .251 of the *Criminal Code*, Canada's 1969 abortion law, to be unconstitutional and demonstrating "state interference with bodily integrity" (cited in Ontario Coalition for Abortion Clinics, 1988:109). As a result, there are currently no criminal sanctions for those seeking or providing abortion services. Although the decriminalization of abortion in Canada provided women with a "negative right" to control their reproductive capacities, "what they lack is a claim, or positive right to access safe, subsidized and efficient abortion facilities" (McConnell and Clark, 1991:81). Despite the absence of legislation, abortion services across Canada are not uniformly accessible. There are many extra-legal barriers to access that vary by province, and within each province. Access varies by age group, ethnic or cultural background, geographical location, and socioeconomic status (Henshaw, 1995; Planned Parenthood Manitoba, 1990).

Abortion has been discussed extensively in public (moral), medical, and legal discourses. As many authors have suggested, the issue of abortion is contentious not so much because it deals with the termination of a pregnancy *per se*, but because of what abortion symbolizes: it challenges steadfast assumptions about the role of women and the traditional family (Ryan, Ripper and Buttfield, 1994; Brodie, Gavigan and Jenson, 1992; Colker, 1992; Condit, 1990; Ginsburg, 1989; Smart, 1989; Luker,

1984). As Grindstaff (1994) observes, abortion serves as a "condensing symbol" around which values and opinions are opposed.

> Abortion is one of those issues that highlights the tensions between tradition and change, played out simultaneously on the individual female body and collectively through social, political, legal and mass media discourses that constitute it. (Grindstaff, 1994:57)

The broader political nature of the abortion debate has been waged around issues of criminality, morality, health care, and fathers' rights, but most often 'protection' of the foetus. As Gavigan (1992:131) observes, despite claims that the object of attention is the foetus, "it is clear that the real objects of the foetal personhood campaign are *women*." As a result, various barriers to access are created and supported within dominant discourses which subscribe to traditional conceptions of women's role and the family. Yet, these discourses do not represent the voices of women who have attempted to access, or have successfully accessed, abortion services.

From a sociological perspective, the manner in which the abortion debate is framed is critical to understanding both the obvious and more subtle barriers to access. Legal, medical and moral discourses define the abortion issue in different ways. The issue of abortion is debated and redefined continuously within these perspectives but, as Willis (1990:131) notes, the debate has become "sexlessly scholastic," as the focus has been on the foetus, and women have been erased from the equation. In order to assess the impact of such discourses on the issue of abortion, it is important to examine how abortion is framed, and if and how these discourses are reflected in the experiences of women who have sought abortion services.

With an unstable climate of access in Canada, and specifically in Manitoba, it is important to determine how those seeking to terminate a pregnancy feel about their own experiences, what barriers these women may have faced in seeking abortion services, and what they feel are necessary measures to ensure that women can freely exercise reproductive choice. It is important to determine if the various discourses *do* or *do not* reflect women's needs and experiences. Although there has been abundant research conducted to determine the psychological impact of the abortion experience (e.g., Wilmoth, Alteriis and Bussell, 1992; Armsworth, 1991; Lemkau, 1988; Greenglass, 1981; Osofsky and Osofsky, 1972; Jansson, 1965), and some studies have examined the impact of refused abortion (Dagg, 1990; Simon, 1981; Hook, 1963), there is a need for more research which focuses on women's experiences of seeking an abortion. I explore these questions from a Manitoba perspective.

The purpose of this study, then, is threefold: to examine women's experiences in seeking abortion services in Manitoba; to discover the range and nature of barriers, if any, that women have encountered in attempting to access abortion services since 1988; and to assess the implications of those barriers. Chapter One provides an overview of the theoretical framework for this study. Contributing to the current climate of access are the dominant discourses of law, medicine and morality, all of which fuel the 'politics' of abortion (Brodie, Gavigan and Jenson, 1992). The politics surrounding the issue are manifest in efforts to deny or improve access for women in Canada. Gavigan (1984:20) also notes how law, in its criminalization of abortion, has been intimately connected with religious ideology (moral discourse) and medical

science (medical discourse). Informed by feminist poststructuralism, a discussion of moral, legal, and medical discourses illustrates the power of dominant discourses in giving meaning to social phenomena - in this case, access to abortion in the province of Manitoba, and how they create and sustain barriers to access. These discourses cannot be seen as mutually exclusive, as they overlap in many areas, and this adds to their power. Chapter Two examines the main substantive issues for this study - the context of access to abortion. Chapter Three describes the objectives of the study and the research methodology. Chapter Four provides a summary of the women who participated in the study, and individual profiles of each woman interviewed. Chapters Five, Six, and Seven present the women's stories - the major themes and the common and contrasting experiences that emerged in the interviews. Chapter Eight examines the results of the study (the women's voices) compared to the theoretical framework and the dominant discourses, strategies for change, strengths and limitations of the research, and conclusions.

CHAPTER ONE: Theoretical Considerations

I. Theoretical Framework

The purpose of this chapter is to elaborate on the theoretical approach or framework which informs the research. The discussion begins by situating the analysis within the broader context of the feminist critique of patriarchy, broadly understood as the (re)production of unequal social relations based on gender. While consonant with other feminist work, this study takes its lead from the poststructuralist perspective, especially in terms of its attention to the production of knowledge and the construction of meanings and subjectivities through language and discourse(s). As such, the basic tenets of poststructuralism will be outlined, including its feminist variant. This will set the stage for a discussion of the dominant discourses (moral, medical, legal) which have prevailed around the issue of abortion.

Feminism and Patriarchy

> As feminists have observed, dominant conceptions of reality and truth in patriarchal Western society have tended to be male constructions which reflect and perpetuate male power interests. (Gavey, 1989:462)

Feminist thought has been critical of how social relations have been constructed, particularly with respect to the unequal power relations based on gender. Particularly in the powerful bastions of politics and the paid work force, and in other social institutions such as the family, women have been afforded little or no power. This power inequality has facilitated the mistreatment and devaluing of women and girls around the world. Feminists identify systems of gender inequality as patriarchal.

From a patriarchal perspective, sexual difference has been constructed as 'natural,' concealing the social construction of power and bodies (Diamond and Quinby, 1988:xv). This stems from privileging (white) male experience. As such, what is 'female' has been viewed as inferior. As Diamond and Quinby note (1988: xv), "masculinist domination has been supported and justified through a whole set of binary oppositions that grant superiority to the first term over the second - male/female, mind/body, spirit/matter." Women are considered closer to nature - passive, emotional, and irresponsible (Smart, 1995:95) - and these linkages are dependent on the binary distinctions. What is female is not male. Maleness is often characterized as rational, logical, and the *standard*:

> In patriarchal discourse, the nature and social role of women are defined in relation to a norm which is male. This finds its clearest expression in the generic use of the terms 'man' and 'he' to encompass all of humankind. (Weedon, 1997:2)

Not only do such traditional conceptions assume that sexual difference is 'natural,' but this notion is used to justify the idea that men and women are suited for different social tasks (Weedon, 1997). This becomes problematic when tasks assigned to males are privileged over those assigned to women. Women's work is devalued. This sexual division of labour is a focal point for feminism. There is an assumption that women are best suited for the roles of 'wife' and 'mother.' Feminism poses a challenge to these assumptions. Historically, abortion has been perceived as a moral sin and a symbol of women's rejection of their 'natural' role. The quest for reproductive freedom *challenges* patriarchal discourse, which has defined women primarily in terms of their role as child bearers (Brodie, 1992:81).

Feminist politics and theories challenge patriarchal ideas and relations (Weedon, 1997). To this end, Shelley Gavigan (1992:8) notes that feminist scholars "have become increasingly sensitive to the power of language and discourse in the social construction of unequal gender relations." To address this inequality, there is a need to change the material conditions of knowledge production, and to do this requires an examination of how and where knowledge is produced, who produced it, and what counts as knowledge (Weedon, 1997:7).

Poststructuralism

> Patriarchy implies a fundamental organization of power on the basis of biological sex, and organization which, from a poststructuralist perspective, is not natural and inevitable, but socially produced ... (Weedon, 1997:123)

According to postmodern theorists, knowledge is a mechanism for exercising power, and power is constituted through knowledge (Weedon, 1997, 1987; Smart, 1989; Foucault, 1978). Further, there are many knowledges. Postmodern theory rejects the notion of a single *truth* which exists and must merely be found, and instead seeks to "reveal those interests on whose behalf 'Truth' is constructed" (Currie, 1991:70). Poststructuralist theory, often conflated with postmodernism, is more specific. Smart (1995: 231) suggests, albeit in a simplified form, that poststructuralist theory "provides analyses of 'things' (subjects, documents, accounts, discourses) while [postmodernism] is about critiques of philosophy and epistemologies."

From the poststructuralist perspective, patriarchy is one of many socially produced phenomena. Although poststructuralism rejects 'totalizing' concepts and categories, such constructions can be understood as historically and culturally specific 'conditions' (Smart, 1995:78-79). When we come to understand the categories of 'woman,' 'man,' and 'patriarchy' as one of many constructions, with many meanings, space is created for alternative understandings which challenge the power that dominant constructions hold.

Foucault's (1978) work on power, knowledge and discourse is central to the poststructuralist perspective. As Weedon (1987:107) states:

> It is in the work of Michel Foucault that the poststructuralist principles of plurality and constant deferral of meaning and the precarious, discursive structure of subjectivity have been integrated into a theory of language and social power which pays detailed attention to the institutional effects of discourse and its role in the constitution and government of individual subjects.

Power is central to Foucault's analysis. Discourses such as those embedded in the institutions of medicine, law, and science stake a claim to *truth*. Foucault (1978) refers to these as 'discursive fields,' which consist of "competing ways of giving meaning to the world and of organizing social institutions, subjectivity and power" (Weedon, 1997:34). In order to exercise such control, they must discredit other discourses which challenge their power. Just as there are several discourses which define a phenomenon in different ways, these do not exist within a vacuum. According to Foucault, the tension between these discourses operates within what he terms 'force relations.' In other words, the discourses themselves take particular forms *through* relations of gender, race, religion, class, and age (Foucault, 1978:101-102). Consequently, the

power conflict (for example, how abortion is framed) has important implications for how subjects (women seeking abortion) are governed. This theory illustrates one way of conceptualizing power as a social construct on a broad scale, and specifically in the case of gender relations.

Although Foucault's theory is not feminist, "his analysis of power as a process that produces particular forms of sexuality and bodily practices is consonant with feminism" (Currie, 1991:73). Weedon (1997) suggests that the absence of feminism from Foucault's analysis is less important than its ability to help produce critical feminist analyses. Diamond and Quinby (1988:x) identify four areas where feminist thought converges with Foucault: both identify the body as a site where power is contested; both point to "local and intimate" functions of power rather than power as an overarching phenomenon of the state; both focus on the role discourses play in sustaining hegemonic power as well as the difficulties faced by more marginalized discourses; and both are critical of how Western humanism has privileged the 'male' experience. To summarize, feminism and Foucault come together in their efforts to "dismantle existing but heretofore unrecognized modes of domination" (Diamond and Quinby, 1988:x).

While Foucauldian thought can inform feminist theorizing around discourse and power, Smart (1992a; 1990; 1989) suggests that Foucault's analysis is lacking because it does not focus on the discursive power of law so much as law at its extreme. She suggests that Foucault's analysis can be extended to include processes *outside* law (which can include medicine and morality), and that law can be positioned in a

'hierarchy of knowledges' (Smart, 1990). These 'knowledges,' or discourses, exercise power in a variety of ways. Of particular concern to this study is the impact of various discourses on the body as a site of contested meanings.

The Body

> Knowledges require the interaction of power and bodies; correlatively, power requires knowledges of bodies and behaviours in order to remain effective and 'in play' ... Bodies are thus essential to accounts of power and critiques of knowledge. (Grosz, 1993:196)

According to Foucault, one major locus of power is the *body*. Particularly in the abortion issue, the body is a site of competing discourses. As Weedon (1987) suggests, "[d]iscourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and *emotional life of the subjects which they seek to govern*" (1987:108, emphasis added). The body *only* has meaning within discourse:

> Neither the body nor thoughts and feelings have meaning outside their discursive articulation, but the ways in which discourse constitutes the minds and bodies of individuals *is always part of a wider network of power relations, often with institutional bases*. (Weedon, 1987:108, emphasis added)

There are numerous historically specific discourses which have an impact on the body. At the beginning of the eighteenth century, according to Foucault (1978), women's bodies were given meaning and were subject to modern science - through the process of *hysterization*. Women were reduced to wombs, "analyzed - qualified and disqualified," and simultaneously made 'nervous'" (Foucault, 1978:104). Hunter

(1994:4) refers to the body in the context of the abortion issue as "a metaphor of the social order." He suggests that this is why the issue has been so contentious:

> If the body is indeed a metaphor of the social order, then a conflict over our understanding of the body ... signals a conflict about (if not a turning point in) the ordering of our social life, and perhaps civilization itself. (Hunter, 1994:4)

Simpson (1994) suggests that changes in late capitalism have affected discursive conceptions of the body. Shifts in the productive sphere have contributed to what he refers to as the "patric body," which metaphorically represents a "distinctively gendered heterosexual body - male or female - producing and reproducing instrumental male dominance and expressive female submission" (Simpson, 1994: 9-10).

Traditionally, women have been regarded "more as unpredictable bodies than rational beings" (Smart, 1989:91). Biological determinism has suggested that women are slaves to their biology, and this rationale has been and still is used to justify discrimination against women on the basis of their reproductive capacities. However, Simpson states that although such conceptualizations persist,

> .... [T]he body-oriented issues that are, today, so much in the public eye - homosexuality, pornography, abortion, and so forth - find their proximate immediate stimulus *in the decline of the 'patric body' or the ebbing of the hegemony of the male-dominated nuclear family*. Thus, where the body-sensibility generated by late capitalism is conjoined to the forces operating to deconstruct the hegemony of the patric body, the contemporary politics of the body arises. (Simpson, 1994:7, emphasis added)

The notion of the gendered body has been extended by Carol Smart, among others. In examining the way that the discourses of law, medicine and social science have interweaved to problematize the female subject, Smart (1992a; 1992b) suggests that the category of Woman is constantly subject to differing constructions. The

interpretations of the category of Woman over time have demonstrated "the dominant idea of disruption and unruliness which is seen to stem from the very biology of the body of Woman" (Smart, 1992a:7). Dominant discourses, as will be discussed, have conceptualized the female body as "unruly" (Smart, 1992b) and in need of surveillance. Particularly with respect to law, Smart (1989:92-93) suggests that the reason that law has taken such interest in women's bodies is because "it has defined them as specific sites of activity over which the law should have jurisdiction." In other words, women's bodies have been a focal point for law because they are the site of reproduction and, therefore, at the centre of legal struggles over inheritance, illegitimacy and adultery. Moreover, women's bodies have, like children's, been subjected to 'legitimate' corporal punishment, and they have been legally defined as the property (sexual and otherwise) of their husbands (Smart, 1989).

Power is exercised over women by dominant discourses in both claiming to define the issue of abortion as either a crime (law), a medically controlled procedure (medical), or a sin (moral). Even in a climate where no law exists, these discursive fields compete to frame the issue in language and practice by creating and supporting barriers to access. The sexuality of the body is also a locus of power which has resulted in the 'policing of sex' (Foucault, 1978:25). The 'confessional mode,' developed in Catholicism, is the most powerful form this policing takes (Weedon, 1997). The 'questioner' (society and the dominant discourses) passes judgement on 'the confession' (e.g., 'I had an abortion'). This creates a climate of stigma.

Grosz (1993) draws a distinction between two approaches to theorizing about the body: the 'lived' and 'inscriptive.' The 'lived body' is experiential - "the body's internal or psychic inscription" (Grosz, 1993:196). For psychoanalysis and phenomenology, the focus is on how the body is "experienced and rendered meaningful" (Grosz, 1993:196). The inscriptive approach focuses on how the body is "marked, scarred, transformed, and written upon or constructed by the various regimes of institutional, discursive and nondiscursive power as a particular kind of body," as in the works of Nietzsche, Kafka, Foucault, and Deleuze (Grosz, 1993:196-97). The former is how the subject experiences her own world, and the latter is the body as it is constructed in social institutions and dominant discourses. This distinction is useful when attempting to contribute to feminist epistemologies. Subjects are discursively constructed, but they are also experiential (Comack, forthcoming).

These ways of theorizing about the body have implications for feminism. Recognizing the 'specificity' of the body, that there is no *one fixed meaning*, means that:

> ....[T]he hegemony over knowledges that masculinity has thus far accomplished can be subverted, upset, or transformed through women's assertion of 'a right to know,' independent of and autonomous from the methods and presumptions regulating the prevailing (patriarchal) forms of knowledge. (Grosz, 1993:187-188)

In examining how women themselves define their experiences of accessing abortion (in relation to the ways dominant discourses construct the experience), women's experiences must be privileged, *as well as* their understandings of those experiences - how the women have been 'scarred and transformed' by those experiences. Language

plays a key role in poststructuralist theory with respect to discursive constructions, and the possibility of challenging those constructions.

Language as a Site of Struggle

> The plurality of language and the impossibility of fixing meaning once and for all are basic principles of poststructuralism. (Weedon, 1997:82)

All forms of poststructuralism "assume that meaning is constituted within language," and that language is "the common factor" in analyses of social organization, social meanings, power, and individual consciousness (Weedon, 1997:21-22). As with other social phenomena, language is socially constructed. By extension, our senses of ourselves (that is, our subjectivities) are also socially constructed through language. As competing discourses struggle to define phenomena and give them meaning, power relations may shift. Poststructuralism suggests that these meanings are not fixed.

A central concept for understanding language from a poststructuralist perspective is the structural linguistics work of de Saussere (Weedon, 1997:23). From his perspective, language is viewed as a chain of 'signs,' which consist of a 'signifier' (sound or written image) and the 'signified' (meaning). According to de Saussere, each sign derives its meaning not in and of itself, but by its *difference* from other signs in the chain (Weedon, 1997:23). Thus, signs are relational. It is in this sense that the true contestability of meaning is illustrated. What one discourse assigns as meaning to a particular word or set of words may not be how other discourses use the language. Similarly, different 'signs' are used to describe the same or like phenomena by

different discourses. For de Saussere, meanings are more 'fixed' (Weedon, 1997). Poststructuralism moves beyond abstract (fixed) notions of language and views meanings to be defined by competing discourses. For any given word, what it means at any particular moment "depends on the discursive relations within which it is located, and it is open to constant rereading and reinterpretation" (Weedon, 1997:25). The way different discourses define abortion is one example (Chapter Two).

Feminist poststructuralism suggests that subjects (women) can resist the positions offered by the dominant discourses by voicing an alternative (subversive) discourse and subjectivity (Weedon, 1997).

Feminist Poststructuralism

While feminism challenges gender inequality and patriarchy, there is a need to move beyond the examination of these social constructions. As Weedon states:

> .... [R]ecognizing contradictions and the power relations and interests which inhere in specific definitions of women's nature and social role is only the first stage in the process of change both for individual women and in the struggle to transform social institutions. This process requires the development of alternative senses of ourselves as women, and strategies for transforming existing institutions and practices. (Weedon, 1997:5)

The 'alternative senses of ourselves' that Weedon refers to are the subjectivities we construct. The term 'subjectivity' refers to "the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (Weedon, 1997:32). For feminist poststructuralism, the focus is on the way that patriarchal subjectivities are constructed, and how these define what we understand and know. Just as meanings are not fixed in

poststructuralism, neither are subjectivities. Discourses create different subjectivities which are in turn part of power relations (Weedon, 1997). It is important to 'decentre' these subjectivities, that is, to reject the notion that any one subjectivity exists. This opens the door for change. Space is created for new subjectivities to be voiced.

According to Weedon (1997; 1987), examining these subjectivities is critical, but alone this is not enough. The experiences of subjective actors need to be situated in material and social power relations. Smart (1995:231) argues that to investigate legal (and other) constructions of women,

> .... is of little value unless we are also talking to women ... Indeed, we could not begin to conceptualize the ... construction as something quite so specific, if we did not already have other versions constructed from accounts provided by women. Putting this in more theoretical terms, we must never forget that women discursively construct themselves. It is not only legal, medical, sociological etc. discourses that can do this. If we forget to do this, we risk disempowering 'women' and overinflating the power of more organized discourses.

What Smart is saying is that women's accounts and understandings of their own experiences need to be examined if we are to examine (and challenge) dominant discourses' constructions of their lives. Subjects share their accounts, and create new subjectivities through language.

Poststructuralism focuses on the "discursive construction of the subject" (Smart, 1995:8). Where poststructuralist theory, generally, takes this as its starting point, *feminist* poststructuralism recognizes the importance of the experiential also (Weedon, 1997). These two elements - the discursive and the experiential - are critical when examining women's lives (Comack, forthcoming).

> This involves acknowledging that there are experiences which women encounter in their lives (the 'non-discursive') as well as women's ways of making sense of those experiences and their effects (the 'discursive'). (Comack, forthcoming:12)

The dominant discourses, while assigning their own definitions and meanings to women's lives, do not have access to the experiential. It is in the stories of the subjects themselves that we can begin to understand how dominant discursive constructions affect their experiences, *and* how the subjects (women) integrate those constructions into their own lives. Through their own language, and the multiple meanings assigned to their experiences, subjects offer alternatives to dominant constructions. As Weedon (1997:85) suggests: "An individual's subjectivity is constituted in language every time she speaks."

Herein lies the potential for subversive discourses to create space for their own words. The silence surrounding abortion, particularly women's experiences, keeps those words hidden. Challenging the dominant definitions of abortion is dependent on the understandings (discourses) of the women who have sought abortions.

Challenging (Subverting) Dominant Discourse

> We are witnessing a struggle over meaning in which challenges to traditional knowledge (power) require no less than a major change in forms of subjectivity and understanding. (Smart, 1989:2)

Traditional, dominant discourses - or bodies of knowledge - have assigned *meaning* to concepts and ideas which both frame that concept or idea, and have an impact on our consciousness. As these bodies of knowledge stake such a claim to 'truth,' other discourses are rendered silent. The experiences and voices of groups that

do not possess the power to frame knowledge are subsumed under those dominant discourses. For example, medical, legal, and moral discourses all hold a claim to the definition of abortion. The 'issue' is debated and reconceptualized on a number of levels. Consequently, the experiences and voices of those most affected by the issue - women - are seldom heard. Instead, the medical, legal and moral discourses 'speak' for women. Further, such discourses influence our own thinking and experiences, including those who are governed by them. As Weedon (1987:33) points out,

> As we acquire language, we learn to give voice - meaning - to our experience and to understand it according to particular ways of thinking, particular discourses, which pre-date our entry into language.

Introducing the voices or discourses of marginalized groups "becomes part of a process of changing our ways of conceptualization" (Smart, 1989:1). Because women as a class have largely been silenced by dominant discourses, traditional constructions of women and the female body have prevailed. Moral discourse has typically regulated anything sexual, particularly women's bodies, and medicine has medicalized and regulated women's reproductive functions. Further, criminal defences such as PMS and other 'syndromizations' (Comack, 1998) reinforce the mind/body link in legal discourses. For discourses to be effective at challenging those definitions, they must be *active* through the agency of the persons they govern as "embodied subjects" (Weedon, 1987:112). This is why the voices of groups that have had discourses *imposed on them* are necessary as a challenge to dominant constructions.

Feminist poststructuralism looks at relations of language, power and subjectivities, social processes and institutions to identify those areas and strategies for

change (Weedon, 1997:40). In examining those dominant discourses, it is critical to find points of contradiction or weakness where challenges may be successful. Where there is discursive disunity, the potential exists to offer alternative meanings. According to Weedon (1997:106-107):

> Reverse discourse has important implications for the power of the discourse it seeks to subvert. As a first stage in challenging meaning and power, it enables the production of new, resistant discourses ... Resistance to the dominant at the level of the individual subject is the first stage in the production of alternative forms of knowledge, or, where such alternatives already exist, of winning individuals over to these discourses and gradually increasing their social power.

Research such as this study which provides a forum for women who wish to have access to abortion services is critical to subverting dominant discourses, expanding alternative constructions of abortion, and "winning individuals over." Particularly with a silenced issue such as abortion, the sharing of information and experiences can bring together, on some level, the women who have had the same experiences.

The next section examines the dominant discourses (moral, legal and medical) and how they construct abortion. This discussion provides a basis for comparison with the subjectivities the women in this study have constructed about their own experiences.

II. The Dominant Discourses

The first step in moving toward an alternate discourse which is reflective of women's views and experiences is to identify those dominant discourses and the manner in which they frame the abortion issue. As Kellough (1996:5) reminds us:

> Like all social practices, reproductive practices are constituted by the discourses in which they are thought, and thus a woman's decision to abort her pregnancy cannot be fully understood without considering the discursive emphasis that a culture places on the rights or responsibilities assigned to reproductive activity.

Moral Discourses

It is perhaps in the realm of morality that the abortion question has been most contentious. A dominant feature of moral discourse is the polarization of positions. The commonly held views on abortion are 'pro-life' and 'pro-choice.' An individual is seen to be either *for* or *against* abortion. Ryan et al. (1994:193) suggest that such polarization "establishes and reproduces abortion as the 'bad' or unfortunate side of a dichotomy in which something else is posited as 'good.'" What is deemed to be 'good' is motherhood. Moral discourse assumes that this role is natural for women, and that barring any interruptions or conscious decisions, the path from conception to birth is inevitable. No 'good' mother would abandon this role. This assumption is pervasive:

> The perception that women provide care for others because of some essential or imposed powerlessness is a core assumption of most traditional and contemporary discourses, regardless of whether those discourses seek to justify or challenge the institutional practices of subordination. (Kellough, 1992:90)

Ironically, discourses on motherhood as an ideal are essentialist and yet, "perversely, motherhood is viewed as a privilege and a duty, only when confined to the realm of a legitimized, heterosexual union" (Timpson, 1996:779-780).

In patriarchal discourses, what is 'male' is considered the 'norm.' Further, masculinist perspectives infuse dominant discourses in a patriarchal society. As Diamond and Quinby (1988) note, this domination is dependent on binary distinctions which privilege 'maleness.' Within moral discourses, the binary distinction between

'good' and 'bad' poses a problem when a woman does decide to terminate a pregnancy. Language used in such discourses does not accord women their own power:

> Within language, women have no inherent power to lose, and they can gain power only by taking it from men. Should they choose to withhold a caring response to the needs of another [e.g., the foetus], they are seen not as asserting their agency but as attacking male power. (Kellough, 1992:90)

Binary distinctions such as this are common in discourse, particularly dominant, male-centred discourses which do not account for women's perspectives. For example, legal discourse has operated on the basis of the 'reasonable man,' with women as 'other.' In essence, legal subjects have been constructed as male. Naffine (1987:3-4) states that the concept of the 'reasonable man' is a "legal abstraction" which "represents the male point of view." The particular experiences of women are not accounted for, as "the mythical man of law is intended to be ungendered" (Naffine, 1987:4). With respect to abortion, there is a dichotomy between 'baby' and 'foetus.' Related binary distinctions that are inherent in moral discourse include: abortion/murder; family values/selfish individualism; and foetal rights/women's rights (Ryan et al., 1994:193).

i. Anti-Abortion Discourses

> When advocates of the foetus state that someone must represent and speak for the foetus, they refuse to allow the mother to be that representative. (Greschner, 1990:662)

In the contentious political 'debate' over abortion, there are two dominant positions: pro-choice and pro-life, or anti-abortion. The latter identify themselves as such because of the belief that abortion constitutes murder. Essentially, for abortion to

be murder, the foetus must possess the full status of personhood. This is the crux of the 'debate': pro-choice advocates do not view abortion as murder, but as a decision made by a woman exercising individual self-determination and reproductive choice. When the issue is framed in such binary terms - murder/choice - there is no room for common ground. Favouring the autonomy of the pregnant woman is viewed by anti-abortion supporters as murder of the foetus, and saving the 'life' of the foetus is viewed by many pro-choice advocates as being at the expense of the woman.

A key focus for anti-abortion advocates is the protection of the foetus, ironically, from the woman. This discourse has moved into the legal realm with several cases arguing in favour of foetal (and in some cases, fathers') rights. In effect, what foetal (and fathers') rights struggles attempt to do is render the woman *invisible*. Emphasis is placed on protecting the 'unborn baby,' without consideration for the woman who happens to be carrying that foetus. Such efforts to 'personalize' the foetus have been manifest in the visual media where images of a *foetus-as-spaceman* floating autonomously create and reinforce the "fetishization" of the foetus, ultimately denying the agency (and even the *presence*) of the woman (Petchesky, 1987:265).

Noonan (1989) suggests that it is necessary for the foetus to be "removed" from the woman in order for it to possess rights. The effect of this is that the woman is rendered invisible, and can only enter such a discourse as the bearer of *competing* rights. A major problem with such discursive battles is that certain actors are pitted against one another - for example, mother vs. foetus, mother vs. potential father, person vs. potential person - and these binary distinctions are then reinforced.

Moreover, the *reification* of the foetus draws attention away from the discourse of women's personal circumstances, particularly "the material conditions of pregnancy and women's role in reproduction as conventionally understood" (Noonan, 1989:670).

One of the tactics used by anti-abortionists to render the woman invisible is *language*.

> Contending abortion partisans are also trying to influence language, as a way of supporting an ideological and political position ... In most instances, language use is unconscious. But where there is controversy and competing terminology, language use is more likely to be deliberate. Abortion partisans are very deliberate in their use of language and are trying to shape the language to support their ideological position and further their political cause. (Rodman, Sarvis, and Bonar, 1987:147)

The language used by those who are pro-choice and anti-abortion is indicative of the power of discourse. The manner in which each perceives the other is interesting. Certain words or phrases frame the issue in a particular and powerful way. Anti-abortion advocates commonly refer to their opponents as "pro-abortion" or "anti-life," whereas pro-choice advocates view their adversaries as "anti-choice." Joe Scheidler, author of *Closed: 99 Ways to Stop Abortion* (1985), recommends that pro-life activists engage in tactics which include: "Use 'Inflammatory Rhetoric," "Use Pictures, Signs, and Effigies," "Graffiti," and "Creative Publicity," among others. In his view, the use of words such as "killing," "baby," and "mother" to refer to abortion, the foetus, and woman respectively are "accurate, actual descriptions and definitions" (Scheidler, 1985:181).

One of the key points of contention in the abortion debate is when life begins. For many who support the anti-abortion position, life begins at conception and the

foetus is a baby from that point forward. Conversely, many pro-choice advocates dispute the idea that the foetus is a baby and establish a "cut-off" point for personhood at varying points from viability to birth. From this perspective, the foetus is separate from the woman.

An interesting trend in anti-abortion activism is the cooptation of pro-choice language. Commonly used is the term "choice," for example: "Life is the right choice." Further, recent pro-life protests have included the use of family violence discourse in their campaigns. At a prayer vigil outside a facility that performs abortions in Vancouver, in December 1994, protesters wore placards with the slogans "Stop Family Violence - Stop Abortion," "Abortion is family violence - Baby Dies," and "Abortion is domestic violence in the womb" (*Alberta Report*, December 1994:30).

Increasingly, anti-abortion supporters have been establishing 'bogus' pregnancy services which in fact attempt to discourage women from having an abortion (Petrillo, 1993:92). In Fargo, North Dakota, the Women's Care Centre claims to provide pregnancy testing and counselling, but once a woman seeks its services she is inundated with anti-abortion 'counselling' and literature. In Winnipeg, the Pregnancy Distress Service and Crisis Pregnancy Centre are examples of this form of anti-choice discourse in practice. A more horrifying tactic of such services is the proliferation of misinformation. This can range from inaccurate, distressing descriptions of the abortion procedure to blatant denial of important information such as gestational limits for obtaining an abortion.

An extension of the misinformation often given by anti-abortion supporters is referred to as 'post abortion syndrome' (PAS) (Hopkins, Reicher and Saleem, 1996). Proponents insist that abortion can only have negative emotional consequences for women and that those who do not experience intense grief and regret are in denial. What this discourse does is further 'psychologize' women's experiences (Hopkins et al., 1996). Hopkins et al. (1996:545) outline three main features of the discourse:

> First, the discourse of PAS contains a complex narrative structure construction of women's experience and hence the foetus. Secondly, it constructs a particular relationship between women and anti-abortion activists in which the latter's accounts of experience are privileged. Thirdly, the caring/therapeutic quality of the psychological discourse allows anti-abortionists to present themselves as caring for and respectful of others' experiences.

Symbolism is an important expression of discourse and a powerful means of communication. Along with the image of *foetus-as-spaceman* so commonly used, other images serve both as expressions of dominant positions on abortion and as representations of a system of meanings. For advocates of the anti-abortion position, images of aborted foetuses are used for shock value. Pictures of six to eight month old foetuses are often altered to misrepresent the first-trimester foetus (when most abortions are performed) or six month old infants are often juxtaposed with foetal images to suggest a linear connection. As one activist commented:

> These pictures show the humanity of the unborn. Pro-abortionists always want to dehumanize the child by calling it a foetus, or a blob of "pregnancy tissue." Pro-abortionists think these pictures are inflammatory, but only because it's the truth. ("John" cited in Hunter, 1994:64)

The morality-based discourses of activists and supporters of differing positions on the abortion issue may appeal to one's own moral convictions, whatever they may be.

When such discourses are coupled with a more dominant discourse, such as law or medicine, the impact is intensified. A popular anti-abortion film, *The Silent Scream*, is one example of the power of the visual to represent many discourses:

> "The Silent Scream" marked a dramatic shift in the contest over abortion imagery. With formidable cunning, it translated the still and by now stale images of the foetus as 'baby' into real-time video thus: (1) giving those images an immediate interface with the electronic media; (2) transforming anti-abortion rhetoric from a mainly religious-mystical to a medical-technological mode; and (3) bringing the foetal image to life. (Petchesky, 1987:264)

ii. Pro-Choice Discourses

Pro-choice discourses can also represent a 'moral' view, though in a different sense than anti-abortion discourses. It is difficult to discuss anti-abortion discourses without contrasting them to the views of pro-choice advocates (and vice versa).

Pro-choice advocates have also attempted to express their own discourse through language and images. The morality of 'right vs. wrong' is not the focus of pro-choice discourse as much as the fundamental 'right' to self-determination. The term 'pro-choice' signifies that abortion is an option that should be available to women, should they decide to terminate a pregnancy. A symbol used in pro-choice politics to illustrate the consequences of a lack of choice is the bloody coat hanger. This image represents women's determination to control their own bodies, as well as the aftermath of illegal abortion. Another image that has been used by pro-choice activists is a picture of a woman who had died following an illegal abortion (much to the dismay of her family). As Michelle Condit (1990:93) observes, such an image is powerful in the face of pro-life discourse, but once again the 'mother' as 'bad' can be pitted against the

'baby/foetus' which is 'good,' and the woman can be blamed for attempting to rid her body of the unwanted pregnancy. As MacGuigan (1994:48) suggests, "the collision between the right of a foetus to live and the right of a woman to determine her own fate is not merely a political one. It is a deeply felt opposition of divergent moral consciences."

Kristin Luker (1984) examined the divergence between pro-choice and anti-choice activists in terms of their world views, and how each position is a reflection of individual belief systems and values that are taken for granted. "People have no vocabulary with which to discuss the fact that what is at odds is a fundamental view of reality" (Luker, 1984:159). At the heart of the issue are the roles of men and women, and the values attached to those roles. Faye Ginsburg (1989) studied pro-choice and pro-life activists in Fargo, North Dakota, and found that, in the abortion conflict, "one sees a struggle taking place over the meaning attached to reproduction and its place in culture" (Ginsburg, 1989:7). In her analysis, Ginsburg situated the respondents' information within the broader social, political, and economic framework. For pro-choice activists,

> ... [I]nequalities between the sexes [are] rooted in social, legal, and cultural forms of gender discrimination, and they seek to remedy that condition by structural change in the economic and political system ... safe and legal abortion is seen as an essential safeguard against the differential effects of pregnancy on men and women. (Ginsburg, 1989:7)

Where pro-choice activists expressed an interest in protecting women in their differential roles, Ginsburg found that anti-abortion supporters were more concerned with preserving those roles.

> Pro-life activists ... accept difference, but not necessarily hierarchy, in the social and biological roles of men and women. Their reform efforts are directed toward creating and promoting a social and political context that they feel will protect and enhance the one essential condition that, in general, distinguishes men from women: pregnancy and motherhood. (Ginsburg, 1989:7)

iii. Religion and Moral Discourse

Much of morality-based discourses on abortion are associated with organized religion. In Western societies, there has been little distinction between what is believed to be *sin* and what should be treated as a *crime*. In fact, the two have often been equated, particularly with respect to such acts as prostitution, homosexuality, and abortion. Earlier views toward abortion were couched in morality, with the belief that abortion constituted murder. MacGuigan (1994) suggests that early Christian opposition to abortion was a reaction to the Greco-Roman code of morality in which both abortion and infanticide were common. As a result, "Christians reacted in terms of their Judaic and New Testament roots with an ethics of compassion towards all stages of human life" (MacGuigan, 1994:36). Gradually, abortion became codified as murder in British Common Law, with the prohibition of abortion *prior* to (and after) quickening. This resulted in *Lord Ellenborough's Act* of 1803. The Canadian *Criminal Code* enacted similar legislation in 1892, which was unchanged until 1969. Interestingly, nineteenth century abortion legislation was enacted in many legal jurisdictions in the United States, but largely as a result of lobbying efforts by the medical profession, rather than by churches (MacGuigan, 1994:37).

Anti-abortion discourse and activism are infused with religious overtones. Morality and organized religion are not mutually exclusive; they do overlap. Organized religion is one medium for morality, and anti-choice advocates often espouse this morality, which spreads to all areas considered the domain of "moral entrepreneurs," for example, homosexuality, capital punishment, prostitution, and "unlawful" sexual activity (Becker, 1963). Such morality constitutes a form of surveillance. As McNulty (cited in Gavigan, 1992:131) notes, women have always been subject to some form of surveillance, but it is poor, pregnant women who are most vulnerable to the "pregnancy police."

Religion plays a central role in anti-abortion activism. In Fargo, North Dakota, for example, protesters outside the state's only abortion clinic repeatedly referred to "God." Biblical references to abortion are used to justify the idea that the willed termination of a pregnancy constitutes murder. Violent acts by anti-abortion zealots are extreme manifestations of the religious right, and the extreme interpretation of morality by organized religion. In 1994, Stephen Scheinberg, a researcher with B'nai Brith, cautioned that American right-wing organizations may be disguising their entry into Canada via anti-abortion groups (*Winnipeg Free Press*, 30 November, 1994). Of particular concern at the time the report was released was the American-based group, Human Life International, an anti-abortion organization. Scheinberg reported that, "the two most frequent examples of mainstream right-wing extremism are among opponents of abortion and gays" (*Winnipeg Free Press*, 4 December, 1994). The

appeal of organized religion, particularly with respect to abortion, speaks to the power of moral discourses in framing issues.

On an extreme scale, the religious-based morality of pro-life activists can have dangerous, often fatal, consequences. Numerous acts of violence against abortion clinics and providers (including bombings, shootings, stalking, and other harassment) have often been couched in religious rhetoric. A 1994 study conducted by the Feminist Majority Foundation in the United States found that among the 314 clinics surveyed in 46 states, the most frequently reported type of violence was death threats. Other types of violence experienced include: stalking, chemical attacks, bombings and bomb threats, invasions, arson and arson threats, blockades, home picketing, gunfire, and vandalism (Feminist Majority Foundation, 1994:2). John Salvi III, the young hairdressing student who opened fire at two Brookline, Massachusetts abortion clinics, killing two receptionists, used religion as his justification. The men who shot and killed David Gunn and John Britton in Pensacola, Florida, referred to their acts as 'justifiable homicide.' A how-to manual for militant anti-abortionists, *The Army of God* (1992), offers step-by-step instruction on how to destroy abortion clinics and advocates the maiming of abortion providers by removing their thumbs. Initially, the book attempted to reject violence against persons in efforts to 'rescue babies.' The following is an excerpt from the Declaration added to the book in 1992:

> All of the options have expired. Our Most Dread Sovereign Lord God requires that whosoever sheds man's blood, by man shall his blood be shed. Not out of hatred for you, but out of love for the persons you exterminate, we are forced to take arms against you. Our life for yours - a simple equation. Dreadful. Sad. Reality, nonetheless. You shall not be tortured at our hands. Vengeance

> belongs to God only. However, execution is rarely gentle. (*Army of God*, Epilogue, 1992)

The increase in violence by anti-abortion extremists, according to Dr. Henry Morgentaler, is "a sign of moral bankruptcy, of defeat. They are frustrated because they have lost the war legally and in public opinion" (cited in Breckenbridge, 1995).

Though religious discourses can frame the issue of abortion in their own ways, they can have power over individual women and play a crucial role in their own reproductive decision-making. A powerful example of a religious affiliation which strongly opposes abortion is the Roman Catholic doctrine. For women who subscribe to this Roman Catholic position, abortion is not a suitable option. Therefore, the reproductive choices for these women are limited.

For women who do not subscribe to religious beliefs, attempts by these discourses to define women's experiences for them is offensive. Claire (1996:74) is critical of "the moral arrogance of those who embrace the religious dogma of their religion and aggressively try to convert others, as if they were privy to an absolute truth." These discourses are an example of social, moral ideas being imposed on individuals. "Religion is highly relevant to a personal quest for moral answers, but it cannot serve as a basis for laws in a pluralistic society" (Claire, 1995:57).

Abortion is such a contentious issue because of the moral polarity that is so pervasive. Such morality finds its way into legal and medical discourses as well.

Legal Discourses

> Women's exclusion and lack of voice within the democratic practice seems particularly unjust and dictatorial with respect to abortion laws. Not only do restrictions on abortion affect women far more than men; the debate about the regulation of abortion is a debate about the role, status, and value of women. (Greschner, 1990:635)

The recognition of law as a multitude of discourses is a significant development in feminist analysis. The guise of neutrality and the monolithic status attributed to "the law" are turned on their head. Identifying law as one of many competing discourses allows for law's power to be challenged. Carol Smart (1989) offers an example of law's power being overshadowed by medical discourse. To illustrate her point, she provides details of a United Kingdom case, *C v. S.* Two young students engaged in a brief relationship which resulted in a pregnancy. The woman had taken the 'morning after pill' and, believing that she was not pregnant, had received an X-ray. She was also taking anti-depressants. Her boyfriend was an anti-abortion activist who wanted her to continue with the pregnancy. The young woman went to court when she was somewhere between 18 and 21 weeks pregnant. The case was brought under the 1929 *Infant Life Preservation Act*, despite the 1967 *Abortion Act* which permitted abortion if two doctors found that the procedure would involve greater injury to the woman, or risk her physical or mental health. It was argued that, with the advances of medical science, the foetus could survive at 18 to 20 weeks: "So the case was not, in legal terms, about whether the putative father had a *right* of veto or a *right* of fatherhood, but about a medical matter of viability of a foetus of 18-20 weeks" (Smart, 1989:17-19). The power of legal discourse can be realized, not only in terms of case

decisions, but in the *absence* of such decisions. Though law, morality and medicine are three dominant, overlapping discourses, legal discourse is unique in that it "carries a kind of performative power open to very few other genres of public address. It marshalls the coercive power of the state behind certain vocabularies instead of others" (Condit, 1990:97). In fact, other dominant discourses such as public/moral, medical, and scientific are often only accorded power when supported by legal discourse.[1]

i. The Essentialism of Law

A common criticism of legal discourse by legal and feminist scholars alike is the essentialism of law (Colker, 1994; Smart, 1992a, 1989). The notion of the 'reasonable man' excludes the experiences and realities of the 'reasonable woman,' as if such a person did not exist. Too, according to Carol Smart (1992a), law is 'gendered,' in both its nature and practice, and the false category of Woman is portrayed as the 'other,' the antithesis of Man. Smart (1992a) traces the development of the ideas that law is gendered in three phases. In the first phase, 'law is sexist.' This suggests law's bias can be easily corrected if subjects are treated equally. However, as Smart (1992a:31-32) asserts, "the concept of sexism implies that we can override sexual difference as if it were epiphenomenal rather than embedded in how we comprehend and negotiate the social order." The next phase, largely advanced by feminist theorist

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[1]The power of particular discourses over the lives of individuals can be significant. In the case of access to abortion, moral discourses create numerous barriers for women, including their own decision-making, and medical discourse may be the most powerful at this point in time because with no legal restrictions, the medical establishment remain the gatekeepers.

Catharine McKinnon, is that 'law is male.' This notion challenges the principle that equality can be achieved by mere equal treatment under law. If law is 'male,' then insisting on equality and neutrality would mean being judged by standards that are masculine (Smart, 1992a:32). The problem with this conceptualization is that it falls into the trap of binary distinctions (male/female), and paves the way for further polarizations. Moreover, divisions such as class, race, and age are treated as secondary. The idea that 'law is gendered' extends the analysis one step further by moving away from a fixed referent of either Man or Woman. Law, according to this notion, is more fluid and can be analyzed "as a process of producing fixed gender identities rather than simply the application of law to previously gendered subjects" (Smart, 1992a:34). The role of law's discourses in *constructing* those identities can be acknowledged, and therefore challenged, rather than assuming those categories as essential. As well as law being 'gendered,' Smart (1992a:36) argues that law is a 'gendering strategy' in that it renders natural "the idea of natural differences."

Ruth Colker (1994) argues that the essentialist nature of law has a negative impact on many women because it fails to realize the impact that particular policies have on women who are not white, able-bodied and middle class. As moral/public discourses contribute to the polarity of the abortion issue by assuming women's 'natural' role as a caregiver, policies often exaggerate, distort or ignore the differences between men and women. With respect to the regulation of human reproduction, biological essentialism, which Colker classifies as a subcategory of essentialism, "tends to see the differences between men and women as natural rather than socialized and is

therefore often insensitive to the differing ways that socialization can act upon biology" (Colker, 1994:xv).

ii. Legal Discourse in Canada

Early legal regulation of abortion in Canada was tied up in the association made between infanticide and the act of abortion. *Lord Ellenborough's Act* of 1803 identified abortion as a statutory felony (Gavigan, 1984:20). This law remained essentially unchanged until the 1969 legislation which legalized abortion in the event that the life of the mother or the foetus was threatened.

The 1988 *Morgentaler* decision effectively meant that abortion became legal in Canada; still, even at this point in time, access to safe abortion is not uniform across the country. Another example of the fragility of legalization of abortion was the U.S. Supreme Court decision in the landmark case *Roe v. Wade* in 1973. As Lamanna (1991:11) notes, "*Roe v. Wade* did not establish a woman's entitlement to an abortion based on *her* decision." These two cases illustrate that a law on the books is not always realized substantively. As Carol Smart (1989:164) suggests, law has developed unevenly, and is "refracted" in nature:

> That is to say that law does not have one single appearance, it is different according to whether one refers to statute law, judge-made law, administrative law, enforcement of law, and so on ... The law is also refracted in the sense that it has different applications according to who attempts to use it.

As Smart (1989:164) reminds us, "abortion may have different meanings for black or native women on whom abortions are pressed, than for white women who feel they can exercise 'choice.'"

Almost immediately following the 1988 decision, the push for a new abortion law began. In May 1988, the issue was put to a free vote in the House of Commons, where abortion has traditionally been viewed "as an essentially moral issue ... rather than a political issue requiring party solidarity" (Greschner, 1990:639, *n*21). In 1989, the Canadian government tabled Bill C-43,

> .... which attempted to respond to Canada's unique constitutional constraints and, at the same time, strike a compromise between the competing demands of the pro-choice and pro-life coalitions both within and outside Parliament. (Brodie, 1992:97)

Bill C-43 proposed the recriminalization of abortion, yet at the same time it allowed individual doctors to determine if the pregnancy affected the woman's 'health.' In the Bill, 'health' was defined as 'physical, mental and psychological,' clearly flexible enough to allow for considerable discretion. However, issues of definition repeatedly led to an impasse, and the Bill was defeated by a vote of 118 to 105. The proposed legislation was designed to ensure access across the country, but fell short of achieving that goal (Brodie, 1992). The power of language and definition had a significant impact on the Bill. As Brodie (1992:100) suggests, "the interpretation of the word 'health' has considerable importance in determining the restrictiveness of the legislation." The emphasis on medical discourse meant that women were still required to seek a physician's approval in order to obtain the procedure, and doctors themselves were placed in a precarious position because they were "subject to criminal prosecution if they performed an abortion under conditions which did not meet the letter of the law" (Brodie, 1992:102). In fact, the Society of Obstetricians and Gynaecologists of

Canada made an announcement that 59 percent of its members stated they would stop providing services if the Bill became law (Dunphy, 1996:373).

The failure of Bill C-43 left Canada without an abortion law once again. However, the legal battles did not end there - the discourse of 'rights' continues to be used in both the courts and the abortion 'debate' after the 1988 decision.

iii. Rights Struggles

As Fudge (1987) suggests, nowhere has the legal struggle for formal equality through *rights* been argued more persuasively than with respect to reproductive freedom. On the post-*Morgentaler* terrain, *women's* rights are an issue of contention and, more importantly, are in competition with other discursive claims. After 1988, the abortion issue became *individualized*, and persons began to use the courts as a discursive battleground in attempts to control the products of women's ovaries (Smart, 1989). Further, rights rhetoric was appropriated by groups in competition with women's rights (Smart, 1986). The assertion of *fathers' rights* and *foetal personhood* assumed that there was an even playing field and that, ultimately, such 'rights' struggles could potentially override a woman's autonomy.

In the high profile cases of *Murphy v. Dodd* [1989] and *Tremblay v. Daigle* [1989], "potential fathers" sought, via court injunction, to prevent women they impregnated from having an abortion.[2] As Martin (1989:570) observes, "[a]n

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[2]Other related cases include *Mock v. Brandenburg* (1988) and *Diamond v. Hirsch* (1989).

injunction is a dramatic remedy because it curtails the freedom of the person to whom it is directed." In *Murphy v. Dodd*, what Greschner (1990:636, *n*10) refers to as the "first of the irate boyfriend cases," an injunction was nearly granted, but was overturned because of insufficient notice to Barbara Dodd. In the case of *Tremblay v. Daigle*, the Quebec courts sympathized with the potential father's position, and granted the injunction. The basis of Tremblay's argument was that the foetus had a "right to life" and that a "potential father" had the right to veto a woman's decision to have an abortion. The Quebec courts may have sided with Tremblay, but the injunction was eventually overturned in the Supreme Court. Chantal Daigle had an abortion despite the Quebec court's ruling. Such narrow 'victories' for the women in these cases speak to the fragility of reproductive freedom in Canada. Unfortunately, the Supreme Court's decision in the *Daigle* case "restores but does not *proclaim* [Daigle's] freedom," because emphasis was placed on the failure to grant rights to Tremblay, rather than recognizing and supporting reproductive autonomy for Daigle in particular and women in general (Greschner, 1990:636, emphasis added). The *Daigle* case illustrates how the courts can be a barrier to reproductive choice. It demonstrates how "vulnerable women's reproductive control is to the biases of individual judges, [and] the embrace of pro-life discourse concerning foetal rights ..." (Brodie, 1992:94, emphasis added). The *Daigle* case,

> .... brings to the surface the question of women's power over discourse (our bodies and lives) and the institutions of democracy that sanction discursive and physical coercion. (Greschner, 1990:654)

The battle over reproduction and fathers' rights has moved from pre-birth to post-birth. In Brandon, Manitoba, a father of a child born following a "botched abortion" filed a wrongful birth suit against two physicians: the one who performed the unsuccessful procedure, and the other who the father claims failed to notify his ex-partner about the possibility that the abortion may not have terminated the pregnancy. The father claimed that the doctors were at fault for allowing the pregnancy to proceed against his wishes, and attempted to sue the physicians for damages to support his son until he reaches the age of eighteen. The child was born healthy and lives with his mother, who was not party to the lawsuit (*Winnipeg Free Press*, 17 February, 1996). The Manitoba Court of Appeal determined that the father could not sue the doctors because the court was never informed that the father was a patient of the doctors and had not consulted them. Further, there was no evidence that the father had discussed the treatment with his ex-partner, and it was pointed out that she had not joined the father in the lawsuit (*Winnipeg Free Press*, 23 February, 1996).

Legal struggles in other parts of Canada illustrate that the fragile nature of women's access to abortion (reproductive choice) is not limited to Manitoba. Again, the voices of women have not been heard:

> Probably one of the most troubling aspects of the abortion debate has been the exclusion of women as active participants in the legal debate in Canada, unlike the United States where the issue has usually centred around a particular woman's decision to have an abortion. (McConnell, 1994:417)

In 1993, Nova Scotia's *Medical Services Act* attempted to prevent Dr. Morgentaler from establishing a free-standing abortion clinic in the province. Although the case

was presented by the province as a medical matter (i.e., that abortions must be performed in a hospital), the *real* issue was about the moral regulation of abortion:

> *Morgentaler '93* is explicitly *NOT* about equality for women or financial and actual access to services, or better quality health care, or decriminalizing women's decisions, or de-medicalizing women's decisions or population control, environmental concerns, or whether the foetus is a person, or really even whether there are abortions in Nova Scotia (in fact, that seemed to be one of the issues glossed over by the Court). Nor is it really about provincial control over funding decisions on health care services - that issue, along with the *Charter* issues, were fairly clearly ducked by the Court, as battles to be fought another day - perhaps. Rather, after a great deal of sifting through comments, the case seems to be about the public moral queasiness that is invoked when contemplating profit-oriented (free-standing) provision of certain kinds of medical services. (McConnell, 1994:419, emphasis in original)

This case is another example of how a legal case about a medical issue can be cloaked in morality. The attempt to regulate abortion services 'medically' at the provincial level has in fact been an attempt to restrict the availability of access to abortion on public moral grounds. The discourses of many women, which have framed the issue as one of reproductive choice and a necessary aspect of women's health care, have effectively been subsumed under this 'medical' discourse.

A recent legal struggle in the Manitoba courts and the Supreme Court of Canada symbolizes how different discourses compete to define abortion and other aspects of motherhood and reproduction. The case involved a 22-year old pregnant Aboriginal woman who was abusing solvents. Three of her children had been apprehended by Child and Family Services, and a motion was put forth seeking a court order to detain Ms. G. until she gave birth, pursuant to the *Mental Health Act*. On August 13, 1996, Justice Schulman of the Manitoba Court of Queen's Bench found Ms. G. to be suffering from a "cerebellar degeneration and cognitive impairment" as a result of her

solvent use (Schulman, 1996:12). The judge also invoked the doctrine of *parens patriae* which "can be engaged to protect an adult person who is 'incompetent' to care for his or herself" (Schulman, 1996:13), and ordered the woman into treatment. The position of Winnipeg Child and Family Services, the plaintiff in the case (and supported by Justice Schulman) is that the foetus deserves protection *in utero*, particularly if actions by the pregnant woman may prove detrimental to that foetus. Child and Family Services had become frustrated in its attempts to help Ms. G and sought the injunction to prevent further damage to the foetus. Aware of the legal pitfalls of attempting to protect the foetus, Justice Schulman handed down his decision as a protection of the "mother" (Chisholm, 1996:17). Initially, this decision was viewed as a victory for anti-abortion groups, while pro-choice advocates saw it as a grave threat to the right of woman to control her own body. An editorial in the *Winnipeg Free Press* states:

> ... [I]t is interesting to me that no one is talking about the other ways in which people could be denied rights to control their person for the sake of another dependent person. For example, I don't hear anyone calling for outlawing smoking by any person in homes with children present, yet we know second-hand smoke can cause damage to kids. I don't hear anyone calling legislation mandating organ donations between family members when there is a need, or blood or bone marrow donation for anyone who happens to match a person in need. (Rubin, 1997)

The discourses which encourage the policing of pregnant women and impose the duty of care are doing so to control the reproductive behaviour of women.

The Manitoba Court of Appeal unanimously overturned the ruling, finding that there was no evidence of mental incapacitation, and declared that the woman did not have to be detained in treatment. The decision concluded: "[T]he court has no power

to mandate treatment. It is a well-established rule that no adult, competent and aware of his or her condition, can be forced to accept treatment" (CARAL, 1997:2). In the interim, a stay of the court order had been granted pending appeal, and the woman had voluntarily entered a treatment facility (she had stopped abusing solvents and gave birth to a baby boy in December, 1996). The Supreme Court of Canada agreed to hear an appeal. Factums were entered by interveners for both the appellant (Winnipeg CFS) and the respondent (Ms. G.). On October 31, 1997, the Manitoba Court of Appeal decision was upheld by a vote of seven to two in the Supreme Court. The decision reads:

> Once a child is born, alive and viable, the law may recognize that its existence began before birth for certain limited purposes. But the only right recognized is that of a born person. Any right or interest the foetus may have remains inchoate and incomplete until the child's birth. It follows that, under law, the foetus on whose behalf the appellant purported to act in seeking the detention order was not a legal person and possessed no legal rights. There was thus no legal person in whose interests the appellant could act or in whose interests a court order could be made. (Supreme Court of Canada, 1997:2)

Once again, the rights of a woman and a foetus are pitted against one another. While it is a *moral* ideal that pregnant women will not engage in any behaviours which may harm the foetus, this is not enforced by law in Canada.[3] To do so would serve a dual purpose of granting foetal rights and a license to 'police' pregnant women. It would be fruitful if efforts were made to address the conditions which contribute to

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[3]In several U.S. states, women have been legally bound to 'protect' the foetus. Cesarean sections have been performed against a woman's will in order to 'save' the foetus, orders have been sought to prevent abortion when the woman is in a coma or critically ill, and pregnant women have been charged and convicted of child abuse and/or administering drugs to a minor (Edmiston, 1990).

substance and solvent abuse, rather than policing pregnant women who are most often lower income. As CARAL (1997:3) argued:

> .... [E]ncouraging the healthiest possible pregnancy outcome for a woman and her newborn is a pressing societal objective. CARAL submits that the measures proposed by the Appellant - detention and forced medical treatment of a competent pregnant woman - are counterproductive and may in fact cause actual harm to the woman and her subsequent child ... CARAL submits that the oneness of a woman and her foetus mean that no such duty of care can be recognized: to find that a pregnant woman owed such a duty would be like finding her to owe a duty to a part of her body.

Instead of encouraging pregnant women to seek treatment, particularly if they are forced to do so, legislation which would impose a duty of care "may well introduce an adversarial element into prenatal health care, [and] exacerbate its paternalistic, impersonal and culturally inappropriate features" (Jackman, 1993:55). Further, such measures may deter pregnant women from seeking prenatal care (CARAL, 1997; Jackman, 1993). CARAL (1997:18-19) concludes that:

> .... [T]he best way to ensure healthy pregnancy outcomes for women and their newborns is to foster conditions in society that will enable women to make decisions in the best interests of themselves and their children. Social support structures are needed to ensure that every woman in Canada has access to optimal prenatal care and support, regardless of her lifestyle and socio-economic status, even when that lifestyle includes drug addiction.

As Miller (1996:A17) so succinctly states about the "G" case: "This woman is not a criminal. This woman is not insane. This woman is not a foetal container. So long as women live desperate lives, they will sometimes be pregnant while doing so."

Despite the Supreme Court's decision to uphold that a foetus is not a person, this case, once again, reveals the fragility of abortion in Canada. Fortunately, in this case, legal discourses were congruent with the position taken by CARAL, but the

absence of legislation restricting abortion does not affirm the Court's position. The vacuum created when section .251 was stricken from the *Criminal Code* leaves abortion vulnerable to such court challenges.

Medical Discourses

i. Professionalization in Medicine

Abortion, while contested on both moral and legal terrains, remains a medical procedure. At present, the very nature of abortion as it is performed in Canada is surgical, and therefore requires medical intervention. Though the termination of pregnancies pre-dated both the criminalization of abortion and the professionalization of medicine (Petersen, 1993:3), it was the latter which changed how both medical and subsequently other discourses would define abortion:

> .... [A]s part of the process of professionalization the medical profession adopted two main strategies. First, it acquired the authority to define what constituted health and illness, and the management of illness. An increasing range of issues have therefore become defined as medical ... Secondly, in its pursuit of professional status, it acquired a monopoly over the health care system and the right of professional autonomy: that is, the right to control over medical work and to self-regulation. (Petersen, 1993:3)

According to Petersen (1993:49), the medical profession assumed authority over reproductive medicine for three main reasons: (a) technology and science provided the expertise needed to perform therapeutic abortions safely; (b) there was a demand for abortions; and (c) the high rate of illegal abortions was causing a serious health concern. The interconnections between these factors, and the dialectic between

medical, moral and legal discourses set the course for the ongoing struggle for medical control over definition.

Medicalization introduced a host of issues which are still contentious in present debates. As noted earlier, legal discourse has often utilized medical discourse when dealing with the issue of abortion.[4] In fact, the medicalization of reproductive health "was an important stepping stone in the recognition of lawful abortion because it provided a basis upon which a distinction could later be made between a therapeutic abortion and a non-therapeutic, or illegal abortion" (Petersen, 1993:3).

Another dimension to the definition of induced abortion as a medical procedure is the issue of monopolization (Petersen, 1993). Professionalization of medicine largely removed control of reproductive health care from traditional caregivers, the midwives. When the Canadian government 'liberalized' the abortion law, it framed the issue in terms of medical discourse, thus making physicians the 'gatekeepers' of the procedure. In Canada in 1969, the requirement of the establishment of Therapeutic Abortion Committees effectively 'institutionalized' abortion as a medical matter (though still criminal and, of course, moral). This, argue Brodie, Gavigan and Jenson (1992), *depoliticizes* the issue. Nevertheless, the 1988 decision *repoliticized* the issue - or unmasked it - and the political nature of the issue was only intensified by throwing abortion onto open discursive terrain. Despite legalization, access was not guaranteed nor uniform at the 'medical' level; women just had to run hurdles on a different track.

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[4]The *R. v Bourne* (1939) decision "provided the first judicial acknowledgment that abortion could be a lawful medical procedure" (Petersen, 1993:180).

As a dominant discursive body, and one with monopoly over the abortion procedure, the medical profession plays a key role in defining abortion. With surgical abortion being the method of choice used by providers, doctors and hospitals remain the gatekeepers. With the 1969 reforms, therapeutic abortions were permitted when the woman's life was in danger. Hence, doctors were in the position of defining 'therapeutic' abortion (Petersen, 1993:49). The medical profession was reluctant to let go of the power to make the abortion decision. In 1988, when abortion was decriminalized, the Canadian Medical Association (CMA) opposed the idea of 'abortion on demand' because it wanted doctors to continue to have input into the decision. The day of the Supreme Court decision, telegrams were sent to the CMA's 46,000 members "urging them to continue as if the law had not been struck down" (Dunphy, 1996:311).

ii. Definitional Issues

One of the most contentious issues with respect to abortion is the definition of 'health.' With improved technology, few pregnancies result in a threat to the life of the woman. The World Health Organization defines 'health' as "a state of physical, mental and social well-being" (cited in Dauphin Regional Health Centre, 1995). The definition of the word 'health' is important to access (Brodie, 1992:100). Recent battles in Alberta over public funding of abortion services have turned to this strategy in order to undermine efforts to improve access, by claiming that abortion is not a medical necessity. The Alberta Medical Association and the Alberta College of Physicians and Surgeons were asked to determine whether abortion was a medical

necessity, as health care is under provincial jurisdiction. Anti-abortion advocates, some whom have argued that "pregnancy is not a disease," fear that the definition will be so vague that "abortion on demand" will continue to be tax-funded and, "[if] politics prevail over science," the definition of 'medically necessary' will be too broad.

This demonstrates how political language is, how politicized medical discourse can be, and how dependent access is on politicized discourses. If non-therapeutic abortions were to be de-insured, access would certainly be further restricted. Ironically, anti-abortion advocates treat medical discourse as a two-sided coin when they claim that abortion is not a 'medically necessary' procedure worthy of public funding, yet they rely on the discourse of medical science to support the claim that life begins at conception and that foetal viability occurs at a given point in gestation (Brodie, 1992:79).

The Canadian Medical Association's policy on abortion is that the procedure should be "uniformly available to all women in Canada, and that health care insurance should cover all costs of the medically required services relating to abortion, including counselling" (Martin, 1992:498). Further, the CMA believes "there should be no delay in the provision of abortion services" and that the procedure should be performed in facilities which meet approved medical standards, but are not necessarily hospitals (CMA Policy Summary, 1988). Despite this fact, abortion is not uniformly accessible. Essentially, even though legal restrictions on abortion were removed, the decision to terminate a pregnancy does not rest with the woman. Hospital boards have to grant

approval to perform the procedure in the facility and once that criterion is met, the decision is thought to be one between a woman and her doctor. As Greschner notes:

> No woman, at any moment after implantation, is able to decide for herself whether to terminate a pregnancy ... [W]omen are not recognized as moral agents with the capacity to make decisions, but must still have their decisions approved or vetoed by someone else. That the definition of health is broad does not obviate the fact that a male-dominated profession will define it, not women. (Greschner, 1990:639)

As Shelley Gavigan (1992:145) succinctly suggests, "it may be that we have been released for the moment from the 'criminal' frying pan only to be burned by the 'health care' fire." Ironically, the status of abortion as a 'medical' procedure may be more beneficial to ensuring public funding than if it were not - adding to the 'legitimacy' of the procedure. Therefore, defining abortion within medical discourse becomes a double-edged sword - removing abortion from the hands of the medical profession would place more control in the hands of women seeking the procedure, yet women may be more likely to access that procedure if it is defined as 'medical,' and eligible for public funds (Gavigan, 1992:128). A universal, fully-funded health care system theoretically covers most medical procedures, but increasingly more services are being de-insured. This is exacerbated by cutbacks in health care funding from the federal government. It is clear that women's difficulties in accessing abortion, and the issues around what constitutes a medical procedure, are illustrative of the general fragility of the Canadian health care system (Gavigan, 1992:127).

Ryan, Ripper and Buttfield (1994) distinguish between *social* and *medical* or *genetic* abortions. This refers to the grounds upon which the decision to terminate is warranted by physicians. *Medical* abortion is based on the physical assessment of the

foetus and the woman and, in many cases, the abortion will terminate a 'wanted' pregnancy (Ryan et al., 1994:4). Therapeutic abortions, as they were initially defined in Canada,[5] would fall into this category as would abortions based on genetic testing which reveals a foetal abnormality. A *social* abortion is one where the decision to terminate is made by the woman, "usually relating to her psychological, relational, or economic circumstances as well as her decisions and desires about parenting" (Ryan et al., 1994:5).

This distinction is preferred over the classic distinction between 'therapeutic' and 'non-therapeutic' abortion because of the lack of clarity in defining what is 'therapeutic' within medical discourses. The term 'therapeutic' brings into question the definition of 'health' and the 'medical necessity' of the procedure, areas not clearly defined with respect to abortion. Further, whether an abortion is social or medical is dependent on the woman's circumstances. A woman may undergo a medical abortion but encounter different dynamics in the decision-making process (and different barriers) because she may have wished to continue the pregnancy. The term 'therapeutic' is ambiguous because it is recognized that there is a fine line in some cases between types of abortions, and some procedures may be classified as 'therapeutic' even when the health of the woman is not compromised by the pregnancy. Despite decriminalization, abortions are still referred to as 'therapeutic abortions' in Canada (Statistics Canada, 1997).

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[5]As the term suggests, 'therapeutic' abortions - permitted when partial decriminalization was introduced in 1969 - were performed if the pregnancy threatened the life or health of the woman.

The strength and persistence of pro-choice discourses has resulted in small victories in the struggle for reproductive choice. That abortion is not only legal, but decriminalized in Canada, and that polls illustrate that more than 70 percent of Canadians feel that abortion is a matter between a woman and her doctor (Dunphy, 1996:195), illustrate these successes. Studies which have contributed to discourses reflecting the experiences of women seeking abortion services are another way to challenge dominant definitions and normalize the experiences of these women.

The definitions and meanings attributed to abortion by dominant discourses have created an uncertain climate of access to reproductive health care for women. In doing so, these discourses constitute less tangible but powerful barriers to access across Canada.

CHAPTER TWO: Substantive Considerations

Access to Abortion: The Context

While considerable research has explored the psychological impact of abortion, few studies have explored women's *definitions* of the abortion issue in a sociological context. One example is an Australian study, *We Women Decide: Women's Experiences of Seeking Abortion in Queensland, South Australia and Tasmania 1985-1992* (Ryan, Ripper and Buttfield, 1994). The study utilized a purposive sample of women who had abortions since 1985 in three Australian states. The interviews were open-ended "focused conversations," and dealt with each woman's experiences of seeking an abortion. Providers, including counsellors, doctors, nurses and social work personnel, were also interviewed. Content analysis of Australian medical literature, parliamentary debates, and print media was utilized to "identify contrasts between this first hand material [interviews with the women] and the concerns that predominate in parliamentary, legal, and medical discourse" (1994:13). The researchers focused on: whether or not compatibility existed between the interviews and those discourses, as well as among the discourses; how the women "negotiated access" to abortion services; the role of the discourses in shaping women's experiences; and what the women felt would improve delivery of such services.

Some regions of Australia examined in their study still had criminal restrictions on abortion at the time. The study concluded that abortion should be decriminalized and moved under the auspices of health care (Ryan et al., 1994). As the title of the report - *We Women Decide* - suggests, the women in the study felt that the decision to

terminate a pregnancy is theirs alone. Further, the authors note that in Australia, "abortion is discussed with fervour in the public arena as a 'moral' issue," but that it is "a common and largely uncontested health issue for women" (Ryan et al., 1994:ix). Other conclusions from the study include: legal and health contexts as well as limits of current service affect women's experiences and treatment; the public discourse does not reflect women's experiences; women have solid ideas about how abortion should be defined and how access can be improved; and provider attitudes and interpretations of the law greatly affected access to abortion services (Ryan et al., 1994:ix).

In Canada, few studies have explored women's experiences in accessing abortion. Paul Sachdev (1993) interviewed 70 unmarried women, aged 18 to 25, in Canada six months to one year after they had an abortion. Approximately two-thirds of first-trimester abortions in Canada occur among young, single women (Sachdev, 1993:1). The study utilized quantitative and qualitative data. Areas covered in the interviews include: contraceptive history and relationships; facing the unplanned pregnancy; choosing abortion; the procedure; and feelings afterward. Although not focused on access, Sachdev's study sought to explore women's experience of abortion. A significant finding of this study is that 78.6 percent of the women interviewed felt relief or satisfaction following the procedure, rather than guilt or trauma (Sachdev, 1993). Sachdev (1993:217) also found that:

> The abortion effects were largely influenced by the women's identification with the pregnancy, moral and religious views of abortion, difficulty in deciding about termination, the degree of support from key people (such as the male partner or parents), and their ability to cope with life stresses.

Further, the study found that most women do not use abortion as a primary method of contraception.

The Halifax chapter of the Canadian Abortion Rights Action League sponsored a qualitative study on access to abortion services in Nova Scotia (Bowes, 1990). Twenty-five women were interviewed between October 1989 and May 1990. The interviews focused on how the abortion decision was made, who was or was not helpful when seeking services, and how they felt about the abortion experience at the time of the procedure and thereafter (Bowes, 1990). Despite legal access, the study found that services were extremely centralized, health care practitioners were remiss in their knowledge of the availability of services and in preparing women for the procedure, waiting periods were long, and there were considerable differences between the experiences of women who had abortions in hospitals in Nova Scotia and those who (at the time) had to leave the province for a clinic abortion[6] (Bowes, 1990).

To date, there has been scant research which examines the details and nuances of women's experiences accessing abortion in Canada. Unfortunately, decriminalization does not guarantee access for women. There are many barriers, both tangible and less tangible, which can make seeking an abortion a difficult process.

i. Barriers to Access

> .... [A] precondition of women's equality in society is that pregnancy be a *chosen* rather than a *coerced* experience. (Colker, Brief of Amicae Curiae in Appendix, 1994:210, emphasis in original)

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[6]In 1989, the Halifax Morgentaler Clinic was opened.

As Lamanna (1991:9) suggests, "since abortion is one important means affording women control over reproduction, barriers to abortion threaten women's efforts to attain equality." "Compulsory pregnancy," according to Wendell Waters (1976:xii), results when a state attempts to deny women access to safe medical abortion early in their pregnancies because it "clearly intends her to remain pregnant against her will." There are many barriers which hinder access to safe abortions. Some barriers are more tangible than others. A U.S. survey conducted by the Alan Guttmacher Institute outlines six key barriers to access: (a) distance; (b) gestation limits; (c) appointment availability; (d) charges [costs]; (e) harassment; and (f) problems faced by providers (Henshaw, 1995). These barriers apply to states where abortion is legal. Legal restrictions impose further barriers.

Less tangible barriers may include: a woman's own decision-making processes (Lamanna, 1991); attitudes of family members and friends; attitudes of health care professionals or counsellors; religious beliefs and attitudes toward abortion; societal pressure; and stigma (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990). Planned Parenthood Manitoba, Inc. (1990) outlines five major barriers to accessing health services: (1) information/knowledge barriers; (2) physical/geographic barriers; (3) cultural barriers; (4) communication barriers; and (5) administrative/systemic barriers. These same barriers can be experienced by women seeking abortion services. Physical and administrative barriers are usually more obvious than less tangible barriers like lack of information, and barriers based on culture and communication. Access to abortion is more complex. The attitudes of friends and family, and of health care

professionals have a significant impact on negotiating access. This is more evident when the services are as contentious as abortion.

Two Ontario studies which explored area variations in abortion services between 1975 and 1985 (Powell, cited in Ferris and McMain-Klein, 1995), and between 1985 and 1992 (Ferris and McMain-Klein, 1995) found that there were significant inter-regional disparities regarding access to abortion. The earlier study found barriers related to the referral process: one in five women had to seek services outside their resident county; late abortions (after 12 weeks) were only performed in eight of 42 counties; and "women were not receiving timely and efficient services or optimal support" (Ferris and McMain-Klein, citing Powell, 1995:1802). The 1985-1992 study utilized secondary data provided by the Ontario Ministry of Health's Therapeutic Abortion Database to determine if similar variations existed. The study found that there were significant age-standardized variations between small areas, and that women in counties with low rates went to surrounding counties for the procedure (Ferris and McMain-Klein, 1995).

Barriers in Canada have shifted over time, largely as a result of the legal status of abortion. In 1969, the *Criminal Code* was liberalized to allow for abortion to be performed in accredited hospitals that had established a Therapeutic Abortion Committee (TAC). At this juncture, "access remained limited by the willingness of doctors to seek TAC approval for a given patient, and seriously limited for women in those regions and provinces of Canada where no approved facility and TAC existed" (Mullen, Slater and Debber, 1994:64). Though abortion was in fact *liberalized*, it

became essentially *medicalized* with the addition of section .251 to the *Criminal Code* (Jenson, 1992) which granted physicians 'gatekeeper status.'

In 1988, the Supreme Court of Canada, in *Morgentaler, Smolling, and Scott v. The Queen*, declared section .251 of the *Criminal Code* in conflict with the "security of the person" clause of the *Canadian Charter of Rights and Freedoms* (section 7). This decision was initially hailed as a victory. The removal of criminal sanctions, on the surface, appeared to grant women the freedom to obtain abortions, hassle-free. However, in similar form to the 1969 amendment, the absence of formal law resulted in the "provincial balkanization of abortion services" (Brodie, 1992:64). Across the country, TACs were dismantled almost immediately, and services that were offered ranged from abortion being a decision between a woman and her doctor, as was the case in Nova Scotia, Quebec, Ontario, British Columbia and the Northwest Territories, to a condemnation of the procedure in Prince Edward Island, with out-of-province procedures only granted funding on the approval of five doctors (Brodie, 1992:89). It can be argued, in fact, that the striking down of the law opened up a Pandora's box from which emerged a greater number of competing discourses intended to disqualify and silence women, and which contributed to more questions about women's freedom of access to abortion across the country.

Although TACs were abolished when the law was struck down, many Canadian hospitals do not offer abortion services. For those that do, approval by hospital boards

must first be granted.[7] One of the tactics which has successfully limited access at the hospital level is the refusal of hospital boards to allow the procedure to be performed in their facility. Therefore, not all urban facilities, and very few rural, will perform abortions. As most rural communities do not have local access, women must travel to obtain the service (which results in lost time from work and added expenses). As health care falls under provincial jurisdiction, some provinces (e.g., Alberta) are currently trying to de-insure abortion services, and this would make a significant aspect of women's health care prohibitive for many women unable to afford the cost. Further, the lack of legislation has thrust the abortion issue onto open ground where numerous groups have challenged women's right to reproductive choice in and outside the courtroom.

Shelley Gavigan (cited in Martin, 1992:498) has commented that the abortion issue has turned from an issue of criminal law to an issue about access, and that:

> Normally, people interested in health care who serve on hospital boards, or in local and provincial governments, are interested in how to facilitate access to health care services. In fact, the takeover of hospital boards by single-issue groups such as anti-abortion forces is all about limiting access to medical care.

A battle between pro-choice and anti-abortion supporters in Nanaimo, BC threatened women's access to abortion, but pro-choice forces were successful in establishing a hospital board which approved the provision of abortions.

Although hospitals require board approval of the procedure, private free-standing clinics do not. Dr. Henry Morgentaler has established free-standing clinics in

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[7]This may change with the recent establishment of regional health boards in Manitoba, replacing local boards.

several Canadian cities. Despite the fact that women seeking an abortion can have a board-approved procedure at an accredited hospital, there are barriers to such a route. As Morgentaler (cited in Bagley, 1992:1532) stated, private clinics may provide a better service because:

> The private clinics are simply more user friendly - women don't have to come to a hospital four times to get an abortion, as occurred in one recent case. The woman had to take an ultrasound, then make a second visit for a consultation with a counsellor, which was followed by a third visit for the insertion of Laminaria [a cervical dilator]. By the fourth visit, 24 hours later, she finally got the abortion, but only after a sleepless night and many cramps - it was like having two abortions instead of one.

Between 1991 and 1992 the overall number of abortions performed in Canada increased due to the establishment of free-standing clinics (*Winnipeg Free Press*, 4 October, 1994). This has since levelled off (Statistics Canada, 1997). As of July 1, 1996, British Columbia, Ontario and Alberta provide full coverage of abortions in free-standing clinics. Provincial funding of clinic abortions was granted by the Newfoundland government in January, 1998. Currently, there are no clinics in Saskatchewan and Prince Edward Island. Manitoba remains one of the only provinces in the country that does not have a publicly funded free-standing clinic.

The increase in free-standing abortion clinics in Canada has helped improve access to abortion services for women. However, the fact that such facilities exist often for the sole purpose of performing abortions makes them easier targets for protesters. Furthermore, because the clinics are private, they are more vulnerable to policy changes.

Another barrier, directly related to the 'medical' nature of the abortion procedure, is the limited number of physicians who perform abortions. The activities of anti-abortion protesters hamper access to those facilities that do provide the service. For example, there are only two clinics in Vancouver, and both face constant harassment from anti-abortion protesters. Moreover, there are fewer providers who will perform such services because of the pressure from peers and/or anti-abortion protesters. Jane Holmes, former Executive Coordinator of the Canadian Abortion Rights Action League, states that there are only 325 physicians in Canada, mostly gynaecologists, who perform abortions, and they do so mainly in hospitals because boards often limit who can perform the procedure (cited in Martin, 1992:498).

Protest activity by anti-abortion groups can be a barrier to access. These activities can range from peaceful demonstrations to terrorist violence, such as bombings of facilities and the shootings of abortion providers. Increased violence against providers in both the United States and Canada has reduced the number of physicians willing to perform the procedure. The fatal shootings of Drs. David Gunn and John Britton of Pensacola, Florida in 1993 and 1994, respectively, sparked increased security which runs the gamut from bullet proof vests worn by doctors to metal detectors in even the most unassuming clinics.[8] In Canada, the May, 1992

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[8]In Fargo, North Dakota, the only community that performs abortions in the state, there is a brand new metal detector just inside the back door of the older, refurbished home that is the clinic. A full-time security guard asks for identification before allowing anyone to enter the clinic. Once inside, visitors must pass through the metal detector and are scanned with a portable metal detecting device. The windows of the clinic are one-way glass. Further, the doctor who performs abortions at the clinic services other clinics in neighbouring states, and is flown into Fargo for the two days a week that the procedure is performed (personal observations, January-February, 1995).

bombing of the Morgentaler Clinic in downtown Toronto and the November, 1994 shooting of a Vancouver doctor, Garson Romalis, sent the message to Canadians that the violence was no longer limited to south of the border. Although no one has been charged in the shooting, the fact that Romalis is a gynaecologist who performs abortions has sparked fear among many physicians who also perform the procedure. The November, 1995 shooting of a Hamilton physician, Dr. Hugh Short, has been linked in the media to anti-abortionists. Dr. Short performed abortions occasionally. As the vice-president of the Society of Obstetricians and Gynaecologists of Canada commented: "'It's not a procedure that brings personal glory, and now there's also a risk to life ... I'd speculate that up to 50 percent of physicians who were doing abortions may stop'" (cited in LeBourdais, 1995:928). This violence has been called "anti-choice terrorism" (Warner, 1993:86), and unless adequate legislation is passed to ensure the safety of providers, access to abortion will become even more precarious than it is at present. Most recently, a Winnipeg obstetrician was wounded by a sniper gunshot in his own home on November 11, 1997. There is speculation that the three shootings are related (*Winnipeg Free Press*, 12 November, 1997).

Cutbacks in funding to health care is another major barrier to access. In 1991, Saskatchewan held a referendum which resulted in a majority vote opposing the public funding of abortion ("Letters," *CMAJ*, 1995:131). The debate over whether or not abortion is a 'medically necessary' procedure has garnered support from the large anti-abortion community in the province. The fact that definitional issues around abortion are so politically contentious jeopardizes women's access to this service yet again.

ii. The Context in Manitoba

Currently, abortion is legal in Canada. The removal of section .251 from the *Criminal Code* eliminated criminal restrictions. However, legality does not equal accessibility. Hospital boards must grant approval for therapeutic abortions to be performed in their facilities and, to date, the only hospitals which do have such approval are in Winnipeg and Brandon (the Brandon General Hospital performs a limited number of abortions). This severely limits access for women who reside outside these areas.

For women who do reside in or near the city of Winnipeg, there are two primary routes to obtaining an abortion. The Morgentaler Clinic is a private, free-standing clinic and is not covered in any part by Manitoba Health. Abortions are performed up to 16 weeks gestation, and the cost ranges from $500 to $550. Clients must call and book their own appointments. In most cases, the private clinic requires two visits. For women who cannot make two appointments, counselling, dilation[9] and the procedure are done in one day on an outpatient basis. The Clinic does not require parental consent for minors. In Manitoba, the use of Laminaria - a seaweed byproduct - to dilate the cervix, often necessitates repeat visits for hospital-based abortions. At the private clinic, a fast-acting synthetic dilator - Dilapan - may inserted the morning of the procedure.

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[9]Dilapan (a synthetic version of Laminaria) is used for the dilation, but only for abortions performed after 12 weeks. Further, when Dilapan is administered at the Clinic it is usually done the morning of the abortion procedure, rather than the day before. This process ultimately reduces both the discomfort of the client and the time requirements for the procedure.

Second, abortions are performed in hospitals. Women are referred to a private physician, or self-refer. Private physicians have admitting privileges at local hospitals where the procedure is performed. There is a limited number of private doctors who will perform abortions in Manitoba. For the most part, the gestational limit for private physicians is 16 weeks, in some cases less. Via this route, minors are required to obtain parental consent to have an abortion. There are some doctors who will perform the procedure on minors without the consent of a parent or guardian. The hospital route usually involves three or four visits (for the physical exam and blood tests, consultation, laminaria insertion, and the procedure). This option is fully funded by Manitoba Health.[10]

There is considerable disparity in terms of waiting periods between the private clinic and publicly-funded hospitals. It can take up to three or four weeks for a TA appointment through the hospitals. The average waiting period is approximately two to three weeks. During that time, the consultation with the provider and dilation appointments are scheduled. At the private clinic, the waiting period is less. In many cases, the procedure date is within a week of the initial call, and usually is no longer than two weeks.

While physical access may have been improved with the establishment of free-standing clinics, financial barriers persist. Currently, Dr. Morgentaler is involved in another court battle to have physicians' fees covered for abortions performed at his Winnipeg clinic. A previous case in the Manitoba Court of Appeal (1993) granted the

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[10]Most doctors charge a 'tray fee' - approximately $20 - for the insertion of the Laminaria tent.

clinic coverage of the fees (about one third of the cost of the procedure). However, shortly after the decision, the Manitoba government passed the *Health Services Amendment Act*, which prohibits coverage of physician's fees for abortions performed outside a hospital. The *Act* is evidence of the power of medical and legal discourses to limit access to abortion.

There are a few health clinics which offer unplanned pregnancy counselling and referral in Winnipeg. These are pro-choice clinics that are committed to providing women with the information they need to make informed decisions about their pregnancies. There are also a few clinics and counselling services which claim to offer counselling about options, when in fact they oppose abortion and often provide women with misleading information (Pregnancy Crisis Centre and Pregnancy Distress Services are two examples). Three women in this study received counselling from one of these agencies. One sought the service after her abortion, and found the counsellor helpful, but the other two women visited them before the abortion and did not find the service helpful at all.

Protests in Winnipeg have been sporadic. For the past several years, there has only been the occasional protest outside the private clinic. More regularly, small groups will walk with signs outside hospitals on a Sunday, when no procedures are performed. Security measures have been gradually increased in the face of escalating violence against providers and facilities that provide abortion services elsewhere.

Statistics for Manitoba provide a comparison to the rest of the country. In 1995, the most recent year for which statistics are available, there were 106, 658[11] TAs performed in Canada. This figure includes procedures performed at clinics - 35, 822 (33.6 percent). There were 70, 549 procedures performed at Canadian hospitals for that year, a rate of 11.2 per 1000, for women ages 15 to 44. In Manitoba, 3,563 TAs were performed in 1995 - hospitals performed 2,927, and there were 548 performed at the Morgentaler Clinic (Statistics Canada, 1997). At the private clinic's 'highpoint' in 1990, approximately 30 percent of the clients were from Saskatchewan. Now a Regina hospital performs most of those procedures (Morgentaler Clinic, personal communication, 1996). In fact, Manitoba is the only province with a free-standing clinic that has fewer procedures performed in the clinic than in hospitals (Morgentaler Clinic, personal communication, 1996).

Only four Manitoba women were reported to have had the procedure performed at a hospital in another Canadian province. The number of abortions performed on Canadian women in North Dakota, for 1994, was five (there is no breakdown by province of origin). This figure climbed to 157 in 1995. In that same year, there were 28 abortions performed on Canadian women in Minnesota[12] (Statistics Canada, 1997).

There are several variables which will determine the path a woman takes when seeking abortion services in Manitoba. As services in the province are limited to Winnipeg and Brandon, it may be difficult for women who live in rural or northern

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[11]Some provinces do not have consistent reporting of therapeutic abortions, so figures do not always match.

[12]Reporting on these figures is voluntary.

areas of the province. The Thompson General Hospital board banned the procedure several years ago following an informal survey in the community. There are heath care staff who provide unplanned pregnancy counselling and referral, but women must travel to Winnipeg for abortion services.

The Dauphin General Hospital stopped providing abortions after anti-abortion forces monopolized the hospital board in 1991 (*Winnipeg Free Press*, 12 September, 1994).[13] Anti-abortion supporters were brought in from outside the community in order to gain control of the board and, consequently, abortion services were no longer offered in Dauphin, except in life-threatening instances. Although there have not been any known requests by physicians in Dauphin wishing to provide the service, the lack of access has been deemed discriminatory against pregnant women by a local women's group. A complaint to the Human Rights Commission was filed by the Dauphin chapter of the Manitoba Action Committee on the Status of Women (MACSW). The case was settled out of court, and board approval of abortions being performed in the Dauphin Regional Health Centre was re-instated in 1995, retroactive to 1992 (Dauphin Regional Health Centre, 1995). The policy states that abortions will be performed where there is a risk of health to the woman, using the World Health Organization's definition of 'health.' Unfortunately, there are no physicians willing to perform the procedure in the area, so the policy is not in practice.

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[13]It is possible that the procedure has been performed by practitioners and hospitals other than those mentioned, and reclassified as another procedure (e.g., D & C)..

Travel time, expenses, accountability and time away from paid or unpaid work and other commitments prove to be a considerable economic - and psychological - barrier for many women. Further, anonymity and privacy may not be protected in a small town. With no services available in her community, a woman must travel and take time away from other commitments to access an abortion. This may arouse suspicion. If health care staff (and others) in her community are aware of the pregnancy, it is difficult to hide the fact that she has had an abortion

The age of a woman at the time of seeking abortion services is an important factor. Adolescent women face added barriers which may include: the possibility that they do not have a regular doctor to refer them, or their doctor is the family doctor; privacy issues if they live with family members and do not wish to notify them; time away from school (and possibly work); and travel from rural areas and locally.

Religious affiliation or spiritual beliefs may determine the course of a woman's decision-making. Access may be readily available to some women, but if their own beliefs do not permit them to make such a choice, or guilt or fear of reprisal are factors, then their choices are further limited.

Race or ethnicity can affect the process of seeking an abortion in Manitoba. Aboriginal women may have very different experiences than non-Aboriginal women. Women whose first language is not English may have greater difficulties accessing information and services. Closely related to race is socioeconomic status. The social and economic circumstances of a woman may be factors in the decision to terminate the pregnancy, and potential barriers to access. The financial barriers for women of lower

income or those who do not have access to, or control over, their own funds are greater than for economically advantaged or self-sufficient women. Whether a woman is a student, employed for pay, or working without pay will affect the decision-making process, as well as her access to information and services.

The social and/or family situation will also influence the path a woman in Manitoba may follow to obtain an abortion. Single parents face different circumstances in their reproductive decision-making than do women in two-parent families. The number of children a woman has can also affect her choices. Not limited to immediate family, a woman's social network can be a barrier or an asset in terms of support and access to information and services. Attitudes of persons close to her can have a significant impact on a woman's decision-making (and this may be more the case with girls under eighteen years of age). Moreover, having the right connections to persons who can help them access information is a definite advantage for women. In short, there are several factors which affect the decision-making process and the experience of seeking abortion services in Manitoba.

iii. Assumptions About Abortion

As in the Ryan et al. (1994) study, the women in the present study were asked about their contraceptive histories and practices. The reason for this is that issues and concerns around reproduction are intimately connected to contraception, its availability, its effectiveness, and its use. The attitudes of health care professionals that women consult about contraceptive choices, and their own views on contraception can greatly

affect decision-making around abortion. There is a widespread belief that fertility is controllable (see Ryan et al., 1994; Lamanna, 1991; Bowes, 1990). Ryan et al. (1994:122) found that there was an emphasis by providers on "reforming women's reproductive practice" which they found to be linked to "a deep seated belief that conception is controllable and consequently abortion represents a failure which can and should be prevented in the future." No method of contraception is 100 percent effective, even when used reliably. Not all methods are appropriate for individual women. For those who are not suitable candidates for oral contraceptives or do not wish to ingest hormones, the methods remaining to them are less effective and therefore entail a higher risk of pregnancy. As Ryan et al. (1994) note, the belief that technologies allow full control over fertility are based on three assumptions:

(a) All sexual encounters are voluntary and mutually affectionate, and that consent and use of contraception are clearly established. Coercion, power differentials and cultural practices and expectations are not considered. "The notion of the rational exchange between equal partners is a fantasy which denies the dynamics of gender relations" (Ryan et al., 1994:196). Further, intoxication clouds judgement and communication which can preclude negotiation.

(b) Education and "knowing" will translate "unproblematically" into changed sexual behaviour. This view fails to account for the complexities of sexual encounters and human relationships. The fact that people continue to engage in unprotected intercourse despite education is evidence of this.

(c) Women are sexual beings and sex can be "unproblematic" if it is approached "rationally and technologically." The authors note that oral contraceptives and Intra-Uterine Devices (IUDs) were the 'quick-fix' in the 1960s, permitting women to engage in "perpetually safe" sexual encounters. The age of HIV/AIDS has changed the sexual climate and, unlike the 1960s, women must now bear the responsibility for making sure that individual sexual encounters are 'safe' (Ryan et al., 1994:196).

Another assumption is that women who have more than one abortion must 'enjoy' the experience or are using abortion as a form of birth control. For many, including women who themselves have had an abortion, women who have had multiple abortions are viewed differently. Despite personal opposition to the idea, many people make moral 'exceptions' if a woman has one abortion (because it was a 'mistake') but, again, the assumption that knowledge translates into behaviour allows some to view women who have more than one as "unfortunate 'failures'" or even "recalcitrant 'recidivists'" (Ryan et al., 1994:35). The term 'recidivist' further stigmatizes women in these circumstances.

There is widespread belief that abortion is separate from contraception. The statement 'abortion should not be used as a form of birth control' epitomizes this. Women are often chastised for 'getting themselves' into an unplanned pregnancy rather than properly using birth control which is believed to prevent contraception. Contrary to this idea, many birth control methods are "contra-gestives" in that they merely interrupt implantation rather than prevent conception (Ryan et al., 1994:197). Examples include the IUD, emergency contraception (or the 'morning after pill,' as it

is commonly referred to) and, in some cases, oral contraceptives which may operate to prevent implantation if an egg has been released and fertilized. Further, in many countries with inadequate access to effective contraceptives, abortion is the most widely used form of birth control. As long as no method of contraception is 100 percent effective, abortion will continue to be used as a back up. Separating abortion from other forms of birth control not only adds to the stigma, but creates another dichotomy in abortion discourses (Ryan et al., 1994:198).

Discourses on motherhood have contributed to the belief that pregnancy will automatically lead to birth and child rearing. This assumption facilitates harsh judgement and blame being placed on women who choose not to continue the pregnancy. Recent debates about the effects of substance abuse by the pregnant woman on the foetus entertain this belief to a degree. The policing of pregnant women *assumes* that the pregnancy will be carried to term, and that a live birth will result. The path from conception to birth is often perceived as a continuum, and any interruptions in that process are unnatural. A related belief is that adoption is a feasible option for all women. This assumes that a woman would be willing to carry the pregnancy for nine months, only to give birth and arrange adoption placement. For many women, this is a positive experience for them. For others, simply being pregnant can be a crisis, and placing the child into an adoption arrangement can be very difficult. As Ryan et al. note, "[n]o evidence exists that adoption presents less trauma than abortion" (1994:38). In fact, Sachdev (1989) conducted interviews with women who continued a pregnancy and chose adoption and found that the experience

was considerably more traumatic than for the women he interviewed about their abortion experience (Sachdev, 1993).

A common misconception held by many and perpetuated by anti-abortion supporters is that abortion causes infertility. As Ryan et al. (1994) suggest, this idea may stem from times past when illegal 'backstreet' abortions were detrimental to women's fertility and health. Complication rates increase dramatically in illegal environments and where there is a lack of support and commitment to ensuring abortion is a safe procedure (Gold-Steinberg, 1994; Ryan et al., 1994). When performed properly, abortion is very safe. In fact, there are more risks involved in continuing a pregnancy to term than termination (Ryan et al., 1994).

Closely related is the notion that abortion causes psychological trauma to women. This assumption is based on the idea that a woman wants to be pregnant, or that continuing an unplanned pregnancy will be less traumatic than termination. Post Abortion Syndrome (Hopkins et al., 1996) is an example. Rather than attaching a 'syndrome' label, some women may experience considerable grief and sadness following an abortion. Ryan et al. (1994) cite two studies which found that 'post abortion grief' only emerges in situations where women did not make their own decision about terminating the pregnancy and/or were coerced into making the decision (cited in Ryan et al., 1994:199; Koop, 1991; Romans-Clarkson, 1989). Studies (including this one) have found that control over the decision-making process and satisfaction with one's decision led to a more positive experience and attitude afterward (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990; Greenglass, 1981).

Legal, medical and moral discourses seldom privilege women's definitions of the abortion experience. A myth which is inherent in many dominant discourses is that the abortion decision is not a woman's decision to make. As Ryan et al. (1994:195) note, this myth "rests on several claims (many of them also myths) which share a common distrust" of women. These include: that women need to be protected because they are misinformed about abortion and PAS; that women cannot make such a moral decision for themselves; that abortion should be a social decision; that all women need counselling in order to arrive at a decision about abortion; and that medical practitioners should regulate women's lives and have the authority to make such decisions (Ryan et al., 1994:195).

The process of determining whether or not to continue a pregnancy is important to understanding the impact of these assumptions and other social processes on the experience of seeking an abortion.

iv. The Decision-Making Process

The circumstances surrounding the pregnancy and the decision to terminate affect both the formal and informal barriers that women may encounter. Public debates on abortion and 'choice' often idealize the decision-making process as a woman's alone. However, as Goldstein (1988:86) cautions:

> .... [I]t would be a mistake to look only to the individual woman's act and fail to see that a broad social debate has determined the availability and kinds of abortion services, social attitudes toward those services, and the language with which we think about abortion. A woman who seeks an abortion confronts the impact of this societal dialogue in attenuated form in her physician and the clinic.

It can be argued that women confront these discourses in many facets of their lives, not just when seeking reproductive health care. While being a decision of a very personal nature, it has been shown that decisions surrounding reproduction are often structurally-based, and involve "manipulation of processes beyond the control of individual women" (Currie, 1988:244).

Part of the negotiating process in terms of reproductive decisions involves finding 'solutions' to what the women identify as problems or concerns. Just as the 'motherhood' ethic is socially constructed and influenced, so too is the decision-making process about whether or not to pursue motherhood. Pronatalism in a capitalist society requires 'enforced' heterosexuality, economic dependency, social isolation, and sacrifice of the mother's needs for those of the infant. As Currie (1988:244) found in her study of women's decision-making processes, "it is the institutional aspects which render motherhood personally problematic." The process of reconciling the material context and a woman's personal views on pregnancy and motherhood can pose a real dilemma when a woman is faced with an unplanned pregnancy.

The decision-making process around termination of a pregnancy has significant effects on a woman's experience of abortion, and how she feels afterward (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990; Greenglass, 1981; Simon, 1981; Ashton, 1980a; Ashton, 1980b). Women who feel that they did not make the decision themselves, were coerced into a decision, or did not feel that they arrived at a firm decision are more likely to feel less satisfied with their experiences, whereas women who feel that they made their own decision regarding abortion are more likely to have positive

feelings toward the experience (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990; Greenglass, 1981).

v. The Climate of 'Choice'

In the process of arriving at a decision about whether or not to terminate a pregnancy, numerous factors come together to create a climate of 'choice.' The term is placed in quotation marks because of the precariousness of choice for many women. Choice is heavily dependent on accessibility, but several other factors can impinge on reproductive decision-making, even when legal or medical accessibility exists. Pressure from partners and other significant persons such as family and friends can make decision-making very difficult for a woman. Even negotiations and decision-making around contraception issues are fraught with subtle and more direct pressures from partners. Women in abusive situations have fewer choices with regard to reproduction. Abusers may coerce or force women to not use birth control, or force women to have intercourse. If a pregnancy occurs, threats of harm may coerce a woman into either continuing or terminating the pregnancy against her will. Further, violence against providers and clinics means that "women have to make childbearing decisions in a climate of hostility and violence" (Hutchison, 1997:23).

Women from different cultural backgrounds face added barriers in their communities. The selective aborting of female foetuses in countries like India and China, the coerced sterilization of minority and economically disadvantaged women around the world, and encouraged abortions for women in similar circumstances all

change the face of 'choice.' The decision to terminate a pregnancy does not occur in a vacuum.

'Choice' is a term which is fluid, depending on the context in which it is used. Being able to choose what to do about a pregnancy is fundamental to women's control over their own bodies. However, without access, 'choice' means little. The term 'pro-choice' suggests one is in favour of a woman deciding her own reproductive patterns. Women will choose to do so regardless of whether some options are socially condoned or not. What is needed is *access* to those options: the social, material and cultural support to allow women to make free choices about reproduction. The term 'pro-access' suggests a commitment to the establishment and maintenance of these supports.

vi. Conclusion

These different barriers and the discourses that support them threaten the availability of abortion services. There is bitter irony in the fact that there are efforts to restrict access to abortion in both Canada and the United States, yet social support systems for mothers and children are quickly eroding. Although these examples illustrate the numerous formal and informal barriers to access, Lamanna and Langworthy (1989:15) suggest that the decision-making process itself may be the ultimate barrier, as women have been socialized in an anti-choice climate. What this represents is the impact of various discourses on socialization, and how they may be internalized in reproductive decision-making.

Even without abortion legislation in Canada, there are many barriers to access. Further, dominant discourses have both created and supported many of these barriers. Examining the way that abortion is framed within dominant discourses is revealing because it illustrates that there are multiple bodies of knowledge battling for supremacy and the power to define, and that such discourses have the power to silence the experiences of those less powerful. Knowledge is power. As Donna Greschner asserts:

> It is profoundly anti-democratic to impose a discourse upon members of a subordinated group, *a discourse which is not their own*, and then tell them they must achieve equality within that discourse. (1990:654, emphasis added)

Dominant discourses such as law, medicine and morality have overshadowed women's reproductive realities. Since the 1988 *Morgentaler* decision, many competing discourses have emerged, struggling to define abortion in a moral, legal and medical context. According to Greschner (1990:668), many emerging discourses (for example, the question of foetal rights) will remain at an abstract level until "women have said more, far more, and have talked in public about the meaning of reproduction in their lives." The purpose of this study is to provide women with this opportunity - to voice their own views on the meaning of reproduction and how they negotiated access to a fundamental aspect of women's health care: reproductive choice.

Feminist poststructuralism illustrates how dominant bodies of knowledge can silence the voices and experiences of certain groups. For women seeking abortion services in Canada, there are numerous barriers to access which are supported by these dominant discourses, and which attest to the fragility of the striking down of the old

abortion law. Legality clearly does not equal accessibility. In order to uncover the silenced experiences of these women, a qualitative study is needed. 'Giving voice' to a group of women whose experiences are not part of these dominant discourses may be a point of departure for the expansion of a more women-centred discourse on the experience of accessing abortion services. This study is an attempt to reveal women's experiences and understandings, and to determine whether or not they reflect or are reflected in the dominant discourses of morality, medicine and law.

The next chapter discusses the objectives of the study, the research methodology, and the research process.

CHAPTER THREE: Research Methodology

Objectives of the Study

The purpose of this study is to explore women's experiences of seeking abortion services in Manitoba. According to Dawn Currie (1988), feminist research has typically focused on the subjective experiences of women. In order to situate those experiences and to illustrate that those experiences do not exist within a vacuum, she argues, there is a need to transcend the purely personal experience and integrate it with the broader structural arena. In doing so, Currie (1988) suggests, there is a greater potential for understanding and contextualizing the experience. Accordingly, in this study, women who have sought abortion services in Manitoba are asked about their decision to terminate the pregnancy, the process of accessing information and abortion services in the province, and what, if any, barriers were encountered. This study focuses on access to abortion services since 1988 as legal restrictions prior to that time would entail a host of different barriers.

Similar to Ryan et al. (1994), the objectives of this study include: determining whether or not dominant discourses are in any way congruent with women's discourses and experiences; whether those discourses address women's needs and experiences; and what barriers women encounter when trying to access abortion services. Research questions that are explored include: How do the dominant discourses (presented in Chapter One) frame the abortion issue and how do they influence women's access to reproductive health services? Do these dominant discourses reflect/address the experiences of women? Where do the two diverge? What types of barriers have

women in Manitoba encountered in seeking abortion services? Do these discourses support barriers to access? The women were also asked about possible changes that could improve access to abortion in Manitoba.

To explore these questions, a qualitative research methodology was chosen. It was felt that in order to elicit the rich, detailed accounts of women's experiences, in-depth, qualitative interviews were needed. A survey or closed-ended interview method would not have garnered these responses. Further, I wanted the women to tell their stories freely and in their own words. To this end, a semi-structured, open-ended interview format was used. The decision-making processes of the women, their personal experiences of both tangible and less tangible barriers to access, and their insights into ways to improve abortion services were revealed through a guided conversation/narrative account. Ryan et al. (1994) use the term "focussed conversations" to describe this interview style.

The idea of the interview as a conversation involves reflexivity between the interviewer and the interviewee. Ann Oakley (1981) found that her own experiences interviewing women were contrary to 'traditional' interviewing methods, which viewed the process as one-way with minimal input from the interviewer. Women in her studies were 'asking questions back,' and the dialogue which ensued became part of the research. As Oleson (1994:166) asserts, "[a]ll feminist qualitative research shares with interpretive work in general the assumption of intersubjectivity between researcher and participant and the mutual creation of data."

This research methodology acknowledges that the research subjects, in this case women who have sought access to abortion services in Manitoba, are the experts of their own experiences. In providing these women with a forum to define those experiences and to share their discursive constructions of those experiences, the dominant discourses can be subverted.

The Research Process

i. Sampling

For this study, nine women were interviewed. The sample was self-selected (between December, 1996 and December, 1997) in response to newspaper advertisements (Appendix A) placed in two university publications (the University of Manitoba's *Manitoban*, and the University of Winnipeg's *Uniter*), one community newspaper (*The Jewish Post*), and posters (Appendices B, C, D) placed in female only fitness centres and in numerous women's health and social service agencies. Advertisements were posted at a few Winnipeg health clinics (Women's Health Clinic, Klinic, and Mount Carmel Clinic) and one in Thompson. Other rural postings were the Parkland Status of Women in Dauphin, the YWCA in Thompson, and Planned Parenthood in Brandon. Agencies in Winnipeg where ads were posted include Fort Garry Women's Resource Centre, North End Women's Resource Centre, and Ma Mawi Chi Itata Centre. Advertisements were posted at the University of Manitoba Fort Garry campus (the Womyn's Centre, Women's Studies Program, Aboriginal Centre, and Aboriginal Access Lounge, and in public washrooms in University Centre

and the Frank Kennedy fitness centre), and at the University of Winnipeg (the Women's Centre and the First Nations Centre). It was hoped that placing advertisements in a variety of locations would result in a sample consisting of a greater cross-section of women (based on age, race, religion, geography, socioeconomic status, family situations, and experiences). As was the case with the Australian study (Ryan, Ripper and Buttfield, 1994), advertising through providers (hospitals, abortion clinics and practitioners' offices) was avoided to ensure that the women did not feel pressure to participate.

Advertising for a study of such a sensitive nature proved to be difficult. Careful attention was paid to the location of the posters. It was felt that women might be less comfortable stopping to read an advertisement for a study on abortion in high traffic, public areas (e.g., bulletin boards in University Centre), so ads were placed in areas that were frequented mainly or only by women. The university newspapers accessed a reasonably large readership which may be more receptive to research projects, and allowed women privacy to respond. *The Jewish Post* was also chosen to place an ad because of the increased chances of a pro-choice readership.

Seven women responded to ads in the community and two agreed to participate after hearing about the study through word-of-mouth. These were the only calls that I received. One woman, upon seeing the ad in a fitness centre, inquired about the study but did not meet the criteria (i.e., she was not from Manitoba and had sought abortion services in her own province). All of the women who approached me about participating and met the criteria were interviewed. A woman who was contacted by a

staff member at a resource centre in a rural area agreed to be interviewed about her daughter's experience of seeking an abortion. As no other women had come forward in this community to speak about their experiences, I chose to interview her, but did not tape the interview. I felt that her information, though not first-hand, would be helpful in illustrating some of the difficulties faced by rural women who try to access abortion services.

Several of the women were cautious when phoning, as was anticipated with a study of this nature. I asked them where they had heard about the study and thanked them for calling me. I explained the general parameters of the study and answered any questions the women had. One woman, during our initial telephone conversation, expressed concern about the interview being audio taped. This speaks to the silence and fear that confidentiality may not be guaranteed. I assured this informant that I would be the only person transcribing the tapes, and that the tapes would be destroyed once transcribed. In a second telephone conversation this woman agreed to have the interview taped. My position on abortion was made clear in the initial telephone conversation. Most of the women inferred this from the advertisements or in hearing about the study by word-of-mouth. A couple of women felt that the advertisements were ambiguous enough that my position was not entirely clear. Once they felt confident that the study was legitimate and that I would not judge them, we discussed their situations, I answered any questions about the study, and interview times were arranged.

In order to ensure that the women met the criteria to participate, a few screening questions were asked. It was important for the scope of this research that the women attempted to, or successfully accessed, abortion services in the province of Manitoba, and since 1988. In this way, all informants' experiences occurred in the same legal framework. Another factor is the age at the time of seeking an abortion. Ethical guidelines pertaining to conducting research with persons under the age of 18 require parental consent. Due to the possibility that a parent or guardian may not be aware of an unplanned pregnancy or abortion, I decided to exclude minors from the study. In the course of sampling, no one under the age of 18 contacted me about participating.

It was not a condition of participation that the women had undergone an abortion. In my study plan proposal, the possibility that a woman may have attempted to access abortion services, or considered this choice, but ultimately did not undergo the procedure, was discussed. One woman described this experience.

Although the size of the sample is small, it is beneficial if the sample reflects, to some degree, the diversity of experiences of women who seek abortion services.

> Women who request interruption of pregnancy ... are not homogeneous in the degree to which their pregnancies are unwanted. They represent a continuum that extends from a group who are irrevocably committed to a course of action that would result in the termination of the pregnancy, to a group who consider interruption as one of several courses of action or whose interest in interruption is, because of the special circumstances of the pregnancy, only transitory. (Simon, 1981:91)

Unfortunately, a small sample size which is self-selected does not afford the luxury of choosing particular variables which will represent the heterogeneity of women's experiences.

ii. The Interviews

Once the women had agreed to participate, interviews were arranged. The location of the interviews varied. The women were asked where they would feel most comfortable for the interview. Four women were interviewed in my study space in the Department of Sociology, two were interviewed in their homes, one was interviewed at her place of work, and two were interviewed in public restaurants. Privacy in a public place can be difficult. For these interviews, there were few people around, which allowed some privacy, and there was little background noise. The interviews lasted between 45 minutes and three hours, with an average of one hour, 40 minutes.

Prior to the interviews, the women were given a consent form and information sheet (Appendix E) outlining the parameters of the study. The form was read and signed to ensure informed consent. Although I asked during our telephone conversations to set up interviews, respondents were again asked if the interview could be recorded on audio tape, for later transcription. The consent form clearly stated that confidentiality and anonymity would be protected, and assurances were made regarding the destruction of tapes once the interviews had been transcribed. Anonymity and confidentiality were protected at each and every stage of the research project, including reporting and dissemination of findings. A pseudonym has been assigned to each of the

women who participated in the study, and any identifying information has been omitted. The consent form provided the option of receiving a copy of the transcript for review and/or a copy of the final report. Six of the nine women requested a transcript and eight wished to receive the final report. I enclosed a note with each transcript sent out reminding that confidentiality would be protected in reporting and that any information which the women were not comfortable having included in the report would be withheld. I also asked them to include any additional comments or information if they wished to do so. Of the six who were given a copy of their transcript for review, one woman returned hers with some comments.

A semi-structured and open-ended interview guide (Appendix F) allowed the women to talk about their experiences in a fluid manner which was most comfortable to them. The guide consists of key areas to be covered, such as: general background information about their personal and family situation; the decision-making process; the experience accessing abortion services; and improving access to abortion services in Manitoba. Within each section, there are several guiding questions or probes which were used to gather further information as needed. As was anticipated, personal demographic information (e.g., age, occupation, cultural affiliation) was revealed in the course of the interview. Ryan et al. (1994) caution that there are "practical and philosophical difficulties" in gathering demographic information about women who have sought abortions. They note:

> Such data are often interpreted by both researchers and readers as identifying the 'risk factors' for abortion, the implication being that something can be found within this profile of 'the aborting women' to identify the individual characteristics of women which leads them to abortion. (Ryan et al., 1994:10)

A significant portion of the interview process focused on the experience of seeking abortion services (including counselling) once the decision had been made to terminate the pregnancy. Reasons for wishing to terminate a pregnancy were given by the women during the course of the interviews. The women were asked about their own attitudes toward abortion prior to the decision, and their perceptions of the views of those close to them. This provided some context for the women's decision-making, as well as their perception of access and potential barriers they encountered. Factors in the decision-making process as well as circumstances surrounding the pregnancy were explored. The goal was to uncover how these women arrived at their decision: was it solely her decision? Were other individuals involved and, if so, were they supportive or resistant? What, in retrospect, are her feelings about the role of others in the decision-making process?

The women were asked about the process of seeking abortion services in Manitoba. I began this study interested in what, if any, barriers women may encounter when negotiating access. Direct questions were not asked about barriers. Instead, probes were used where it was felt that further elaboration was needed. This format allowed the women's own perceptions and experiences of barriers to surface.

The women were asked about their perceptions of attitudes held by persons they encountered when seeking the abortion(s); for example, counsellors, nurses, providers, and others they may have consulted during the decision-making process and the procedure itself. Their views on persons or services most and least helpful were sought. Issues such as violence against providers were explored to determine if and

how these affect a woman's perception (and experience) of accessing abortion services and/or her decision to seek an abortion.

The final part of the interview explored the insights and suggestions of the women about what, if anything, is needed to improve access to abortion services. Such suggestions were examined in light of the discourses (Chapter One) which have contributed to the barriers the women may have encountered (Chapter Two). Careful attention was paid to particular changes which may afford women in Manitoba greater access to abortion services both in Winnipeg and rural areas.

Using a semi-structured interview format allowed some flexibility during the interview process. Questions which were not applicable were omitted when necessary, and I could use the probes for clarification or to get the interview back on track. In some cases, where informants had more than one experience of seeking an abortion in Manitoba, I would ask them what way they preferred to talk about those experiences and followed the format most comfortable to them. In most cases, I asked them general questions about one experience, and then started at the beginning of the interview guide again for subsequent experiences. The interview schedule is flexible enough to accommodate this. I took notes during the interview as a precaution if there was a problem with the sound quality on the audio cassettes, and to provide me with a written record of each interview until the tapes were transcribed.

Once the interviews were completed, I asked the informants how they felt about the questions asked. This was to provide an opportunity for feedback on the interview process and specific questions. One informant, Heidi, expressed concern over one

question: "If you could go back in time and you were in the same situation, would you do anything differently?" The question was worded in this manner to determine both how the informant felt about the experience and services and, knowing what she knows now, would she take any different steps in accessing an abortion, or would she go the same route? Heidi interpreted the question to mean, "Do you regret having an abortion?" If a woman did feel regret about her *decision*, rather than the route taken to access abortion services, this would come out in her response. However, that was not the intent of the question. The primary purpose was to encourage the informant to reflect on the process of seeking an abortion, and to think about whether any steps taken were not helpful or presented some difficulty for her. It was felt that her definitions and experiences of barriers would be revealed. Heidi stated that she did not feel it was a "fair" question and explained that:

> *I don't think a person should have to go back and think about what they did wrong, or what they did right, or if they could have changed it, because it's a thing that's happened and you can't change history. You can only accept what's happened ... I've had some tough moments in my life, but I think all of those things have been a learning experience and have brought me to the position I am today - who I am today. And I like myself, so how can I regret something that happened in the past that made me who I am?* (Heidi)

I explained what the intent of the question was and that her comments were very fair and I appreciated the feedback. She further responded:

> *I don't think I would have the insights into my life if I hadn't had that experience. And I don't think I would have changed it one bit. I might say that, oh, it was sad that this happened, but really, like if I had to look back on it and change anything, I don't think I would change a thing ...* (Heidi)

These comments were made during the course of the interview after the question was asked. At the end, we briefly discussed the question again. Unfortunately, some

women do have regrets about the decision itself. After thinking through what this experience means in her life, Heidi was not comfortable with looking back and thinking of changes. For the last interview, I changed the question to read: "If you were to be in a similar situation sometime in the near future, would you do anything differently?"

At the end of each interview, I asked the women how they were feeling and we often continued a discussion once the tape recorder had been turned off. A primary concern during the course of the interviews was the comfort of the women participating. I offered each informant a copy of the resource list I had made up, and all but two women took one with them. I asked their permission to contact them should any further questions arise, and invited them to contact me at any time if they wished. I assured the women that I would not identify the nature of the phone call should I need to leave a message, just my name and phone number. My home phone number was on the information sheet that informants were given at the beginning of the interview.

I did have to contact two women after completing the third interview. I decided to include a question on RU 486, commonly known as the "French abortion pill," after it came up in the third interview. I also contacted by telephone the six women who requested a copy of their transcripts once they had been completed.

iii. Data Analysis

Once the interviews were completed, I transcribed the tapes into a word processing program verbatim. For the most part, the sound quality was excellent, but

for those times where a word was muffled or very quiet, the notes I had taken during the interview were very useful. Pauses and gestures, such as a laugh or a moment when a woman was upset, were noted in square brackets. Each transcript was assigned a numeric code.

For this research, inductive analysis was chosen rather than deductive. The latter involves examining data in light of pre-existing categories. I had several questions that I wished to answer in the course of this research, but I wanted the themes and categories to emerge during the course of the data collection and analysis. As Tesch (1990:90) describes, "inductive analysis begins with empirical observations and builds theoretical categories, instead of sorting data pieces deductively through pre-established classes." Throughout the data analysis process, as well as throughout data collection, themes regarding one's experience seeking abortion services in Manitoba were highlighted. Shared experiences and those less common or contrasting were examined, as was the diversity of responses. Quotations from the informants were assigned codes. These were grouped together to allow for the identification of themes and categories, and to provide a visual matrix of responses and the relationships between them. As Huberman and Miles (1994:437) note:

> Technically, cross-case analyses are most easily made with "displays": matrix or other arrays of the data that allow the researcher to analyze, in a condensed form, the full data set, in order to see literally what is there.

Analysis within and between cases was done, as was analysis to compare the women's responses to the dominant discourses covered in the literature review. The manner in

which the abortion issue is framed in the minds and experiences of the women was compared to those discourses.

Once the transcripts were coded, the major themes were established. These began to emerge during the course of the interviews. The codes were arranged into sub-categories within the major themes. During the analysis process, the women's responses were compared to the dominant discourses. As observations arose, I began to piece together sections which would later become the discussion. The characteristics of the sample were divided up and serve as an outline of the research participants and a context for individual profiles. Profiles of each individual woman summarize the views and experiences revealed in the interview. Pseudonyms have been assigned to these profiles and are used throughout the analytic themes (Chapters Five, Six and Seven) and the discussion and conclusions (Chapter Eight).

In writing up the results, priority is given to the words of the women interviewed. Emphasis is placed on quotations and narratives which are presented under three main themes. These quotations are presented in italics in order to distinguish the women's words from my own. Careful attention was paid to revealing the detailed experiences of the women who participated, while protecting their confidentiality and anonymity. The women were each assigned a numeric code for the purposes of transcription, and a pseudonym which has been attached to particular quotations to provide continuity in the presentation of each woman's experiences. Identifying information (e.g., names of persons and places) which might compromise

anonymity has been omitted. To protect the confidentiality of the informants in this study, the names of facilities have been omitted from the quotations.

iv. Logistical Issues

Undertaking research on a sensitive topic requires careful attention from study design through to reporting. Researching a sensitive topic such as abortion requires efforts to protect the confidentiality and emotional safety of the respondents. The sample was obtained through self-selection in response to advertisements. The location of the posters was carefully chosen to avoid those where women might feel pressured to participate (e.g., facilities which perform abortions), and limited to places where women might feel comfortable reading the advertisement. Women's centres and agencies in Manitoba and fitness centres and women's bathrooms in several locations in Winnipeg were selected over public bulletin boards in high traffic areas. Almost all of the agencies were receptive to posting the advertisement. Some required board approval before the ad could be posted, which amounted to a minimal delay, and others agreed to post the ad for a limited time. Only one location - a women's fitness centre - which had previously posted the ad for part of the 1996-97 winter, did not allow a second posting in the fall of 1997.

As the researcher, I used my home phone number on the posters and in the newspaper ads. Although the advertisements were somewhat ambiguous about my personal views on abortion, I was careful about where the ads were placed. I felt some apprehension, particularly in light of the recent act of violence against a Winnipeg

abortion provider, about advertising for this study in such a public manner. One cannot guess who might be unsympathetic to a research topic, but I tried to avoid places more likely to be noted by anti-abortion supporters.

Initially, several women responded to the advertisements posted in the late fall of 1996, and early 1997 (Appendix B). Once nine interviews were completed, efforts were made to attract women who had travelled from rural and northern Manitoba to Winnipeg seeking abortion services as none had responded to that point. This second advertisement (Appendix C) was posted during the summer of 1997 but there was no response. In the fall of 1997, a new ad (Appendix D) was circulated in university residences, university newspapers, and a few clinics, with no response. It was at this point that I decided to end my recruitment efforts. The experiences shared by the nine women in this study offer insights into a subject that is rarely talked about. The difficulty in recruiting study participants speaks to the silence and secrecy.

Throughout the research process, I was conscious of the potential power imbalance between myself, as the researcher, and the women I interviewed. As Ristock and Pennell (1996:9) note, " good research (that is, valid and ethically supportable research) requires that researchers critically analyze their own power and use it responsibly." The question becomes, how do we do this? Throughout the study, I felt (and feel) that the women are the experts of their own experiences. I wanted to present their words in a manner which privileges their experiences and understandings.

Another goal of this research was to empower the women who participated in the study (and others who may read this). The structure of the interviews - loosely

guided conversations, and the way the sequence of the interviews was led by the women, I hope, was a start. However, empowering the women in this study (and others who may have shared some of their experiences) involves more than the research itself. As Ristock and Pennell (1996:10) state: "A culture of empowerment disentangles and reworks relations of power by making their previously obscured workings visible and therefore more open to disruption." The way the dominant discourses have defined abortion has taken power away from the women who seek them. These discourses can only be challenged and subverted if they are exposed. Their contradictions then allow alternative constructions to be heard.

CHAPTER FOUR: The Women in the Study

Summary of Participants

The women in this study come from a variety of backgrounds and had both similar and differing experiences seeking abortion services in Manitoba. At the time of the interviews, the women's ages ranged from 20 to 37 (mean = 25.6). When seeking abortion services, the ages ranged from 15 to 30. All but one woman were under the age of 26 when services were sought (one woman was a minor). At the time of the interviews, one woman was married, two were cohabiting with their partners, and six were single. When seeking abortion services, one was married and eight were single. Four were living with parents at the time of the abortions, and three were living with parents at the time of the interview. Two women had one child each at the time of the interviews.

The dates when abortion services were sought ranged from 1989 to 1995. The average number of years since seeking services was 4.38. At the time of the interviews, there were 16 pregnancies for the nine women. Three women reported having a miscarriage. Five women had one abortion, two women had two abortions, and one had three. Eight of the nine women interviewed had abortions, with a total of 12 procedures. Four women had abortions at a clinic (five procedures), four women at a hospital (seven procedures), and one woman sought abortion services but chose to continue the pregnancy. At the time of the abortion, one procedure was performed at seven weeks estimated gestational age (e.g.a.), six at nine to ten weeks e.g.a., five at 11 to 12 weeks e.g.a., and one woman sought an abortion at 16 weeks but continued

the pregnancy. One woman reported complications following both abortions she had at a hospital. Four women went for a post-operative check-up.

The women in this study accessed a variety of services for both information and referral, counselling, and the procedure itself. Seven of the nine women accessed more than one service. Six women received counselling and referral at a pro-choice health clinic. Two women only accessed the counselling services of the facility where the abortions were performed. One woman did not receive counselling before or after the procedure because she worked in a pro-choice environment and knew the options. Two women also went to an anti-abortion counselling session prior to pro-choice counselling, and one woman after the procedure. For the women who had more than one abortion, the same pro-choice counselling services and facilities for the procedure were accessed each time.

All of the women interviewed for this study are Caucasian. It is regretful that the experiences of women from other ethnic backgrounds are absent. At the time of the interviews, four women were university students, four were employed full-time, and one was involved in volunteer work. All of the women have completed some post-secondary education. Four had completed an undergraduate university degree and one had completed a technical program at a community college.

The women in this study, despite common experiences, accessed or attempted to access abortions for different reasons, and through different processes. All nine women reported that they were pro-choice both when seeking abortions and at the time of the interview, though some had commented on earlier negative feelings toward

abortion due to their upbringing. The decision-making process when faced with an unplanned pregnancy is much more complex than one's personal view. Some knew quite quickly that they were going to obtain an abortion, others took some time to decide, and some felt coerced into making a decision before they were ready. Some women reported relatively little difficulty in obtaining an abortion, whereas others faced numerous barriers. The women define their experiences in light of this process and how it fits into their lives. The next section provides a brief profile of each participant to provide a context for their experiences. To protect anonymity and confidentiality, pseudonyms have been assigned and any identifying information has been withheld.

Individual Profiles

Anna

Anna is a thirty-seven year old married mother of a three year old. She lives in Winnipeg with her husband and daughter, and is involved in volunteer work. Growing up, religion was not a big part of Anna's life. Anna had one abortion in 1990, at the age of 30. She had been married ten years at the time, and both she and her partner decided that it was not a good time to continue a pregnancy. They wanted to have children when they were both ready.

Anna has experience working in a pro-choice environment so she is aware of the options that are available to her. She feels that this helped her to access abortion services. For a "brief moment," Anna considered going to the United States for a

menstrual extraction, but changed her mind. She personally knew a health practitioner who performed abortions so she self-referred and did not have to wait long to have the procedure. She chose to have the abortion performed at a local hospital rather than a clinic because she was very familiar with her doctor, and she knew some of the staff at the clinic. Her partner was very supportive throughout the process.

Anna found the staff very helpful at the hospital, although she felt a little more privacy "might have been nice." It was early enough in the pregnancy that dilation and the aspiration were done in the same day. After the procedure was over, Anna felt "physically crampy," but also felt relief. Anna's experience was virtually barrier-free. Knowing where to go for information and having personal connections to practitioners enabled her to obtain an abortion quickly and with little stress.

Despite her pro-choice position and supportive environment, Anna still felt some of the stigma attached to having an abortion. She only told a few people close to her about the abortion. When Anna decided to have an abortion at thirty years of age, she felt a little "silly" because "everybody else I know did this when they were 15."

Anna feels fortunate that her experience in accessing an abortion went smoothly, and she does not take that for granted. She knows that it is not that easy for everyone. One of the most important factors to improve access, for Anna, is accurate information. To this end, Anna wanted to participate in the study to share information with other women.

Betsy

Betsy is a 25 year old full-time university student working on her second degree, and employed part-time. She lives with her mother and brother in Winnipeg, and is engaged to be married. Betsy was not raised in a religious home. She had one abortion in 1995, when she was 23 years old. Betsy and her partner, now her fiancé, had discussed how they would deal with an unplanned pregnancy, and both felt that they wanted to be married before they started a family.

When Betsy discovered she was pregnant, she and her partner were very upset. Reflecting on her views at the time, Betsy said she had "always been pretty much pro-choice." For her, "school was number one," and she was still living at home, so she did not wish to continue the pregnancy. After discussing options, she and her partner agreed that abortion was the best choice for them. Betsy told a few friends about her plans to terminate the pregnancy, but they did not react favourably. She did not tell any family members at the time. The same day she found out about the pregnancy, Betsy visited her family doctor. She was very upset that the doctor assumed she would continue with the pregnancy. Betsy and her partner found it difficult to find information on abortion. The next day, Betsy contacted an abortion clinic about obtaining an abortion. After discovering that a hospital abortion could involve a three to four week wait, Betsy chose the private clinic. The ultrasound, counselling, dilation, and the procedure were all within a week. Betsy's partner was very supportive throughout the process.

She found the clinic environment and staff to be "nice." During the counselling session, Betsy was very disappointed that a question sheet about circumstances of the pregnancy (e.g., the possibility of coercion and abuse) was voluntary. She believes that these questions need to be explored to make sure that a woman is mentally prepared for the abortion and it is freely chosen. She also feels that the partner should be interviewed as well to allow him more involvement in the process. The procedure cost $350 which, according to Betsy, "seemed like such a small price at the time for great relief."

Betsy sought counselling services several months after the abortion, and found that helpful. Overall, she is happy with her decision and has no regrets. Betsy wanted to share her experience because "it feels good to have it acknowledged."

Corinne

Corinne is 23 years old, raised in Winnipeg, and currently lives alone. She completed post-secondary education and is employed full-time. Although her father was Catholic, Corinne was not raised in a very religious environment. She is "strongly against organized religion," and has "always" been pro-choice. Corinne has had two abortions, in 1993 and 1994. She also had a miscarriage later in 1994. All three pregnancies were with the same partner, and he strongly encouraged her to terminate all three of the pregnancies despite her wishes to continue them.

To this day, Corinne does not feel that she made a decision about her pregnancies. The first two were coerced decisions and the third was taken from her

because of a miscarriage. Although she did not feel, for the first two pregnancies, that she was as ready to be a mother as she would have liked, Corinne did not want to have abortions. She told a few friends about the first two pregnancies and they were supportive. After "flip-flopping" during the decision-making process, Corinne finally gave into the pressure from her partner and her mother.

Corinne sought information from a local health clinic, and contacted an anti-abortion service which she wishes she'd never done. She then received counselling from a pro-choice clinic which she felt was helpful. Both abortions were done at a local hospital. She had to wait four and five weeks, respectively, for the procedures. The staff were "very nice," but Corinne found the abortions quite painful and experienced complications after both.

Corinne feels she is ready to have children, but is experiencing difficulty becoming pregnant. She does feel guilt over the abortions which she never really wanted in the first place. Corinne is very aware of the stigma attached not only to abortion itself, but to multiple abortions. Talking about her experiences, says Corinne, is "kind of a purging thing." She feels that women who have had abortions "should have a voice instead of everyone else who has no idea what's going on."

Darla

Darla is a 24 year old full-time university student. She is the mother of a three year old daughter. She lives in Winnipeg with her common-law spouse. Growing up in Western Canada, Darla was not raised in a religious environment, though her

mother is "pro-life." Darla is pro-choice and always felt it was an "individual thing." When she found out she was pregnant in 1992, Darla was "stunned" and, as she recalls, "it was just decided that, well, abortion is naturally the choice." Darla went to see her gynaecologist who confirmed the pregnancy and assumed that she would continue it. After taking a week to think about her decision, Darla returned to her doctor who told her that the pregnancy was further along than he originally thought, thirteen weeks. He told her that she had "no choice," she would have to continue the pregnancy.

Darla told few people about the pregnancy, and was discouraged from abortion by her sister and mother. She found it difficult to gather information on abortion. She did manage to see a counsellor at a pro-choice clinic, but the pregnancy was past the gestational limit in Manitoba at that time (16 weeks). At the clinic, Darla was given information and a referral letter for the abortion clinic in Fargo, North Dakota which would have cost approximately $900. After deciding against going to Fargo, Darla and her partner separated. She moved in with her mother, and continued the pregnancy.

Darla wishes she had known then what she knows now about abortion services in Manitoba. If she was back in time in the same position again, Darla would have had the abortion. Thinking back on the experience and the misinformation makes Darla angry. She feels that girls and women need to know where to find information and what services are available.

Eve

Eve is a 27 year old full-time university student living with her partner. She has lived in Winnipeg most of her life, and was raised in a Catholic home, but it was "never really a faith issue." She has always been pro-choice. Eve has had three abortions and one miscarriage since 1989. When she first found out she was pregnant, Eve was "devastated." She was in a relationship with a partner who was not very supportive. The few family members and close friends that she told were supportive.

Eve knew right away that she did not want to continue the pregnancy. She contacted a hospital about obtaining an abortion and had the counselling and procedure about two weeks later. The cost of an abortion at the private clinic discouraged Eve from seeking an abortion there. After the procedure, Eve felt very guilty because of the secrecy and hiding the abortion from her father. For the second and third pregnancies, Eve had to wait four weeks to obtain an abortion. She found the hospital staff to be "fine" for all three procedures, but was very embarrassed about the multiple pregnancies.

Eve found access to the abortions to be easy. If she were pregnant and seeking an abortion, Eve would access the pro-choice counselling that is available as she feels it helps with the decision-making process. She does not regret her experiences, but is very aware of the stigma around multiple abortions. Eve wanted to share her experiences because she feels that women need information and education about abortion services.

Fiona

Fiona is a 26 year old university graduate and is employed full-time. She currently lives alone in Winnipeg. Fiona grew up in a religious rural community in Manitoba and was taught that abortion was wrong. She was living in Winnipeg when she found out she was pregnant in 1993. Unlike many of her friends, Fiona felt she was "more career-driven than motherhood driven." She felt "stupid" when she became pregnant. Having talked to some friends who have had abortions, Fiona knew the options available to her. It was just a matter of deciding what to do. She was still in school at the time and was not in any rush to have children. Her partner at the time was very supportive.

When seeking information, Fiona unknowingly contacted an anti-abortion service which was upsetting for her. She contacted numerous other places and heard a lot of "we don't do this." After a couple of weeks, Fiona was able to see a counsellor at a pro-choice clinic. The abortion was performed at a local hospital. Fiona found the hospital environment "cold, clammy and sterile." Privacy was a concern for her, and she felt like she was rushed out after the procedure.

Though she was feeling some guilt after the procedure because of her religious background, Fiona feels she made the right decision. It feels good for her to talk about the experience, to remove the silence and the idea that abortion is a "sin" or "evil."

Gloria

Gloria is a 26 year old university graduate living in rural Manitoba. She is working full-time and lives with her parents and younger sibling until she moves in with her fiancé. She lived in several places in Western Canada and the United States when growing up, and returned to her home community after completing her post-secondary education. Gloria was raised in a Roman Catholic home. She has had two pregnancies; a miscarriage in 1992, and an abortion in 1993. Gloria was living in Winnipeg at the time of the abortion, and felt that the partner she was with was not someone "you could be relying on as a father." She was still in school and decided that it was not a good time to have a child. Her partner was not very supportive during the process, except financially.

Gloria did not tell many people about the pregnancy and felt very alone during the experience. A close friend who worked in a pro-choice setting helped her set up appointments and offered support. Gloria chose to go through the private clinic because she knew she would get the support she needed. The abortion was paid for by her partner as she could not afford the cost. Her appointment was within a week. Gloria found the abortion procedure "uncomfortable," but not painful. She found the clinic environment "wonderful."

After the procedure, Gloria felt a "big, big sense of relief." She has no regrets about her decision and feels that access needs to be improved in Manitoba, particularly in rural areas.

Heidi

Heidi is 22 year old university graduate and is employed full-time. She grew up in Winnipeg and currently lives with her parents. Growing up, Heidi was raised in a Catholic household. She had an abortion in 1990 at the age of 15, and a second in 1992 when she was 17. For the first pregnancy, Heidi was in an abusive relationship and was pressured into having an abortion. Although she was frightened and felt she was too young to have a child, Heidi feels like she never really made a decision. For the second pregnancy, Heidi's partner was out of the country. She told only a few friends about the pregnancies, and they were supportive.

Being a minor during both pregnancies, Heidi was faced with the difficulty of obtaining an abortion without parental consent. She received counselling at a pro-choice clinic both times. For the first abortion, Heidi was referred to a doctor who admonished her about contraception, and told her he would not perform an abortion on a 15 year old girl. The only other option available was the private clinic. Both Heidi and her partner were teenagers, so they found it difficult to come up with the money to pay for an abortion. Keeping the abortions a secret from family members, missing school, and transportation were difficult for her.

Heidi found the counselling at the clinic brief, but the environment was "relaxing." After the abortions, Heidi felt "pretty happy." Heidi does not regret her decisions and feels she has grown as a person because of the experiences. She found accessing the abortions "difficult," but also felt fortunate to be living in an urban centre where the services are available. Heidi believes that talking about abortion is

difficult for members of society, and that education is needed "to open their minds a little bit."

Iris

Iris is a 20 year old full-time university student living in Winnipeg with her parents and younger brother. She grew up in Central and Eastern Canada, and has been in Winnipeg for six years. Iris attended church until she was 16, but does not "believe in the whole organized religion thing." She felt that abortion should be available to women, but not overused. Iris had an abortion in 1995 at the age of 18. Her partner was supportive, but she feels he unconsciously pressured her into having the abortion. She told a friend who was supportive during the process.

When Iris found out she was pregnant, she was upset. She had plans for school and did not want to disappoint her parents so she decided that there was "no way" she would continue the pregnancy. She had the pregnancy confirmed at a walk-in clinic, and sought counselling services at a pro-choice health clinic. Iris and her partner decided to go to the private clinic because her partner had heard negative things about hospital abortions. Her partner paid the $350 fee for the abortion.

Iris felt some pain during the procedure, but found the staff and the clinic environment "really good." She felt uncomfortable sitting in a waiting area with other women, and would have liked more privacy. Iris wanted to share her experience because she wanted other women to know about the services she found helpful when seeking an abortion.

PART II: The Women's Voices

The next three chapters present the findings of the interviews with nine women about their experiences accessing abortion services in Manitoba between 1990 and 1995. Despite the small sample size, there were interesting differences, but also some remarkable similarities in the women's experiences. Some of the findings were anticipated, others less so.

Several categories began to emerge during the course of the interviews. I have chosen to organize these categories into three main themes: The Meaning of Abortion; Barriers to Access; and Stigma and Silence. The first theme highlights how the process of seeking abortion services in Manitoba, and the abortion experience itself, fit into the lives of these women. The second theme explores the process of negotiating access to abortion services, and barriers to access identified by the women. Some of the barriers are more concrete, while others are less tangible. The third theme reveals the stigma and silence surrounding abortion and the barriers they create and sustain. These themes are not mutually exclusive. They have an impact on each other.

These chapters contribute to a discourse on women's experiences that has been under-acknowledged. As such, their words are given priority. How these discourses compare to the dominant discourses will be discussed in Chapter Eight.

CHAPTER FIVE: The Meaning of Abortion

In order to determine whether or not the dominant discourses are congruent with the views and experiences of the women in this study, it is important to explore the concept of *meaning*. For each of the women in this study, the experience of dealing with an unplanned pregnancy and the decision to terminate a pregnancy are a part of their lives. Legal, medical, and moral struggles over the definition of abortion tend to receive more exposure than the actual words of women who have had these experiences. One of the objectives of this research is to provide an opportunity for women to talk about their experiences and what abortion means to them. Some interview questions directly explored meaning, whereas other information emerged during the course of the interviews. I felt it was important to present this section first to provide a context for the others.

Views on Abortion Before the Experience

How one feels toward abortion can have a significant effect on the experience of seeking access to abortion services and the abortion itself (Sachdev, 1993). Although all of the women identified themselves as pro-choice at the time of the interview, some felt differently before they had the abortion. A religious upbringing, particularly one which denounces abortion, can have a significant impact on one's thinking. For example, Heidi said, "back then I think I had a lot of mixed feelings about the issue. I think, with my upbringing ... it basically told me it was murder." Fiona was also

raised in a religious home, and was told that abortion was 'murder.' Darla's mother was 'pro-life' and she recalled the anti-abortion literature around the home:

> *We used to get these horrible letters in the mail ... [My mother] used to wear a little flower and stuff ... we would come out of high school and there would be flyers and pictures of the garbage can foetuses ... I think a little of that was instilled in me, so I was little morally righteous when I was younger.* (Darla)

Darla found that when friends and people close to her experienced unplanned pregnancies, "I kind of changed in that way. I looked at it as totally an individual thing." Others expressed their views on religion at the time of interview:

> *I'm strongly against organized religion.* (Corinne)

> *I don't believe in the whole organized religion thing. If somebody gets something out of it, that's great, but I just don't. I don't identify with it at all.* (Iris)

The women were asked how they felt about abortion before they discovered they were pregnant. Most of the women had always identified themselves as pro-choice:

> *Well, I'd never really thought of it as a terrible thing. I think I'd always been pretty much pro-choice ...* (Betsy)

> *I've always been pro-choice. I've always thought nobody could make that decision for me ...* (Corinne)

> *I certainly was for abortion. I always have been, as far as I can remember. Because my mom's been very open about things like that, and pro-choice kind of stuff. So, there's always been no question.* (Eve)

> *I never had any like religious or moral qualms about it. I don't think people should just be able to use [abortion] as their form of birth control.* (Iris)

Heidi, Fiona and Darla were raised in an environment where abortion was considered 'murder.' However, their views changed over time, and they now identify themselves as pro-choice.

Anti-abortion discourses insist that abortion is 'murder' and that women are choosing to 'kill' their 'babies.' A distinction between this discourse and that of women who are seeking or have sought abortions is clear when one acknowledges women's own perspective. As Henry Morgentaler has said: "A woman who wants an abortion doesn't want to kill a baby. She doesn't want the product of conception to become a baby" (cited in Claire, 1995:69).

Defining the Pregnancy

... [I]t was just not a good time to be having a child. (Gloria)

In order to understand how a woman feels about the abortion experience, it is important to know how she felt about the pregnancy. The experience of an unplanned pregnancy conjures up a wide range of emotions.

> *I felt dizzy, ran to the bathroom and I threw up. And when I'm over the toilet bowl I'm thinking, this cannot be morning sickness. Please God, don't let it be morning sickness ... [I took the pregnancy test] and those two lines came up saying 'pregnant' and I flipped out. I think that's every female's worst nightmare, and it happened to me ... I just, I just felt half sick, this can't be right, I don't believe this. I was in denial, but I was also going, 'Yes. This makes sense,' because the week or two before that I was feeling really weird and I was extra tired, but I just attributed it to the training, you know? ... I remember grabbing the stick and I didn't realize how much I was shaking. I was just holding it, and trembling, and I threw it in the garbage. I buried it under so many things ... I took the garbage, and I tied it up, and I threw it [out].* (Betsy)

For Betsy, the positive pregnancy test was her 'worst nightmare.' At the same time, she said:

> *I remember looking at myself differently in the mirror, and touching my stomach, [thinking] I cannot believe this. I just couldn't. I don't know if it was happiness or [what], [it was] kind of neat that I could actually get pregnant.* (Betsy)

For many women, it takes a pregnancy to realize that they *can* become pregnant. Luck or good timing may keep a woman from becoming pregnant when not using contraception, and this may be interpreted as a sign of infertility. Moreover, it may seem paradoxical for a woman to feel unhappy about a pregnancy and happy at the same time, as Betsy expressed. Others have found similar reactions from pregnant women (Claire, 1996:35). The other women in this study had these comments about their reactions to being pregnant:

> *I was very surprised. Not because the birth control had failed, I was just so surprised. Just a very spinning feeling. I remember [the doctor] telling me very well and just [thinking], 'Oh my God, oh my God.'* (Corinne)
>
> *I called [a clinic], and like talked to the lady and she said, 'Well, the results were positive' and then the first thing out of her mouth [was], 'Is this a good thing or a bad thing?' [I said] 'Uh, a very, very bad thing.' And so then I kind of started crying and went into the bathroom. I didn't have to say anything. [My partner] knew that it was [positive].* (Iris)
>
> *Oh, my first reaction was I cried. I didn't know what to do. I was devastated.* (Eve)
>
> *I was probably a little naive, a little confused. I hadn't had my period regularly before that, and I was using birth control pretty regularly so I didn't think I'd ever get pregnant ... and I was totally astonished. I couldn't believe it.* (Darla)
>
> *[I was in] utter shock, and feeling stupid.* (Fiona)
>
> *Well the thing is, they told me [the pregnancy test was positive] right then and there. They took me into a room for counselling, and that's when they told me. The boyfriend at the time was there too. And so, I think it was like a thing of shock, 'What am I going to do? I'm only 15.'* (Heidi)
>
> *I wasn't very happy with the fact ... I was not pleased. I was upset, very upset. I wouldn't say I was hysterical though, in the situation.* (Gloria)
>
> *It was just a really bad time ... [W]e'd sort of gone through a health crisis ... and I was just feeling a real sense of, I guess, relief that I had some choices ... It just wasn't meant to be.* (Anna)

Being confronted with an unplanned pregnancy can be a very distressing experience, as these women revealed. Discourses on motherhood often assume that pregnancy is a positive experience, or if it is not at first, it will become positive. For many women, several aspects of their lives need to be in place before they embark on motherhood, if they plan to become mothers at all. An unplanned pregnancy can be very disruptive. The women offered reasons why they did not feel that the pregnancies could fit into their lives at the time.

> *The partner that I was involved with, there's just no way he was someone that you could be relying on as a father to your child. And also I had just come back from backpacking for four months. I was broke, had very little money. I was back at university. It was just not good timing at all. And this individual, I had found out, was not staying committed to the relationship and was kind of fooling around. So it was just not a good time to be having a child.* (Gloria)

> *Well, [my reaction was] there's no way. I have plans for school and stuff like that, there's just no way. My parents would just freak out. I don't know what they would do exactly, but they would've freaked out. I wanted to get finished school and stuff like that ...* (Iris)

> *[My partner] went away for a year and I found out [about the pregnancy], and I thought, 'Oh my God. What am I going to do?' I wasn't only thinking about myself. To me, I know that I wasn't ready for a child and I had come to that decision before ...* (Heidi)

Heidi commented that she knew she did not want to continue the pregnancy because she had come to that decision in a previous pregnancy. Sachdev (1993:54) found that the decision-making process for many women may not be as difficult if they have already gone through the process before.

Betsy identified a number of reasons why a pregnancy would not fit into her life at the time. She had plans and priorities and it was important for her to fulfill them.

I had two jobs at that time, actually ... And [I was training] lots. ... School was number one. Number one. No one in my family has post-secondary education, and so to me it was a really big thing. My brother had just finished at that time. He went to [university], so I thought, 'Well, my brother's the first one to do it ... I have to do this. I really want to finish.' I'd finished one degree and I was going on to the other one, and I thought, 'I've gotta finish. I've worked so hard.' And that was so important to me. And, I don't know, maybe it's old fashioned, but I wanted to be married, I wanted to be moved out. None of this living at home with my mom and, and I thought, 'What is this going to do to our relationship? Like our relationship was great ... but I thought what's going to happen to it with this extra stress on it?' Maybe that sounds terrible, I chose our relationship above, you know, a baby ... (Betsy)

These quotes illustrate that a woman's life circumstances are central in how she views the pregnancy and the decision-making process involved. Pregnancies do not occur in a vacuum. For most of these women, being students did not facilitate having a child. As Corinne recalled, she did not want to have the first abortion, but she, too, had important plans:

[For] the second and third [pregnancies] I was in school. They were both so close together, and I was just so scared that I wouldn't finish. I [said], 'Okay, fine, fine, fine, I'll just do it. Just leave me alone, just leave me alone.' I was too scared to think about it. (Corinne)

Another common consideration by women faced with an unplanned pregnancy is economics. They are aware of the reality of raising a child and the associated expenses. Corinne felt that she was not financially 'ready' for a child, but because she wanted to continue the pregnancy, she would have found a way:

I have never been a slacker. I've never been one that's going to work at some five dollar an hour job all my life. I've never, ever been that way, and if it was harder so it would be harder. (Corinne)

Directly related to whether or not a pregnancy will fit into a woman's life is the desire to have control over the timing of a pregnancy. The decision to have children

requires sacrifices. The concept of 'planned parenthood' affords women and their partners the possibility of deciding when they want to pursue parenthood. A few of the women talked about the timing:

> *We had talked a lot about [it], were we going to have kids, and I was the one that was really on the fence. So, I knew that when I did it, it would be planned, and it would be when I wanted it to happen.* (Anna)

> *I just want to have a baby so bad. But I want to have it under the right conditions. I want to be in a stable relationship. That's what I would like, but it doesn't really matter ...* (Corinne)

For Eve, she has decided that she will continue the pregnancy, if and when it should happen again, 'whether I'm ready or not.' The word 'ready' is very important in this process; it symbolizes the wish to control the timing of a pregnancy, and to be prepared for parenthood. There is also the issue of responsibility. Fiona commented on the pressure felt by some to have a child when they are not 'ready':

> *What good is it if the person is going to have a baby they don't really want? ... If they keep it and they're not ready for it, [what are] the repercussions of that?* (Fiona)

The physical experience of pregnancy, while not necessarily a deciding factor to terminate, made the situation more difficult for some:

> *[For] the third pregnancy, I wonder if it was because I was very calm about keeping it, [because] I was not nauseated, not once. I think that contributed [to the decision to abort], I really do. I mean you were so sick all the time. Not that I had the abortion because I had morning sickness, but I think it makes you more tumultuous too. You're so nauseated ... I lost ten pounds when I was pregnant because I couldn't keep [anything down], I couldn't eat. Everything turned me off and when I did eat, I threw up. With both pregnancies, it was very bad that way, and being that sick doesn't help you make a decision for keeping it. Not to say that was my decision-maker or anything like that, but it doesn't help.* (Corinne)

I wasn't very late for my period. It was only a few days, but I had been, like, throwing up for a week. Throwing up, all the time. And I just kind of felt different. I know that sounds weird. I was puking, like, every single morning ... And I lost, like, about ten pounds because [I was] puking all the time. It was just horrible. (Iris)

It was just the feeling. I couldn't function. I have terrible sickness when I'm pregnant ... I just couldn't function. I wasn't able to move around or do anything. I was sick all the time ... Some people would think it was terrible, but I just wanted it out. Just didn't want it. (Eve)

I was so sick, unbelievably sick. (Fiona)

I was feeling a bit anxious about it. I wanted to get it over with. I was physically feeling poor, I was starting to feel ill. (Anna)

Just the feeling I had, nausea every morning. I was very, very ill. I just remember it was so bad I couldn't even walk ... I was just really sick. I couldn't go anywhere. Just puking. If I walked five steps, I'd throw up. I actually had to stop working. At this time I had a part-time job working at a clothing store, and I couldn't even stand up to work. I literally told them, 'I'm sorry, I can't work because I'm too sick.' (Heidi)

For these women, the physical experience of pregnancy was difficult, and may have been exacerbated by their reaction to the pregnancy and the difficult decision-making process. Added to that is the length of the waiting period between the decision to terminate the pregnancy and the appointment for the abortion. As Eve said, 'I just wanted it out.' Bowes (1990) found similar reactions from the women interviewed about their experiences seeking abortions in Nova Scotia. Feeling ill, coupled with the desire to terminate the pregnancy does not shed a favourable light on the experience for these women.

How the women felt about motherhood and children at the time they were pregnant is illustrative of how they defined the pregnancy. Some women were quite

sure that they wanted to have children some day, but not at the time they were faced with these pregnancies. Others were ambivalent about motherhood.

> *I think we both had less than desirable childhoods, so we just had so many plans. We had plans to do so many things. And we had a lot of those things in common, like travelling, which is not conducive to children [laugh]. Going to school, other places, going out to eat every night, stuff like that we liked to do that we didn't really want to give up. That was the hardest thing, and that was just the deciding factor. I don't think it was a definite thing. I just said, well, for now I don't want to have any children, for a long time at least, or if ever.* (Darla)

> *I guess I'm kind of more career-driven than motherhood-driven, compared to some of my friends. I don't dream about, 'Oh, I can't wait to have a kid,' which probably influenced my decision, too. I don't want to stay home and change dirty diapers.* (Fiona)

> *[I was thinking] I'm going to university and how am I supposed to deal with this? I still think at 17 I wasn't mature enough, and I don't even think right now I would be mature enough to have a child.* (Heidi)

For these women, motherhood was either something they wished to put off until they were ready, or something they were not sure they wanted to pursue at all. For Corinne, motherhood was something that she was willing to experience at the time, and especially now. She wonders if the abortions, which she never really wanted, have influenced her views.

> *I'm so jealous of women all the time. I'm so jealous of women with babies. I'm so jealous of pregnant women. I am jealous of my brother ... his girlfriend is due in three weeks. I'm so jealous of him. I'm buying all this baby stuff and my mom [asked me], 'Why are you buying them so much stuff?' And then she said, 'Well, I guess I know why.' I just need to. If I buy this stuff then maybe people will think I have a baby. I helped raise my boyfriend's oldest, first-born, being with this baby all the time, until he was two years old. I wanted people to think that he was mine. I don't know if I'd feel that way if I'd never been pregnant.* (Corinne)

It is important to understand that not all pregnancies will be defined in the same manner. Women may express different sentiments toward an unwanted versus a wanted pregnancy. Depending on how a woman defines the pregnancy, the term 'foetus' or 'baby' may be used. This distinction has been criticized by anti-abortion activists. Such criticisms do not permit women to define their own pregnancies. Pro-choice discourses (and legal discourses in Canada) view the foetus and woman as one entity. However, the term 'baby' may be used by the willingly pregnant woman. The important distinction is that the woman has willingly accepted the pregnancy and "the transformation of identity and personhood that pregnancy involves" (Hopkins et al., 1996:552). The point is that it is up to the woman, and her alone, how she defines any particular pregnancy.

In anti-abortion literature, "the willingly pregnant woman's painful experience of miscarriage is used to construct the experience of abortion as a means of naturalizing a particular construction of the foetus" (Hopkins et al., 1996:557). This essentializes women's bodies and experiences without considering how each woman chooses to define her own pregnancy. Three women in this study experienced a miscarriage. For Gloria and Eve, the pregnancies were unplanned, but Corinne had chosen to define this pregnancy as a positive one, and planned to continue. She states that she had to have a D & C (Dilatation and Curretage) "because I lost the baby." Language is very powerful and other discourses have chosen to define pregnancy and abortion with little or no regard for the individual circumstances and feelings of women.

For the women in this study, pregnancy involved a complexity of feelings. Not wanting to continue a pregnancy does not translate into wanting to abort. As Corinne and Gloria said:

> *I think there are two questions: whether you're ready for a baby or whether you're ready to abort. That's a whole other thing. Maybe you're not ready to have a child, but are you ready to put an end to a life? I mean, you have to come to terms with that as well.* (Corinne)

> *[I told the counsellor] I don't have any second thoughts about this, and I really don't feel overly terrible about it. This isn't a nice thing ... If this could have not happened, I would have preferred it not to have happened, but the reality is it's happening and I have to deal with it.* (Gloria)

Contrary to anti-abortion discourses, these women may define a pregnancy in a particular way, but still have ambivalence about the decision to abort. Sachdev (1993) found that the degree of ambivalence felt by a woman when going through the decision-making process was related to how she defined the pregnancy. Further, some anti-abortion discourses assume that negative feelings toward the abortion experience results from this ambivalence. For some of the women in this study, negative feelings arose because of the fact that they simply wished that they had not become pregnant. For others, the circumstances of the pregnancy, and the context of both the decision-making process and the abortion experience itself greatly affected how they viewed their experiences.

For Heidi, the first pregnancy was representative of her ambivalence about her relationship. Her partner was abusive, and the sexual intercourse was not something she engaged in willingly. She reflected on her reaction to the pregnancy: "I think it was a denial of being sexually active."

With the societal attitudes and discourses toward women and motherhood, abortion becomes one side of binary opposites. The 'good' mother wants to be pregnant and carries the pregnancy to term, and the 'bad' mother aborts. How a woman views her own pregnancy is affected by many factors, including social (and other) discourses and attitudes toward abortion.

The attitudes of others when a woman is going through the decision-making process can have a significant impact on the experience. In this study, I encountered several women who were not sure about what to do about the pregnancy, and felt pressured by partners (and others) to terminate the pregnancy. In particular, how these people (especially the partner) defined the pregnancy (wanted or unwanted) had a definite impact on how the women viewed the pregnancy themselves, and the process of seeking an abortion.

The Decision-Making Process

> [He] then asked, 'If you don't want the baby and you don't want an abortion, what do you want?' 'That is my dilemma,' [she] replied. (cited in Claire, 1995:110)

The decision-making process, when faced with an unplanned pregnancy, is an important area to explore. As pregnancies do not occur in a vacuum, women have both circumstances and people to consider when making these choices. Further, the decision-making process is reflective of what those circumstances are, and the pressures that women are faced with, both direct and subtle. Some women knew almost immediately what their decision would be:

> *We decided that we both didn't really want children, so it was kind of a big thing for us. It was just decided that abortion is naturally the choice.* (Darla)

> *There was never really an issue for me of what would be the right or wrong thing to do. Should I get an abortion? It was right away. There was just no way in hell I could have this kid ... I knew right away that I wanted to get an abortion. I didn't want to continue the pregnancy ...* (Eve)

For most of the women, the process took longer and was less straightforward. When asked if she made a decision right away, Corinne responded:

> *No, definitely not. My boyfriend was with me. He wasn't in the room when I found out. He was in the waiting room, and first thing he did was take me over to his house and tell me, 'Get an abortion.' He had a son already. His son was a month old. He had just become a father and he didn't want this and I needed to get an abortion, and I guess that's what planted the seed. Not that I wouldn't have thought of it but, honestly, right up until the abortion and still today, my mind flip flops, literally one second to the next. I wanted it but I was scared to death. It took me a while before I told my mom and I only told my mother because I wanted to keep it.* (Corinne)

Fiona stated, "I knew the options, it was just a matter of figuring out what to do ..." Even if a woman is aware of options available to her, an unplanned pregnancy can be fraught with ambivalence and fear, as Corinne and Heidi recalled:

> *I was flip-flopping. I wanted to keep it but ... because I was scared, I did also want to have an abortion. I can't say that I wanted to keep it one hundred percent of the time, because I didn't.* (Corinne)

> *I think I [had the abortion] out of fear, and out of pressure ...* (Heidi)

An unplanned pregnancy can be difficult enough, but feeling pressured to make a decision can create further stress. Some women felt that they did not have control over their decision because of pressure. Heidi recalled the pressure because of the time limits imposed on decision-making, and pressure from her partner when confronted with the first pregnancy.

Things are rushed so much. You're rushed to make a decision. The people dealing with you don't even really know who you are. They're just in there to get you in and out, for the decision. They don't even know if you're leery, and you can't even be leery because there is such a time limit. You can't even be really unsure because it's either you do it or you don't. (Heidi)

I think it was a lot of pressure from [my partner], and at the same time feeling scared. I know I didn't want to be having a child at 15. I don't regret anything that I chose to do then, because I really think that it was the right decision at the time. (Heidi)

Other women spoke of feeling pressure when trying to arrive at a decision about the pregnancy.

I think the closest I ever came to a decision was still wanting to keep it. I don't know if it's a decision, but it's something that really stuck out in my mind. I was sitting across this table from my mom and she said 'Well, if you're going to keep this goddamned baby, you're going to need some sleepers, you're going to need this and you're going to need that.' And then I just started to cry because she was so cruel about it. I don't know if that was a decision but maybe it was the turning point that I was too scared to be alone. I still flip-flopped after that, but she was so cruel and so mean and I was so scared and so young ... (Corinne)

I think it was rather quick, the decision. I almost think [my partner's] brother was pushing more towards the abortion ... I kind of had the sense that that was the choice I was supposed to make in front of him. (Heidi)

I didn't want to have to tell my parents, so it was kind of like my choice was made for me before I even had a chance to think about it. (Iris)

The pressure to either terminate the pregnancy or continue can prove to be a significant barrier in the decision-making process, and can directly affect how a woman feels going through the abortion experience and afterwards. In fact, studies have found that women who are pressured to have an abortion when they do not want one have more difficulty dealing with the abortion afterward than those who were not pressured (Ryan et al., 1994; Sachdev, 1993; Greenglass, 1981). A woman may feel that she

did not make the decision herself, or that she really did not have ownership over that decision:

> *To me, I don't really feel like I really made the decision. I think he was going [with me for the abortion] just to see that it was actually done. In my eyes, that's how I feel. I really don't think that there was any sense of [him asking], 'How do you feel?' ... I think he was just there because he was the other person involved.* (Heidi)

> *No, I never really came to a decision, I remember just giving in. [I] just [said], 'Fine'... I made the appointment and you know, to go and, I just went through the motions. Even to this day I don't remember making a decision.* (Corinne)

There is considerable conflict within many women when dealing with an unplanned pregnancy because wanting to have an abortion implies responsibility. A miscarriage is not something that is 'chosen.' Three women in this study experienced a miscarriage. Gloria had one before her abortion, Eve experienced a miscarriage with her third pregnancy, before the third abortion, and Corinne miscarried with her third pregnancy, after the two abortions. The feelings expressed by Eve and Corinne about the miscarriages reveal much about the ambivalence surrounding the desire to control the timing of terminating a pregnancy, and being able to arrive at a decision:

> *I felt really unusual. I knew what I wanted to do as far as getting an abortion, but I did feel a sense of loss, I guess, in a sense. Because you do feel a sense of loss when you have the abortion, anyway. That's part of it too, but I guess it was just the eeriness of nature doing it for me.* (Eve)

> *Maybe if I had the miscarriage first, I wouldn't have had the abortions. Because my choice was taken from me. [Imagine] thinking about killing yourself because you don't want to make this kind of decision. Not seriously, but I wished that a bus would hit me and kill us both instead of me having to do it ... Make that decision for me. Yet when I had a miscarriage and the decision was made for me, I was angry ... That my decision was taken away. Not that there was any decision to make, but had I gone through losing a child [with the miscarriage], becoming attached to a child and losing a child through no decision of my own, first, then I think if I got pregnant again the same way I*

> *had the second time, I think I would have kept it. Because you experience loss and it's different with abortion because you have to experience the guilt that goes along with it and the guilt is sometimes a lot more than [the loss] ...* (Corinne)

Corinne also felt that she did not make a decision about the first two pregnancies, due to the pressure she felt. She makes a distinction between the 'decision' to have an abortion, and the miscarriage. Women will define 'choice' in many different ways, just as they do with their pregnancies. The concept of 'choice' is complex. There may be any number of barriers, both tangible and less so, which constrain and mold the decision-making process for women.

Though most of the women eventually decided they would terminate the pregnancy, Corinne recalls the second pregnancy when she did arrive at an immediate decision to continue, only to have pressure from her partner to terminate. She ended up having the abortion.

> *No, I was dead set against [having an abortion]. I wasn't going to let myself. I didn't want to have the first one [and I thought], I'm definitely not going to have the second one. I wish I hadn't told [my partner], or anyone [about the pregnancy]. I probably would have followed through, but I had his pressure ...* (Corinne)

For Darla, she immediately decided, with her partner, that abortion was 'naturally' the choice. However, she encountered barriers when attempting to seek abortion services. Darla's mother, who was opposed to Darla having an abortion, suggested she come to stay with her. Despite her initial decision with her partner to terminate the pregnancy, she arrived at another decision:

> *Just a lot of outside pressures like people saying, 'Don't do it,' or 'Yeah, you should do it.' I just kind of took a couple of days by myself and [thought] I think I'll continue [the pregnancy]. And [I thought], I know it will be difficult,*

> *but I just don't want to do this anymore. I don't want to put myself through this ... I think I thought it was a good decision at the time. What made it a little easier, I think, was [that] I was looking for someone to tell me the right thing to do. And I think the worst thing I did was phone my mom ... I shouldn't have phoned her and been in that kind of vulnerable position.* (Darla)

That Darla was hoping someone would tell her 'the right thing to do,' again, speaks to the ambivalence that is sometimes felt in the decision-making process.

The women in this study defined the decision to have an abortion as their own to make. Betsy felt that partners should be included more in the abortion experience, but in a supportive capacity. In this study, women who felt that they made the decision to terminate the pregnancy without coercion and with support reported a more positive experience than those who were coerced, had unsupportive partners or family, or those who had no support.

Support of Partners

The role of partners, family members, and friends in the life of the woman faced with an unplanned pregnancy can have a significant impact on the decision-making process and the experience of seeking and having an abortion. Betsy, Anna, and Fiona had supportive partners throughout the decision-making process and the abortion itself.

> *I was flipping out. I was crying and we drove to the park and he hugged me for about half an hour. He said, 'What do you want to do?' And I said, 'I want to have an abortion.' And he said, 'I'm fully behind you. I was hoping you were going to say that because I hope we can do this in the future one day, but not right now.' And I said, 'Okay, that's what we'll do.' So, I said 'I can't deal with making the appointment already and all that,' I said, 'I don't even know where to start, this is too much.' You know? I said, 'Give me a day just to think about it,' and I mean he was awesome throughout the whole thing.* (Betsy)

> .... *[W]e have a very stable socioeconomic situation, so I guess part of me thought, well, maybe this wouldn't be what most people [in our situation] would do, but we just knew that it was something that we wanted to do. I guess part of me thought that if I hadn't been feeling [that I wanted to have an abortion], my partner would've just gone along [with it], but he was really supportive ... I was just really glad that I had somebody who was supportive.* (Anna)

> *I will always be linked to that guy, just because of the [abortion]. We'll always, not be buddies, but I know he went through some stuff too, and I should've been more supportive of him. He's such a nice guy and he just felt so guilty that I went through it all.* (Fiona)

Darla's partner was supportive when she found out she was pregnant:

> *I was just kind of stunned. I went and told him and he was really supportive at the time ...* (Darla)

However, Darla and her partner separated for the last part of her pregnancy, when she returned to stay with her mother.

> *We were both really upset. It wasn't a happy thing, but it was the best kind of thing to do for both of us. It just kind of happened over the course of the pregnancy. We kept in contact and stayed on the phone, and we'd write letters. We worked out some arrangements and some conclusions. And then we moved back in together when [our daughter] was a month and a half old.* (Darla)

Iris, realizing the importance of having some support when going through the experience of seeking an abortion, talked about how difficult it would be for a woman to go through the experience without the support of a partner.

> *I know there's probably some people that do have trouble with [having an abortion], but I think people [may] also have trouble sometimes [because] they might not have the support from their boyfriend. If I didn't have him, then I probably would have went a little loony. Just all the pressures and stuff like that.* (Iris)

Iris spoke of the importance of having support to deal with the 'pressures and stuff.' However, she did feel some pressure from her partner when trying to arrive at a decision:

Even when I was wavering, [saying], 'Oh, you know, that would be so nice [to continue the pregnancy].' He [would say], 'No way, we have to get one [an abortion].' He wasn't rude about it, but he was staunchly supportive of abortion... but he was very good throughout the entire thing. I'm not saying he was rude about it ... he didn't put pressure on me but it was almost like he did, unconsciously, because he was so for the abortion. (Iris)

Pressure from partners and persons close to them can range from the very subtle to blatant coercion. Women may feel pressure to either continue a pregnancy, or have an abortion. Gloria's partner was 'supportive about the fact that he wanted me to have an abortion, but he wasn't giving me hugs or anything like that.' She, too, found the process very lonely because very few people knew. After the abortion, her partner took her back to his place, tucked her in bed so she could rest, and asked her to let him know if she needed anything. She recalled, 'I actually was surprised he was that supportive.' She then fell asleep.

I guess I woke up around nine o'clock, and I went downstairs. His mom told me that he had gone out to the bar with a group of friends ... And he didn't come home for two days either. (Gloria)

For Eve, she had an on-and-off relationship with her partner, and his support was inconsistent:

Well, he was [supportive] and then he wasn't. It depended on his mood. If he was in a bad mood and he was angry at me, I was a 'murderer' ... Initially he was fine, but afterwards he was an asshole. He was abusive ... Whenever it took his fancy I was a 'murderer' and a 'baby-killer' and all that lovely stuff. (Eve)

It was a difficult situation for Eve, because she kept the abortions secret.

The only person I could talk to was this jerk. The only person who knew. Every time I'd phone and try to talk to him he'd [say], 'You know, I'm kind of busy.' [I said] 'But you know, nobody knows about this. I need to talk to somebody.' [He would say] 'I can't, you know,' so all of sudden I felt that I was becoming very bitter and cold. (Eve)

Despite knowing that she wanted to terminate the pregnancy right away, the lack of support from her partner was difficult for Eve because she had nobody else to talk to.

Heidi was only 15 years old when she found out she was pregnant. She was in an abusive relationship, and did receive support from her partner.

> *The person I was with wasn't a very supportive person. The first thing he said to me was, 'Well, you're going to have an abortion.' And, it was a very abusive relationship. I was very undecided at that time [about] what I should do. But there really wasn't a lot of time to think about the decision that I was making.* (Heidi)

In Heidi's situation, her partner was not the only one pressuring her to have an abortion. She said he basically "told" her to have one, and "he had his friends calling me to tell me [to have an abortion]."

Corinne's partner was with her when she received the positive test results, and told her to 'get an abortion.' She ended up 'giving in' to the pressure from both her partner and her mother, and had the abortion. For the second pregnancy, her partner again pressured her to have the abortion, but was even less supportive than for the first pregnancy.

> *He could've taken me [to get the abortion done]. He really wanted to but he [said], 'Well, I'm looking after [my son]. You've done it before.' That was his excuse, 'You've done it before.' The day I had the laminaria tent inserted he wasn't there either. I don't know if I mentioned [this] ... but that was very, very painful. Very, very painful, and I was almost admitted [to the hospital]. They would give me pain killers, and [I had] diarrhea and a high temperature and [was] turning red and sweating and shaking. I don't know if it's a form of shock or what it is, but it was really bad. He never phoned. I was at a friend's house. Finally I phoned him that night and he had forgotten that I had to go in the day before and I said, 'Oh, am I disturbing something?' And he just [said], 'Well you've done it before, what's the big deal?' Maybe he didn't mean to be cold or maybe I'm must making excuses for him but, he was kind of cold ...* (Corinne)

Although the third pregnancy resulted in a miscarriage, there was still pressure from her partner, over the phone, to have an abortion:

> *My boyfriend was gone [out of town] at that time, for the third pregnancy. I told him, 'Oh yeah, I have the appointment to have it done.' But I never had the appointment. I'd tell him [that I did] so he would stay off my case. I didn't need that pressure of him telling me to get it done.* (Corinne)

Support of Friends and Family

A woman's support network is dependent on who knows about the pregnancy and her decision to abort. For some of the women in this study, friends and family members were part of that network. Some women spoke of the support they received from other family members at the time they were going through the experience:

> *I did tell my sister, and she was really supportive, and I told a really close friend who was also very much behind me. Nobody questioned me or tried to influence me. And actually at the time I didn't tell my mother but I did after the fact. [She said], 'Oh God, it must have been really hard for you'... And I think the regret was that [my mother said], 'I wish you could have told me,' but everybody has been supportive.* (Anna)

> *My mom knows everything, but we kept it all from my dad because it would just not go over well at all ... I was really fortunate in the sense that I had my mom there. I had an excellent support system. And oddly enough, my sister too, in her own little odd way. Not so much my boyfriend at the time.* (Eve)

Gloria did not have much support when going through the decision-making process and having the abortion, which she described as very 'lonely.' A close friend was very helpful to her, but her partner was only supportive financially. She did not tell any family members until after the experience.

> *This is still something that I never told my dad and I think it would kill him to know. I did tell my mom almost a year after, and she was disappointed but she wasn't overly upset. I could sense the disappointment, so I guess that is the*

only negative. But she was actually really supportive about it and I think that's because my younger sister became a teen mother at 17, and she knows all the difficulties my sister had as a single mom, or still has as a single mom. So mom's actually okay about that too, I think. (Gloria)

Fiona's friends were 'great,' but she said that the pregnancy did not 'go over well' with her brother as his wife had just become pregnant. He discouraged her from continuing the pregnancy. When faced with her pregnancy, Darla and her partner had initially made the decision to terminate. She said:

My sister didn't want me to have an abortion ... I don't really know her reasons but she was kind of coaxing me into telling my mom and going back home with my mom. [She would say] 'Don't [have the abortion]. You'll regret it.' That made me think a bit, but I wasn't really dissuaded by that. (Darla)

Corinne's mother was not supportive of her interracial relationship. Not only was she pressured to have an abortion by her partner, but by her mother, too:

I went to counselling and my mom was drilling into my head how I'm going to have to go on welfare and my life will never be my own and don't look to her. Other times she would say, 'Oh, I could never kick you out.' ... And then [she would say], 'What? You think you can stay here?' - my bedroom was in the basement - 'You can't have a baby live in the basement - it's too cold, it's too drafty, you're going to have to leave and go on welfare. Do you want to be the only one in this family on welfare?' Not so much the shame of welfare but my mom drilling it into me all the time. I know she wanted the best for me, but it seemed, a lot of it, to revolve around her. I remember one morning, she came downstairs and she woke me up. She was pushing me awake and she said, 'How can you do this to me, how can you do this to me, how can you do this to me?' I'm scared to death of my mother. I'm scared to death. (Corinne)

Some of the women found support in friends that they told:

A lot of my friends knew [about the second pregnancy]. I think my friendships with people were a lot different. I had become very close with a lot of people as opposed to when I was in grade ten, or in 1990 [for the first pregnancy]. [At that time] I had one friend that I had since kindergarten [and] I was really isolated in that relationship. (Heidi)

My friends took me for [the dilation] and took me again the next day [for the procedure]. Then I stayed over at my friend's house. I had taken her to get [her abortion] done and she stayed over at my house. She got an infection as well ... She was bleeding profusely and high fever and her mom had to take her [to the hospital]. I think her mom had figured it out. She said [to my friend], 'Did you have an abortion?' and she said 'Yes,' so her mom knew. So when I came over, her mom knew that I had had an abortion as well and she was really, really nice to me. (Corinne)

My folks didn't know about [the third abortion] either, so my friends came to pick me up. I had a really good roommate at the time. She was really supportive. (Eve)

My best friend knew. She was just supportive whatever I decided to do. She's not the type to put pressure on you about stuff. When she found out, she was just mostly comforting. (Iris)

Betsy recalled telling some close friends about the pregnancy only to have a negative reaction:

I told a few of my friends and I'm not friends with them anymore ... They said, 'See ya.' I haven't talked to them since that day ... Two of my girlfriends won't talk to me now. So, I guess they really weren't that good of girlfriends ... They supported my decision but they didn't want anything to do with it. They said 'I would do the same thing.' I know it sounds really weird, but they wanted nothing to do with me. Nothing, avoided me. (Betsy)

Corinne was happy when she became pregnant for the second time. She was hoping for a positive reaction from the friends that she told.

When I told my friends, most of them were horrified. I have one friend, she was the only person who said 'Congratulations.' (Corinne)

The Abortion Experience

The experience of having an abortion involves much more than the actual procedure itself. How the women found the procedure is reflective of access, as well as how the experience fits into their lives now. Anti-abortion discourses often claim

the procedure is extremely painful and traumatic, but this is more common with illegal, unsafe abortions. The availability of safe, legal abortions by trained professionals is different.

> *I didn't feel anything. I just [heard] the sounds, the doctor, the people talking ... You feel like you feel pain, though, because of the vacuum sound ... You have instruments up you which, it's not like you can't feel, but you can tell [laugh].* (Fiona)

> *Oh no, the first one was okay. The first one I fell asleep and the second one I was wide awake ... It was painful, I felt everything. I felt the needle, I felt the scraping, I felt the suction. Not that it's as bad as the pro-lifers make it out to be. It was not so much physical pain but it was awful ...* (Corinne)

> *Because of the date of the pregnancy, I had to go in the night before and be dilated with the seaweed ... Through the night that was very cramping ... I just basically remember looking out that glass, and it was cramping. The procedure was maybe five minutes.* (Heidi)

Corinne said that the second abortion was 'awful,' but not so much because of the physical pain. She did not want to have the abortion, and gave in to the pressure from her partner. Eve did not feel anything during the abortions: "[T]hey pumped up the volume on the drugs. I was knocked out. Woke up two hours later, or an hour later." She did feel cramping from the laminaria tent.

Some women had the dilation and the aspiration in the same day, usually at the private clinic. In some cases at the clinic (when the pregnancy is over 12 weeks gestation), a synthetic, fast-acting dilator will be inserted several hours before the procedure, rather than overnight. More typically, when the pregnancy is early enough, dilating rods may be used right before the procedure.

> *Well, there wasn't that cramping the night before. I didn't have that dilation. There was cramping and, of course, afterward there was this bleeding, but there really wasn't much. They asked me if I wanted the Valium, and I said 'Sure,*

drug me up.' You know, might as well ... There was a person holding my hand the whole time, which was different [than the first one] ... And that person was talking to me during the procedure as to how I was feeling. And I do remember crying, like during it. And they were asking me why I was crying and I just remember being so worried about how [my partner] was going to feel in Japan? That ... was the main difference, that somebody was there beside me. (Heidi)

I couldn't relax, and I said 'I'm nervous, I've never had surgery before.' Then the nurse came in, and then she gave me a sedative to relax me because I couldn't relax ... Then she said 'We're going to dilate you now,' and I said 'You know what? I really don't want to know. Don't tell me'... [T]here were two nurses standing right beside [the doctor], monitoring, and then they turned on this vacuum, and to this day I can't listen to the vacuum cleaner ... So, I remember [at the time] it kind of calmed me ... I felt quite a bit of pain, and then she said 'We're almost done.' ... I remember thinking okay, that was painful, but it really wasn't that bad, and it's over with. I mean it wouldn't be as painful as giving birth right? So this isn't that bad, it's done with, I can move on ... (Betsy)

They did the dilation thing [with rods], and then they had to do a little bit longer procedure thing, so I think [the procedure] was not longer than 30 minutes, probably even less than that. It wasn't long ... But I had quite a bit of pain. I could feel everything he was doing. (Iris)

[The doctor] used rods and, I mean, he had me so I was clinically awake, but I was a zombie. I remember nothing ... I know it was a local [anaesthetic], but there was an anaesthetist who got me right out of it ... I just remember feeling cold ... After everybody had left, I was really nervous and silly. I don't remember anything. I just remember waking up [in the recovery area] and having a big pad between my legs [laugh]. (Anna)

Anna was fortunate that her own doctor performed the procedure, and the dilation was done at the time of the procedure. The pregnancy was early enough to allow for dilation by rods. Most procedures performed in a hospital involve insertion of a laminaria tent the day before to allow for gradual dilation of the cervix.

Complications

Of the nine women interviewed, one developed complications. Corinne developed infections after both abortions, and was admitted to the hospital. She felt 'searing' pain, and there was heavy bleeding which persisted for several days after the procedures.

> *It was probably about three days, or four days after [the first abortion]. I was bleeding quite heavily, which I was concerned about, and I was feverish. I get infections really, really easily, and I knew something was up. My boyfriend took me in that day to the hospital. [I was] in the waiting room for three hours, as usual. That time I haemorrhaged, after the second [abortion], [I was] waiting for at least an hour and a half. I don't know if it was the hospital or if it was the triage nurse but [she asked me], 'How many pads have you been through today?' [laugh] ... [I told her] 'I've been through my coat over here,' you know? ... So they went in and physically removed some [tissue] with their hands to help stop [the bleeding] ... That's why I was bleeding, because they didn't remove it all in the abortion. But if they can remove some of the larger clots then it would slow down the bleeding, which they did, and they were very rough. It wasn't very nice at all ... I wasn't impressed both times that I got an infection either. I had no precautionary antibiotics ...* (Corinne)

Of abortions performed in Canadian hospitals in 1995, only 1.1 percent resulted in complications; 0.1 percent resulted in haemorrhage, and 0.1 percent resulted in infection (Statistics Canada, 1997:25). Complications are rare when abortions are performed by trained providers in suitable medical settings.

Clinic Environment

Four women had abortions at the private clinic. I asked the women how they felt about the facility they chose for the procedure. There were positive recollections.

> *What really helped through all of it was that I had a friend ... and she went in with me ... Right beside me. And it was quite interesting because I think there were six other, five other women there, and we were upstairs and we were all*

kind of looking at each other, and we all knew why we were there. We all started making conversation and talking to women there, and we all kind of really supported one another. I remember the youngest one, I think she was probably in her late teens. She was the first one to go in, and she was this tiny little thing. And she came out and she just looked awful, and she ended up throwing up. We just felt terrible for her because we all knew how she was feeling. But it was really nice because we were all really supportive with one another. (Gloria)

[My partner and I] went in, and there's a little reception area ... [T]he receptionist was very nice, the nurses were nice ... I felt they were pretty good to me and there was a lot of information around, like around the table and stuff ... I looked up on a bulletin board and there were a million thank-you cards. 'Thank you for the experience' [and] 'My life has changed but you were there to help me through it' ... [T]here were tons of them, and I thought, okay, this might not be all that bad. (Betsy)

I was saying that I wanted [my partner] to come in [to the procedure room with me] and then I think they said, 'Well, we could do that.' But then I think [my partner] said 'I don't really think that's a good idea' or something. Which would have been, like, it's nice that they were going to let him do that if he wanted to ... [T]hey're very nice there and everything ... It's a lot more relaxed than I thought. I thought [the doctor would] be wearing surgical stuff or something. He was wearing normal clothes, so that was a little bit more comforting. It wasn't as ... impersonal ... I really appreciated having the one woman there during the procedure. They kind of hold your hand, and tell you what's going on and stuff. I think that was very helpful. (Iris)

Although she found the environment relaxing and the staff helpful, Iris was uncomfortable sitting in recovery after her abortion, with other women present:

That wasn't good at all. I didn't like that at all. I'm sitting there, and I'm not feeling anything yet from the sedative, so I'm just like watching everything. There are women coming out and they ... looked all pale ... There [are the women] that are sleeping, and the ones that are waiting [for their procedure]. I didn't like that very much ... I think I would have rather just been in a room by myself or something [laugh]... (Iris)

Heidi found the clinic environment to be "a relaxed atmosphere ... [Y]ou just felt real relaxed." She said that the counselling session was brief. She would have preferred it to be a little longer. There were protesters outside the clinic when Heidi went for both

of her abortions. She said: "[I]t's like this feeling of them pointing at you, almost." Heidi commented on seeing the other women coming down the stairs after their procedures:

> .... *[Y]ou know who's had [an abortion], you know? ... [E]ven though it's a more relaxed feeling, it still has that aura, and that could just be because of the situation, not the actual structure of the building.* (Heidi)

The advantages of having a free-standing clinic to provide women with abortion services include: privacy; a relaxed atmosphere; and staff trained specifically in dealing with a particular clientele. For the women in this study, this environment helped to make their experience a little easier. Funding clinic abortions would make this facility more accessible.

Hospital Environment

Four women in the study had their abortions in a hospital - Corinne, Anna, Eve and Fiona. Although the environment has changed somewhat since these women had their abortions, there were disadvantages to having the procedure in a large facility:

> *You're lying in a hallway on a bed. For any kind of surgery, nobody likes that ... They also had ... students putting in my IV, and she kept missing. I wasn't mad at her, they have to get their education. I guess this is the difference between a hospital and [the private clinic].* (Corinne)

> *Since never having stepped foot in a hospital since the day I was born, [the experience was] shitty. [laugh] ...Yeah, it was really shitty ... I don't have any other hospital experience ... I just had no idea. It was cold. Cold, clammy, and sterile ... We're all in [a] room, and that's where I got pulled aside. And then, out of there, they wheeled us out of there in the hallway, and we lie on this gurney in the hallway. For another half hour, and the whole thing took forever. And you're just sitting there. Of course it's a little nerve-wracking ... And that's when I got my IV out in the hallway which they couldn't get in. They were stabbing me relentlessly.* (Fiona)

The 1990 study by CARAL in Nova Scotia (Bowes, 1990) found that women's experiences of clinic abortions were much more positive than those received in a hospital, for many of the same reasons as those expressed by the women in this study.

Fiona's abortion was in 1993, and Corinne's were in 1993 and 1994. Since that time, abortion services at the hospital have improved considerably. The atmosphere where the procedures are performed is more relaxed, with soft colours and lighting. Staff are specially trained to work in the environment (personal communication, hospital staff, 1998).

Post-Abortion Feelings

> A woman's feelings about abortion depend largely on her reason for choosing to end the pregnancy, the conditions during the procedure, and her response to the experience. (Claire, 1995:17)

Women experience a wide range of feelings after having an abortion. Social pressure dictates that women are to feel depression, guilt, and a deep sense of loss. The assumption that motherhood is a goal for women creates a climate of expectations, and reinforces the binary distinctions between 'mother' and 'murderer.' While many women feel these emotions, there are often many other feelings. Claire (1995;15) interviewed a psychotherapist in London who has counselled women post-abortion for twenty years. The therapist identified three main responses following abortion and other possible reactions. *Euphoria* may be felt initially once the procedure is over - "an expression of the feeling of relief and freedom at having solved a problem, having got rid of a burden and having executed a decisive action" (cited in Claire, 1995:18).

During this time, a woman may feel the need to keep busy and may not feel any guilt or remorse. *Detachment*, or a sense of shock may set in and is usually "an attempt to avoid experiencing the painful feelings connected to the termination" (cited in Claire, 1995:18). Distancing and a sense of emptiness usually accompany this emotion. The third main feeling that is identified is *depression*. Other emotions identified by the therapist include: *fear of sexuality*, or discomfort with sexual relations for some time following the procedure; *ambivalence*, for many reasons including whether or not to have a baby; and *envy*, where some women find it painful to be around women with babies or anything associated with babies (cited in Claire, 1995:18). Most women who have had abortions do not experience depression, in the clinical sense of the term (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990; Greenglass; 1981), though sadness and a sense of loss may be felt.

It is important to acknowledge that while some women may feel these and other emotions, every woman's experience is unique. Another counsellor in London, England, said that in her counselling experience, most women do not have a 'moral qualm' about abortion, and that at least 90 percent feel no ambivalence (Butcher cited in Claire, 1995:19-20).

Studies have found that a common feeling after an abortion is relief (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990; Osofsky and Osofsky, 1972). In Sachdev's Ontario study of 70 women who had abortions, 78.6 percent expressed relief and euphoria (Sachdev, 1993:189). These feelings are often because the burden of an

unwanted pregnancy is lifted, and anxiety about the surgical procedure is overcome. The women in this study described these emotions, and others.

> *Relieved. Big, big sense of relief. But alone. I didn't want to keep troubling [my friend] about it because I knew this was something that she dealt with everyday [in her work], and I know she wouldn't have minded [if I asked for more support], but I felt really alone. I hadn't told any of my family, just the one friend in [my home town], but she had gone away. She was out of the country, and I felt really alone. Nobody knew what I was going through. That was very lonely and very hard.* (Gloria)

> *I just felt such a sense of relief. I actually felt physically crampy, and then I felt really good and just wanted to go home. I felt really well. I didn't feel sad, I just felt like I had a heavy period.* (Anna)

> *It was over and I didn't have to think about it ... But, you can think that after the procedure is over, but I don't really think it is.* (Heidi)

> *Oh, glad it was over. I was just happy that the whole thing was [over] ... we rented a bunch of movies [my partner and I]. I was just happy to have it over with.* (Fiona)

After the second abortion, Heidi said: '[W]alking out of there I was pretty happy. It was like a happy feeling.'

Often, a woman may feel several different feelings at once, as these quotes illustrate. Ambivalence is a common reaction (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990). For many women, there are feelings of loss and guilt following an abortion. These feelings may be conflated with feelings toward the pregnancy and contraception, or may result from self-blame or the circumstances surrounding decision-making:

> Grief and loss are the most confusing emotions associated with abortion. Somehow, because a woman chooses to have an abortion, it is not considered appropriate or socially acceptable for her to grieve publicly or, in many cases, privately ... Some women are suprised by the depth of their feelings of loss

> after an abortion, and they assume responsibility for this grief through a sense of guilt ... (Claire, 1995: 22)

The women in this study described some of these feelings:

> *I felt really shitty ...Very guilty ... Of course, at that particular time it was still sort of a secret thing. Especially for myself, I couldn't let my dad know, and we all lived in the same house ... I just felt really sad. Plus, maybe if I had a little more of a different support system as far as my partner went, it would have been different. But with him being there, telling me how much of a bad person I was, that didn't help at all.* (Eve)

> *Being someone who is pro-choice, who's somewhat educated, and who had at least somewhat of a positive experience from all this, it is still a loss. And it's still something I think about maybe once in a while, and it will get me down. It doesn't get me down anymore, but I think, up until last year, I'd think about it and maybe I'd have a little cry and that would be it, because it's still a loss. For your body to be pregnant one minute and then not pregnant the next, there's a lot of emotions and things that you go through. And what was really hard for me - when I was not pregnant. You'd feel your tummy and you'd think, okay, don't touch your tummy, because you don't want to bond. [pause, upset] And I guess it's still kind of hard, once in a while ... but I don't regret it.* (Gloria)

> *I felt very selfish for having the abortion, and my mom was telling me it was self-less to have the abortion, and I don't know which is right.* (Corinne)

> *I could totally tell [that something was different] ... When I went home that night, I felt empty, really empty. I don't know, I guess it was psychological, but I felt really, really empty and you can tell that something was gone. It was kind of a weird feeling, especially since it's not supposed to very big, you know what I mean?* (Iris)

The stigma and shame that cloud abortion are often internalized by women, and this makes the process - and grieving - more difficult. Abortion may also become a beacon for other problems in one's life. Relationship issues and other personal dilemmas may be intensified by an abortion, or feelings toward the abortion may be intensified by other dilemmas (Claire, 1995).

What is lacking from debates about post-abortion feelings is a critical assessment of the motherhood ideal. To expect that all women are prepared for pregnancy and motherhood any time it might occur is naive and righteous. Because motherhood is an essentialized facet of womanhood, there is an assumption that "loss" of the pregnancy will result in intense feelings of guilt and sadness. For some women, this is the case, often for women who have miscarried. Control over the circumstances of pregnancy (or lack of) play a very significant role in feelings about termination of a pregnancy.

Women who have undergone an abortion and a miscarriage may compare the two experiences and, although there may be feelings of sadness for each circumstance, they differ in degree because of the way the pregnancy and 'choice' are defined. Feelings after an abortion are intimately connected to the decision-making process and taking ownership of that decision. Feelings of sadness and guilt may be more intense for women who were coerced into having an abortion, as in the case of Corinne.

Post Abortion Syndrome (PAS) in anti-abortion discourses suggests that all women who have had abortions are 'victims' of that experience, and feel symptoms akin to Post Traumatic Stress Disorder (Hopkins et al., 1996). Further, if a woman does not feel these symptoms, then PAS asserts that she is in denial. This discourse is an attempt to control the way that the abortion experience is defined, and in turn denies the definitions of those women. The psychological discourse of 'denial' is critical because it "reconstructs" alternative discourses - such as the women's own experiences - and "delegitimates" them (Hopkins et al., 1996:560). Further, by labelling women's

feelings after an abortion as a 'syndrome,' PAS essentially universalizes the experiences of individual women. The women in this study have defined those experiences for themselves, and PAS does not speak for these women.

The women in this study had more to say about anti-abortion discourses than any other. Some of their feelings about the decision-making process, the abortion, and afterward were affected by these discourses. Feelings of guilt, shame, and ambivalence may stem from the internalizing of anti-abortion sentiments. For many, these discourses are in direct opposition to the women's own views. How they feel about these discourses is related to the *meaning* that abortion and their own personal experiences have for them. Feeling sad and guilty after an abortion do not necessarily mean that a woman is sympathetic to the views of those who are not pro-choice:

> *I think that those commercials, that Arthur whatever foundation on TV ... [Saying] that each one of these children were going to be aborted, I mean, God. I've been diagnosed with clinical depression since. Let's just put it that way. I think they're awful. They made me scream and cry. They were awful. I mean I looked up numbers to call the League for Life and stuff like that and tell them off. I really have a problem with them ... I mean those are obviously obsessive people.* (Corinne)

> *I don't think you should be pushing your views on somebody else, especially using violence. They go in there and kill some of the doctors and stuff. Excuse me, you're saying about pro-life and all this stuff, but you're being violent enough to kill somebody else ... I just don't agree with all these people who are saying, or doing things with violence, and who are making women feel that they can't go and get something that is legal ... people with those posters with the pictures of foetuses and things like that.* (Iris)

> *Well, I just feel that there should be some means that people can work in this area and doctors can be ensured safety. There's got to be cooperation. I know that in the States now, they're having these laws where people can't go within a certain area of the [abortion] clinic. In Canada, I think there should be more, I think there should be more support for abortion providers. But these nuts, it's hard for me to even imagine.* (Anna)

> *People getting shot in their kitchen. I mean, you're supposed to be pro-life people, what are you accomplishing by shooting someone else? But they figure they're saving more lives that way because they're shooting one person and then they're saving all those others ...* (Betsy)

Eve commented on the distribution of power among anti-abortion advocates. Abortion affects women most directly, but as she said: 'What amazes me are the people that are into these pro-life organizations. People who head them up are all *men*, okay?'

Women do not, contrary to essentialist discourses, exist solely for the purposes of procreation and motherhood. A large proportion of pregnancies are unplanned, and the unhappiness and stress of an unwanted pregnancy are often ignored. The suggestion that adoption is an option for all women ignores the fact that for many women, carrying a pregnancy to term and proceeding with adoption may be more traumatic than either continuing the pregnancy or abortion. The desire to terminate a pregnancy is deeply rooted in how a woman views a pregnancy and whether motherhood will fit into her life. For many, a positive pregnancy test is a terrible experience, fraught with anxiety and stress.

For these women, the experiences of an unplanned pregnancy and the decision-making process focussed less on how morally right or wrong abortion was than on how a pregnancy would fit into their lives. The consideration of life circumstances in reproductive decision-making is supported by Currie (1988). Women in her study often spoke of the 'right time' for a pregnancy and how this affected their decisions. While some women in this study thought of the foetus as a 'potential' and a 'loss,' the pregnancy did not fit into their lives at that time. Abortion fits into their lives as a

consequence of the wish to have children when it is the right time for them, if they want to have children at all.

Views on Abortion After the Experience

Though a woman may have feelings of sadness and loss following an abortion, this does not mean that she regrets having the abortion. Further, women who are not overwhelmed with grief and regret following an abortion do not necessarily approach the decision or the procedure lightly.

> *It wasn't a happy decision, it was a very strong decision.* (Heidi)

> *It was the hardest thing I've ever had to do but the easiest decision I've ever had to make.* (Betsy)

To some degree, the self-identity of the women changed after having an abortion. Their views on how the abortion experiences affected them reveals the meaning it has in their lives.

> *I do think I judged people because of my religious background - if it doesn't happen to you, you don't have to worry about it. If it doesn't [affect you] ... Or even the research you donate money to. If you have a mother with breast cancer, you're probably going to look at the whole situation differently ... All of a sudden I was on the other side of the fence. I was one of them. Like when you'd have group statistics, I was over here now. And I always think of it that way. I'm one of them. It's just weird, the whole thing.* (Fiona)

> *I really learned a lot about myself. You say one thing but you never know if you're gonna actually do it one day. And just knowing I did it, I look at myself differently. I find I define myself as 'before the abortion' and 'after the abortion.'* (Betsy)

Though their views on abortion did not change much, some women became more sensitized to the issue and the importance of access:

I don't think I look at abortion any differently. I don't think it's the worst thing in the world. I never really understood, though, the emotional part of it. I thought that I would feel relieved and I might have a few regrets, or I might cry about it sometimes, but I had no idea how sensitive I would be to it. For example, I'm reading in the paper and it will say some heading [with the letters] 'Abor,' and I automatically go [gasping noise]. (Betsy)

No, [my views did not change]. I guess the only thing it did for me was just to re-emphasize how you just never know. Now, having gone through the experience, I guess I just realize at the time I was pretty lucky that I had these connections, that I could get in. I remember thinking, 'I know it's not this easy for everyone.' (Anna)

It's something I don't regret, but it's something that wasn't so nice either. It's not a nice thing to do, but we live in a country that we can now have a choice. (Gloria)

At the same time, some felt that their views on abortion did change, in certain ways:

I thought I knew [what it would be like] before I had one. I thought I knew ... I remember reading stories about people, how they felt a month after, one year anniversary, and I remember thinking, 'Come on, it's just an abortion. You haven't grown attached to this baby yet. It's not even a baby yet, it's a foetus ... How can you feel all these things? Come on. Get over it. You've made the decision. You've done this to yourself. What do you expect? Do you want me to feel sorry for you that you're having all these flashbacks and all these poor feelings? I don't feel sorry for you, you did this.' That's what I thought the night before, okay? ... Now I think completely differently. It's amazing. (Betsy)

I've always been pro-choice and I will always remain pro-choice but, yeah, it's changed my views. I'm never going to be a pro-lifer, but I understand where they're coming from. I'm sure anybody, any pro-choice person can understand. It's so important that you're not pro-abortion, you're pro-choice. It made me think a heck of a lot more about it ... I see what they mean, definitely, and it's not something that wasn't going through my mind all the time ... But I have more of a hatred for pro-lifers because they're in front of the abortion clinics and do they not realize no one wakes up and says, 'I'm having an abortion today,' just has an abortion, and it doesn't mean anything to them. I don't know one person, I know people who made hasty decisions, but I don't know one person who doesn't think about their decision after or have regrets. (Corinne)

Heidi still considers herself to be 'pro-choice,' but expressed some ambivalence about her views:

> *I'm not even sure where my views stand. It's still that question of where does life begin? And I haven't really answered that question still in my mind, where it begins. You can say it begins after three months, but how do you put that limit on it? To me, I guess I just view children in a different way, and where they place themselves in your lives. I think abortion is an individual choice. I don't think society or anybody else should be saying who should have one or who shouldn't. It's for the individual to decide, I know that much for sure. I would say I'm pro-choice.* (Heidi)

Iris did not say that her views on abortion changed in any way having gone through this experience. She still identifies herself as pro-choice, but does not feel that women should use abortion "as their form of birth control."

The women were not asked directly how they felt about abortion at the time of the interview. It was anticipated that those views would emerge. Corinne offered her view.

> *I wish people would understand. I know I told one friend that I was pro-choice and she said, 'Oh, you're for abortion.' No, I'm not for abortion. Like my boyfriend said - the only thing he ever said that made sense - 'Nobody ever wants to have one. It's nobody's first choice.'* (Corinne)

This speaks to the distinction between reaction to the pregnancy and how one feels about abortion. For most women, they choose abortion because they simply do not want to be pregnant. As Eve said, when asked if she would do anything differently: "I wouldn't have gotten pregnant."

Did the Experiences Affect Other Views?

Abortion affects women differently. Going through the experience of seeking and having an abortion can have a significant impact on a woman's life, and may affect her views on other matters. Pregnancy, particularly a first, is confirmation of one's fertility. As Claire (1996:34) suggests, pregancy can make a woman and her partner more conscious of contraception and its use. The women were asked very generally if the experience changed their views in any way. Some spoke of how the experiences changed their views on relationships and sexuality:

> *I think it changed my opinion on sex ... [The] consequences were unbelievable for such a fun little activity. It seems so innocent.* (Fiona)

> *I'll tell you what the experiences did, [they changed] my views on birth control and how important it is. How essential it is to be protected whether you're in a long term relationship or not. Screw the heat of passion. Stop in the middle of it and make it work, and get some condoms out, or get a diaphragm in or do something ... So, if anything it's made my awareness of the importance of birth control, and I tend to try and promote it as much as I can.* (Eve)

> *I don't think I would ever get myself in that situation again. I would never go without protection with somebody now. It's just so dangerous now with all these diseases ... So I was a lot more strong on that, a lot ... [It] solidified in my brain that [I] don't want to go through all this stuff again. So, let's protect [ourselves], and now I'm on the birth control pill. But I still use a condom because I don't think the birth control pill is [enough].* (Iris)

> *You know, now my views have completely changed. The way I've been in sexual relationships has changed, and the protection I use, that's changed ... I think people should really be going for counselling afterwards.* (Heidi)

For Heidi, her views on sexual relationships were changed by the abortions, but after the first one, her views on religion were affected also:

> *I think through [the debate in highschool] that I had researched it a lot. I think I had a lot more opinions about the topic and my views had started changing about religion, and what children are. I think they started maturing, my*

> *thoughts ... I really don't say that I am a Catholic. I think I'm more agnostic than I am Catholic.* (Heidi)

For others, their views on pregnancy and motherhood changed, or were brought to the fore:

> *Not on abortion, really, but on motherhood, I guess, because I sort of forced myself into motherhood if it ever happens [that I am pregnant again]. I suppose next time it happens, whether I'm ready or not, I'm going to be having a baby [laugh]. I didn't like looking at babies, I didn't like looking at women with babies. I didn't like looking at kids, I didn't like being around kids, I didn't like being around babies ... After all, after each of them, after all of them. It would make me cry.* (Eve)

Many of the women expressed a desire to pursue motherhood in the future. There is an assumption in anti-abortion discourse which defines abortion as the 'antithesis' of motherhood (Timpson, 1996). In fact:

> Contrary to the dichotomized construction of abortion within the media and anti-abortion literature, women's accounts place women's decision to abort as integrally related to their desires about motherhood. (Ryan et al., 1994: 163)

For the women in this study who said that they would like to pursue motherhood in the future, they wanted the circumstances to be right, and wanted having children to 'fit' into their lives. The abortion decision needs to be redefined as one of many "fertility control strategies." Events in a woman's reproductive lifespan - birth, unintended pregnancy, sterilization, 'false alarms' about pregnancy, infertility, miscarriage, and abortion - all "cause women to evaluate their desires and capacities to mother" (Ryan et al., 1994:208).

These responses illustrate the impact that the abortion experiences had on the lives of these women. Regardless of whether their views were changed by the

experiences, they have integrated them into their lives and assigned them their own meaning.

How Should Abortion be Defined?

As the literature review discussed, the meaning of abortion is contested by many different discourses. Legal, medical, and moral or social discourses define abortion in particular ways, as do individual women. Peterman (1996:6) states:

> Other groups give different meanings to abortion. Civil libertarians refer to it as a privacy right. Feminists claim that a woman has a right to control her body and to determine her own life plan. Many opinion polls implicitly assume that abortion is a necessary evil, with questions that suggest that an abortion needs to be justified by one of a list of circumstances such as rape or poverty ... In view of how controversial abortion is as a social issue, it is important to begin to understand women's experience of it ...

In Peterman's research (1990; 1996), some of the women used language from other discourses when talking about their abortion experiences (as they did in this study), but the 'essence' of what was really going on is 'women-centred.' This means that abortion and pregnancy take their meaning "from the woman in whose body the pregnancy is unfolding" (Katz Rothman cited in Peterman, 1996:6-7). In her study of twenty Puerto Rican women (Peterman, 1996), there were four main categories which emerged that "characterized the meaning of abortion for individual women." Those categories were: 'keeping on being who I was'; preserving life or health; coping with physical or emotional abandonment; and resisting or escaping male control. These categories were the main reasons why the women in her study chose to have an abortion, and how they integrated the decision into their "entire life" (Peterman,

1996:13). In fact, the decision to terminate a pregnancy, and all the factors which underscore that decision (e.g., life circumstances, persons involved, and attitudes) *are* the meaning of abortion for these women. The words of the women in my study illustrate this:

> *I don't know how one would do this, but the perception should be more that it's a medical procedure, and I'd like to see it addressed more as a medical procedure versus everything in the paper. It's always about these emotional things, and glue sniffing ... I wish it was less emotionally depicted in the media.* (Anna)

> *It's nobody's first choice ... It should always be my option. I would hate to live in a country where it wasn't my option. I can't imagine ... places where you can't have it, no matter what, not even in cases of rape. Or if I had a one night stand and I didn't use protection, if I was an idiot and I got pregnant and didn't want to have a baby, it would make me very, very angry that I did not have that choice. And I'm sure these pro-lifers would feel that same way if they'd been in that situation.* (Corinne)

> *I think it's looked upon very negatively ... [T]here's this big hush over the whole subject. It doesn't exist, you're not supposed to talk about it. I find that very frustrating because it is a legal thing. And people are very passionate about it. They have very strong feelings. You're never in the middle. There's never any grey areas. You're either pro-life or pro-choice. I don't care what you say, you're one or the other.* (Betsy)

> *I think basically people that are, radical pro-lifers we'll call them, just don't understand it. Don't really know what it's about. [They] just don't have the knowledge or the understanding of our society and the patriarchal system, and all that stuff. They see it as black and white. I believe, too, that the life begins at the moment of conception. There's part of me that thinks it starts later in the pregnancy. I believe it starts then, but I just think until that nine months, it's a little more iffy because it still belongs to that other person that's still involved.* (Fiona)

For Fiona, she believes that 'life' does begin at conception, but this does not change her view that a foetus is part of a woman's body, and it is her choice to terminate or continue that pregnancy. Anna spoke of her wish to have abortion defined as a

'medical procedure,' rather than the emotional issue depicted in the media. Her reference to medical discourse is not dissonant with her own pro-choice views. Defining abortion as a medical procedure does afford some degree of normalization and legitimacy as a procedure deserving of funding, which in turn improves access. Betsy is bothered by the fact that abortion is so silenced, when in fact it is a legal procedure. These statements are what abortion means to these women. Meaning is reflected as well in the quotes presented throughout this section, and the chapter as a whole.

Abortion means different things to people, particularly for women who have either had one, or considered having one. The meaning of abortion has been contested by numerous discourses, many of which have not considered the experiences of individual women who have sought abortion services. A second major theme throughout the interviews was the barriers to access the women identified.

CHAPTER SIX: Barriers to Access

I. Barriers the Women Encountered

As outlined in the literature review, there are numerous "barriers" which affect access to abortion services. All over the world, women are denied access because of stricter than necessary medical regulations, burdensome administrative requirements, lack of public funds, lack of information or referral networks, lack of trained providers, extreme centralization of services, and local opposition or reluctance to enforce national laws (Jacobson, 1990). Ryan et al. (1994:203) identify two key factors which affect accessibility: the location of services and their cost to the client. Further, the authors note:

> Availability of [abortion] services is mediated by the practicalities, ideologies and bureaucratic imperatives of health care polices, as well as individual providers' attitudes, training and clinical practices. (Ryan et al., 1994:191)

There are many variables, both tangible and less so, which affect access. For the women in this study, one of the most pronounced barriers was access to information.

Access to Information

Determining how to deal with an unplanned pregnancy involves knowing what the choices are. In order to access an abortion, one needs to know which services are available and how to find the necessary information. This is quite a significant barrier for women seeking access to abortion in Manitoba. One of the first barriers that many women face when seeking information is where to go:

> *[I] didn't have a clue [about where to go] ... Lack of information. There are no posters [which say], 'Do you need an abortion? This is who you call.' ... I*

> *guess it was a lot easier once you had the information. Once you're in the rotation of what was going on, you were laughing ... [but] that was the hurdle.* (Fiona)

Through her own work, Anna was aware of abortion services in Manitoba and found the information "readily available." She was fortunate in that she knew where to get the information, the services offered, and had connection to a provider. Most of the women were not aware of available services, and in the course of phoning around, were often told that abortion information and services were not offered. Darla recalled hearing a lot of 'We don't do this.' When asked if it was easy to find information, Betsy responded:

> *No, we went to about five different libraries ... We were trying to look it up on this computer, abortion, abortion, nothing's coming up ... We found a couple of books and they were pretty much, you know Roe v. Wade, [or] 'You can't do this, that's awful' ... And there was one place, [I] phoned there, and she said, 'We can't help you here.' She was pretty rude to me, actually. I phoned [another clinic] and they said, 'No sorry, we really don't have anything for you.' They weren't nice about it, but they weren't really snotty either. It was just, 'No, we can't do anything for you.'* (Betsy)

Other women commented on their own lack of knowledge about information and services that were available.

> *I didn't really know much about how to obtain an abortion in Manitoba, except for [the hospital] because that was the first place I ever went. I was 19 so I stuck with it, you know?* (Eve)

> *I didn't know anything about how to get an abortion. I knew it was legal here but I thought it cost money. I didn't think it was covered by Medicare, like I do know now ... I didn't know about [a pro-choice clinic] ... I didn't know we had a [private clinic] here, I didn't know we had [clinics] that would do counselling and stuff. I just had no knowledge of the kinds of resources. I just thought you went to your doctor and they told you what to do ... I was naive.* (Darla)

Others had heard scant information from friends or from school, or an unknown source.

> *I thought I could get one of those [pregnancy] tests, but sometimes they're wrong, and it's just better to go to a clinic. I don't remember where I heard about [a pro-choice clinic], but that was the first time I had ever been there. I probably just heard about it on posters and things like that, and just decided that would be the best place to go ...* (Iris)

> *By that time I was about 15 weeks [pregnant], and that's I when I went to [a pro-choice clinic]. I was kind of in a deep depression for those two weeks. It was really a pathetic time of my life, when I think about it. I can't remember who told me about [the clinic]. I remember someone saying you should go there, but I can't remember who it was exactly. It was probably just an acquaintance.* (Darla)

Even at the time of the interview, Betsy felt that she still did not know much about seeking an abortion through a hospital, as she had gone to a the private clinic:

> *I know nothing about an abortion in a hospital. I have no idea what to do or where to go about doing that, that was never given to me. The doctor never told me ... No one said, 'These are the places you get abortions.' I heard of the [private clinic]. I knew there was one in the city, but I didn't know where else.* (Betsy)

Knowing where to access information and services can be a real advantage when a woman is seeking an abortion. Heidi said about the second abortion:

> *I don't think the decision's any easier [the second time], but it was easier as in knowing where to go and what to do. And the pathways to take.* (Heidi)

Misinformation

Not only can it be difficult to find information about abortion services, but accurate information can be out of reach. Instead of providing women with accurate information on pregnancy options, there are pregnancy counselling 'clinics' and

services which withhold information on abortion. In some cases, these 'clinics' will tell women that there is no gestational limit when the procedure can be performed. In one case in Winnipeg, a woman from a rural community came into the city for this 'counselling.' She went back to her home town after being told that she could have the procedure when she returned to Winnipeg to attend school that fall. Unfortunately for this woman, when she did return, she was well over 20 weeks gestation, beyond the allowable period in which doctors will perform the procedure in Manitoba.

In other cases, women are shown films such as *The Silent Scream*, a highly exaggerated, inaccurate 'documentary' of the foetus during an abortion, or they are given pamphlets with 'doctored' pictures and inflammatory rhetoric. Both Corinne and Fiona went to anti-abortion counselling services that they had found in the phone book.

> *The clinics that are ... sort of religious organizations [are] .... detrimental. Whatever decision I was working through, they took me back, like, a good week.* (Fiona)

> *I called the [anti-abortion clinic], which I wish I'd never done. They are obviously pro-lifers and showing me videos and pictures. You are trying to make a decision, an informed decision, [and] you don't need stuff like that. I mean, obviously they're there for a purpose but I wish they'd say they're with the League for Life or whatever ... It was awful ... They gave me stuff to read. [It said], 'She felt as though her insides were being vacuumed out and now she had an infection and she can never have children again.' You wouldn't believe the stuff.* (Corinne)

In Fiona's case, she had gone to a pro-choice health clinic for the pregnancy test, but it would have been weeks before she could get in for counselling there, so she looked in the yellow pages. She was shown *The Silent Scream* and ended up leaving before the 'counselling' was over.

Services which use the words 'crisis' and 'distress' in their name are usually anti-abortion. Or they will claim to offer abortion 'alternatives,' co-opting the language of choice, when in fact the alternative of abortion is portrayed very negatively. It is difficult to determine whether an agency or service is anti-abortion because they usually will advertise for 'abortion counselling' or 'abortion alternatives.' As Eve said: "Most difficult is to know what place to call ... [women] are going in blind-sided, they don't know the do's and the proper places for phoning." These organizations are aware that if women realize that they may be talked out of seeking an abortion or given inaccurate information, they may not access their services. Corinne's mother assisted her in seeking information:

> *I know my mom was phoning and trying to find out which ones were pro-lifers and she [asked], 'Well, how are you being supported? What's your financial support?' And the woman was trying not to answer her.* (Corinne)

In other cases, friends or family members were repeating the anti-abortion discourses:

> *A lot of people tell me, 'Oh, you'll never be able to have children if you have an abortion'... There's always these people telling me that you can't have children after you have an abortion ... But [the counsellor] told me ... it's just misinformation, that's not true.* (Heidi)

Misinformation denies women the ability to make informed decisions about their reproductive health. Access to abortion services depends on the availability of accurate information. Despite misleading information in some cases, eight of the nine women interviewed were able to access abortion services. In Darla's case, she was initially told the pregnancy was at ten weeks. When she returned to her doctor, he told her that the pregnancy was in fact at 13 weeks, and that it was too late to obtain an abortion. After two weeks of "a deep kind of depression," Darla went to a pro-choice

clinic. At this point, the pregnancy was at 15 weeks. She was sent for an ultrasound several days later, and by this point the pregnancy was 16 weeks gestation. Darla was told that it was too late to have an abortion in Manitoba, because the waiting period would have been two or three weeks at a hospital, and the private clinic's cutoff was 16 weeks. Darla is still angry about the misinformation she was given.

Counselling Before and After the Abortion

Counselling services, either through a pro-choice health clinic and referral agency, hospital, or private abortion clinic are standard practice when seeking abortion services in Manitoba. This is to ensure that a woman is making a decision with informed consent. The counselling received at different facilities can vary. In Anna's case, she had close connections inside the pro-choice 'movement' and did not receive pre-abortion counselling. She was aware of the options that were available to her, knew how the procedure was done, and had access to a physician who would perform the procedure.

Several of the women in this study received pregnancy counselling at a few local health clinics. Clinics mentioned by these women include Women's Health Clinic, Klinic, Pregnancy Counselling Clinic, and Mount Carmel Clinic. These agencies are pro-choice, providing information on continuing a pregnancy, adoption, and abortion services that are available. The counselling is necessary for referral to a private physician who has admitting privileges at a local hospital. Fiona found the counsellor she saw before the abortion to be "great." She was given information about

services available and the procedure, and felt this clinic was the most helpful throughout the process. Both Iris and Corinne found the pre-abortion counselling at one of these pro-choice clinics to be helpful:

> *It was good to talk and have a mediator between me and my mom, and being on foreign ground instead of my mom's turf. To make my decision it basically didn't push me either way, which is what they're there for I guess.* (Corinne)

> *.... [T]hey were pretty good there [for] the counselling and stuff, and that was good. They told me what would happen and different things like that. So that was good. I really like [a pro choice clinic], I think they're a good organization.* (Iris)

For the first pregnancy, Heidi went to a pro-choice health clinic for counselling, but found it overwhelming for a 15 year old:

> *I think I made the decision being not very sure. In the counselling that I did partake in, they more or less went over what happened and why it happened, but, they start taking out pamphlets after pamphlets. Things that you can do, adoption, abortion. Raising it on your own. They just throw these pamphlets at you the first time, that's what I remember.* (Heidi)

For the second pregnancy, Heidi went to a local health clinic for a pregnancy test, expecting to find out the results right away:

> *I had to go home. I expected that day that they were going to give me the results, but they said, 'No, you've got to phone back.' Because my first experience, they told me right there. So I went home, and the next day I called. It's just so cold I think.* (Heidi)

Counselling services are offered through a hospital in Winnipeg. Women may be referred to this counselling through a pro-choice health clinic or may self-refer. Corinne also received counselling at the hospital for both her abortions, as did Eve for hers. For the second procedure, Corinne recalled the counselling at the hospital:

> *I didn't have any problem with it. Maybe it was a little bit harsh. Mostly telling me, 'Leave him, leave him. Obviously this guy's no good.' Like I said,*

it wasn't mostly about whether or not to have the abortion, as I recall, but a lot of it was ... (Corinne)

For the third abortion, Eve again went to the hospital. When she discovered she was pregnant, she "called them immediately," as she was an "old pro now." She said that experience,

> .... *was a little bit more humiliating than the others. I was on my fourth round here. And everybody said, everybody would sit with me and they'd go, 'This is your fourth time? This is your fourth pregnancy?'* (Eve)

Fiona recalled waiting for the abortion at the hospital.

> *I got pulled off of my gurney thing you're lying on, and taken into another room just to make sure [I wanted to have the abortion]. Whether this is what I wanted to do, if I knew what I was doing, if I was aware of what I was doing, if anyone was making me do this ... I just had this little chat with this lady, in this room which had a really big grate, and she talked really loud, and I'm positive everyone in the other ward heard ... I remember turning around and looking at the grate in the door, and [the other patients] were right behind that door. Nobody knows each other so they're quiet as a mouse and they're all just sitting there. Bored out of their tree. What else are they going to do but listen?* (Fiona)

Fortunately, women do not have to wait in hallways on a gurney at this hospital. Services have improved considerably in recent years. Staff are well-trained to address the needs and concerns of patients seeking an abortion, and privacy is primary.

For women who choose to have an abortion at the private clinic, they do not have to receive counselling at a pro-choice referral clinic, though they may choose to do so. The private clinic does provide counselling services to its clients. At the time she went to the clinic, Betsy was given a questionnaire which was 'strictly optional.' She said this of the questions:

> *I still can't believe it to this day. These are voluntary questions, you don't have to answer them. Are you in an abusive relationship currently? Is someone*

forcing you to have this abortion? Is this abortion the result of a rape? Are you here against your will ... These are like serious questions, don't you think? ... Are you an alcoholic? Are you physically abused? Are you dependent on any drugs? Do you have any children? Are you religious? Interesting questions. You didn't have to answer those. I answered all of them anyway and just gave it to them. (Betsy)

The private clinic uses the question sheet to assess the client's situation for the counselling, and if the questions are left blank, the reason for this would normally be explored (e.g., language barriers, shyness, coercion). Heidi found the pre-abortion counselling at the clinic to be quite brief:

It was 20 minutes in the office, you know? Even though it was a relaxed atmosphere. The colours were all blended and you just felt real relaxed. It wasn't like these sharp white colours or whatever coming at you, [but] you still felt like you were part of this process. Come in, get out type of thing. (Heidi)

As mentioned, both Fiona and Corinne received 'counselling' at an anti-abortion organization. They did not find this helpful in the decision-making process.

They showed me a video and it showed all the instruments they use for the abortion. They showed me all these sharp instruments and, I'm trying to remember, but after that I realized what was going on. I wasn't an idiot. I didn't pay a whole lot of attention, but it still affects you ... It definitely put more into my mind that, whether it's a mass of cells or a foetus, whatever, it's still ending a life ... I was naive. Very, very, very naive. I mean, you knew about pro-lifers, but I didn't think they were opening up clinics and trying to scare you. (Corinne)

Many women seek counselling services after an abortion. There is a wide range of feelings, and they may surface immediately, or months later. These services are offered to women if they wish to come back for counselling. This was not the case for Eve at the hospital:

If you go through [the hospital] you don't get a post-TA [therapeutic abortion] counselling session. You don't get to sit down and sort of debrief [about] your

experience ... I had to seek it out myself. I had to go to a social worker on staff there and actually do it myself. (Eve)

After her negative experience at the hospital, feeling rushed out of recovery, Fiona contacted the clinic where she received counselling before the abortion.

I guess [the counsellor] was doing some sort of report, and [she] had called me and asked if I would give my name, saying my experience overall [at the hospital] was poor - that it wasn't the greatest experience ... It was good to have someone to tell. (Fiona)

Although post-abortion counselling is usually offered, it is not required. Heidi was only 15 when she had the first abortion. She felt that there should be some mandatory counselling after the procedure because 'obviously the time before is so limited.' Yet, her ambivalence is evident when she spoke of why a teenager might not want to go for counselling once the procedure was over.

If you wanted to come back and talk [you could]. But, you know, I think at a young girl's age you think that it's pretty crazy to go see a counsellor. And why go talk about it when it's a thing that's been done? What can you do? Go on with your life, you know? But you really don't talk about the other problems that are involved and the issues ... Like, if I didn't have this view that a child could be replaced ... I think that could have been something that could have been explored more during that time, but at the same time, I don't know how you're supposed to force somebody to go to counselling. (Heidi)

Iris had the intention of going back for post-abortion counselling, but decided not to.

I was going to go back for counselling, but when I called [a pro-choice clinic], I wanted to see the same counsellor, and they [said], 'Well, she only works on certain days' or something like that. I think she only worked one day a week or something. So it was really, really not convenient at all. (Iris)

Betsy did seek out counselling some months after the abortion. The counsellor told her that she was a Christian, but that she would not judge her. Betsy said, 'I felt comfortable with her right away.' Corinne was aware of the anti-abortion counselling

services, having been to one, and had this to say about the post-abortion counselling they offer:

> *[They] do offer post- [abortion counselling], but I've never wanted to call because all I can think about is it's just going to be a big guilt trip.* (Corinne)

Pressure to Start Oral Contraceptives

All eight women who had abortions were offered oral contraceptives following the procedure. This appears to be standard practice. This is only one of many birth control methods available. This practice limits women's choices of contraception by failing to explain all of the options. Further, not all women are suitable candidates for oral contraceptives, which can have mild to serious side effects. It is difficult to address the issue of contraception immediately following the procedure (and in some cases before) without sounding judgemental.

> *They were really kind of pushing, 'Oh, you can sign up to get on birth control right now.' They were really pushing. [I said], 'No.' Because I was just worried about my parents. I would have to talk to them about it. I wouldn't tell them I was having sex, but I was figuring out how to do all that, so I felt very pressured to get it. [I said], 'No, it's just too hard right now in my life.'* (Iris)

> *I'm sitting on the table, the operating table, and they're just talking, 'So, are you going to go on the pill after this?' And [I said], 'Well, I guess so. I don't know, I hadn't really given it much thought.' [She said], 'Well, what we'll do is we'll set up a prescription for you. We'll get you started on one kind or we'll phone your doctor, whatever you want us to do. When was your last period?' I'm thinking to myself, I can't remember when my last period was. Why didn't they ask me that beforehand? The nurse the day before sort of went through birth control, but she wasn't pushing anything on me, do you know what I mean?* (Betsy)

> *I think they wanted to know what my birth control method was going to be. At that time, [I said], 'I guess I'll go on the pill.' They gave me the pill, but I*

> *don't think I used it ... They didn't [pressure me after the second abortion]. No, you know why that was? Because I wasn't sexually active afterwards ... They did ask me, 'Are you going to think about it?'* (Heidi)

Similar pressure was found in other studies (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990). Although medical discourse may be helpful when defining abortion as a medical procedure deserving of funding, this is not necessarily the case with respect to birth control. As Ryan et al. (1994:193) found, in medical discourse on birth control, there is a dichotomy of contraception being 'good' pitted against abortion, which is 'bad.' This is another example of dominant discourses - medical *and* moral - defining abortion (and contraception) in binary terms.

> The 'good' characteristics associated with contraception include the notions of planning, responsibility, rationality, prevention, and carefulness. In short, 'good contraception' involves the rational surveillance of self control of bodies and desires. The 'bad' side of this birth control dichotomy is abortion, which is viewed as a failure in control by women who are ignorant, wilful, careless, irrational, or non-compliant and who therefore fail to put the required effort into controlling fertility. This perception that 'resorting to abortion' represents a failure of self-control pervades many women's consciousness, and contributes enormously to distress surrounding unintended pregnancy. (Ryan et al., 1994:193)

Therein lie the myths that fertility is controllable, and that abortion is the act of 'capricious, whimsical' women (McConnell, 1989). Ryan et al. identify another dichotomy in medical discourses on birth control. Contraception is equated with modern, technological advances, whereas abortion is equated with "the primitive, the pre-technological, and the 'backyard'" (Ryan et al., 1994:193). Abortion is still the main form of contraception in most developing countries because there is no access to other methods. The separation of abortion and contraception is facilitated by these dichotomies. The "ethnocentric variant" suggests that those cultures which rely on

abortion for birth control are "less 'humane' or less 'developed' or less 'civilized' than countries or cultures where contraception is distinguished from and valorized over abortion" (Ryan et al., 1994:193). Unfortunately, the risks to the health and lives of women in many developing countries (and others where abortion is illegal) is inhumane because the procedure is often performed in non-sterile conditions.

Attitudes of Health Care Personnel

During the process of negotiating access to abortion services, the women in this study came into contact with many different health care personnel. For the most part, staff who the women encountered were helpful.

> *Very professional ... Actually, it was bizarre because they were mostly men. [Laugh] I had all male nurses ... I'm aware from working in a hospital that everybody knows why you're there, so I was impressed ...* (Anna)

> *The nurses seemed to be really nice. The counsellors were all really nice. During the second [abortion], they all gave me names of social workers to talk to and counsellors that I could talk to ... The nurses and everybody were all very nice, getting me warm blankets, putting them on me because you get left out in hallways.* (Corinne)

> *When I was getting the ultrasound, [one of the nurses] asked me, 'Was this a planned pregnancy?' And I said, 'No.' She put her hand on my knee and she said, 'Everything will be okay,' she said, 'It'll work itself out.' I just started to cry. It was just acceptance ...* (Betsy)

> *The nurses were wonderful [at the hospital], they were really great. I told them I was scared. They were very supportive, they were very caring.* (Eve)

Iris found the staff at the clinic where she had counselling and the private clinic to be helpful. She also commented on how they were with her partner:

> *They gave him pamphlets and stuff on being supportive. So he had something to read, too ... But they were good at the [private clinic] with him. I guess when I*

went upstairs, and when I went in the counselling room, the women ... in the reception area were talking to him. (Iris)

All of the women had positive comments about at least some of the health care personnel they encountered. However, there were some negative experiences.

[The reception at the hospital was] not good at all ... I mean they all look at you, kind of look you up and down. I could have been super sensitive to it, but I really don't think so, because I remember feeling distinct looks and [my partner] even said it to me too. (Betsy)

Yeah [the staff were helpful], except for having the abortion itself. The nurses [were] yelling at me, 'Just open your legs!' (Corinne)

I can't remember if it was a doctor or a nurse that told me. She just came in and said, 'Yeah, [the pregnancy test is] positive.' I kind of sat there for a few minutes and she said, 'Do you have a doctor that you go to?' And I said 'Well, I have a gynaecologist,' and she said 'Well, I suggest you make an appointment,' and that was kind of the end. (Darla)

Eve felt that the treatment by hospital staff was different for the third abortion (her fourth pregnancy) than for the first and second:

Very different than the first [abortion] ... [B]y the fourth [pregnancy], I'd sit in a room and wait to recover by myself. They really didn't ask questions or cared or said much. I don't remember the experience being as comforting and helpful as the first experience. (Eve)

Fiona recalled how she felt once the abortion was over:

I just felt like shit [when I woke in the recovery area]. I needed another five minutes ... [and I was told] 'No, you have to go.'...That was my big beef there. [I said], 'I just need five minutes.' The thing is, though, my drug hit me late. So I'm thinking the whole little percentage of time it's supposed to woo me for, that it just hit me late ... [They told me], 'Get your clothes, here's your locker key.' (Fiona)

For some of the women, when the results of the pregnancy test were given to them, there was an assumption that the news of the pregnancy was positive, or that the woman planned to continue the pregnancy:

When you first go in it's just a blood test or a urine sample. It's not a big deal. They're just basically finding out if you're pregnant. I think that the problem came when they actually phoned me and told me that I was. The first thing they said to me afterward was 'Would you like me to make an appointment for your first pre-natal?' (Eve)

Positive, non-judgemental attitudes from health care personnel made the experience easier for these women. However, Betsy and Eve both felt judged by some of the staff they encountered. Fiona felt rushed out after her abortion, when she needed more time to recover. For Eve's first pregnancy, there was an assumption that she was going to continue the pregnancy. This assumption can make women feel that they are doing something wrong if they choose abortion. The attitudes of health care personnel play an important role in accessing abortion services. These women were very conscious of the treatment they received and how it affected their experience as a whole.

Attitudes of Doctors

The women in this study had much to say about doctors they encountered in the process of seeking an abortion. The women had so much to say about doctors because doctors have considerable control over access. The doctors performing the procedure are only a fraction of physicians, and may only be one of many that a woman encounters when seeking an abortion. The difference in treatment by doctors who perform the procedure and those who do not (e.g., family physicians, walk-in clinics) is notable. Though a woman may eventually find her way to a provider, negative attitudes, assumptions about pregnancy and motherhood, and misinformation may be

what she hears first. Heidi and Gloria did encounter doctors, though not providers, who were helpful:

> *I mean, Dr. _____ is very straight-to-the-point person. There's not a whole lot of chit chat that goes on. She wasn't miserable about it or anything, but she wasn't overly compassionate. But she asked me if I had plans, and she wasn't nosey as to what those plans were. She asked if I needed help arranging any sort of plans, so I mean she was good at trying to be supportive and that. If I did need help she would help.* (Gloria)

> *[My family doctor] said that if my mom asked [why I was sick], that he would say it was the flu. He had written me a note for work saying it was the flu, and that it would give me time to think. He said that even if I chose an abortion, or if I chose to have the child that he could be the doctor for me afterwards.* (Heidi)

Gloria found the staff at the clinic where she had the abortion, including the doctor, to be "wonderful." Fiona said that the doctor who performed the abortion was "fine," but that she "wouldn't have chosen" that particular physician if she had the choice.

Some women told of some horrendous experiences which made the experience very difficult. For Heidi, her choices were limited because she was a minor for both abortions, and did not wish to inform her parents. Heidi was referred to a doctor who would perform abortions on minors without consent. She said:

> *I went there because it was recommended by [a local clinic], and [they told me] that he would have to go through this interview to determine if he would, through the maturity of you, perform the abortion on you ... Thinking back on it now, I really think he was very unethical. I went there and basically [he] asked, 'Why didn't you use protection?' And he dated the pregnancy. He said, 'You're having twins' ... It was just a horrendous experience ... I think now, I might have phoned the physicians board, but at age fifteen, I didn't have the guts to. I don't think [doctors] should be judging ... Especially telling you that you're going to have twins, when he knows when I'm there for a purpose. I'm thinking of having an abortion and he's supposed to be dealing with it. He basically told me that he usually does it for people that are maybe 17, turning 18, but I was too young and the only way he would do it was if I told my parents.* (Heidi)

This would be a very frightening experience for any woman, but Heidi was only 15. As there were no other doctors available who were willing to do the procedure without parental consent, Heidi's only other option (unless she travelled out of province) was the private clinic. Betsy had a similar experience with her family doctor who, after she arrived at his office upset by the positive home pregnancy test, was not very sensitive to the fact that she might not wish to continue the pregnancy.

> *I had pretty much flipped out in the office and then he said, 'We want to determine how far you are.' So I laid down, he gave me a pap test, that's when they found out that I had cervical dysplasia. They put a foetal monitor on my stomach, because they didn't know how far along I was. Now, you gotta remember, I just found out I was pregnant. I don't need to hear a heartbeat ... So they put the foetal monitor on my stomach, and I heard the dunk-dunk, dunk-dunk ... And he said, 'You must be at least ten weeks because if you're not, then I wouldn't be able to hear anything on the monitor.' I just couldn't believe it. He scanned along my stomach and he said, 'See that sound, the light dunk-dunk, dunk-dunk,' he says, 'That's your heart beat.' Pulls it down lower and says, 'That's the foetus' and it was, like, dunk-dunk, dunk-dunk, this strong heart beat ... I said, 'Get that fucking thing off of me!' He said, 'I'm sorry, but this is the routine. We have to do this. I don't know how far along you are.' He asked me to weigh myself. And of course I'd just lost like 20, 25 pounds ... He said, 'You've lost?' And he flipped out, 'You can't lose!' I said something I think really disturbed him, I said, 'It's just in the way.' And he, the doctor just looked at me ... [He advised me not to lose weight] I guess for the health of the baby ... He was assuming [that I would continue the pregnancy] ... So [I said], 'Just let me go, okay. You've already completely freaked me out by letting me hear the heartbeat.' I think maybe what he should have done was ask me what my plans were ... He said, 'Please phone me, tell me what you're going to do, and we can set up vitamins and so forth.' He just assumed I was going to keep it.* (Betsy)

Not only did she have a negative experience with her own family doctor, but Betsy was sent for an ultrasound at a hospital before her abortion at the private clinic. She had this to say about the doctor there:

> *I went in, had the ultrasound, and the doctor asked 'Do you mind if a resident comes in and views this, watches the ultrasound, so he learns how to do it?' I*

said, 'That's fine.' And it was cold, you know, he was trying to find it and I said, 'Just find it already!' I was losing my patience, because the last thing I wanted [to hear was], 'Looks really healthy.' I said, 'Good, well I don't really care.' (Betsy)

Darla had a similar experience with her family doctor:

I don't know if he did an internal, I can't remember, but I can remember him feeling my stomach, my abdomen, and kind of just pronouncing that, yes, I was ten weeks pregnant. He was kind of a brusque doctor anyway, very hard to talk to. His English wasn't that good for one thing so it was kind of hard to understand him, and he was always really fast, in and out. By the time you wanted to ask him a question you're always out of the room. So, he went out of the room for a couple of minutes, came back and handed me these new mother books. 'Well, just a minute,' I said, 'Is it all right if I take a week, to kind of come to a decision and what I want to do about the pregnancy?' He just said, 'Talk to the receptionist on the way out,' and then gave me these books [laugh]. I left and I thought, 'This is kind of strange,' you know? (Darla)

When she went back to see the same doctor about a week later, Darla told the doctor she had decided to have an abortion:

This was about a week later, or five to seven days later. I went back and saw him, and he didn't really know why I was there ... He was kind of like that. He wouldn't know why you were phoning. He doesn't seem like he remembered you at all. It wasn't a very personal relationship. I should have seen a different doctor ... I went back and I said, 'Okay, I've decided that I'd like to have an abortion.' And he kind of looked at me astonished and said, 'Well you can't,' he said, 'Actually you're not ten weeks, you're more like 13 weeks.' And, he said that's too late. 'It's too late to decide, there's really no choice.' So then I was just, astonished, and I said, 'I asked you a week ago, I said do I have time?' By this time I think I was so confused and overwhelmed and still so intimidated by doctors, which I'm not anymore. I felt, it's no use arguing. He knows what he's talking about. I went back home and told [my partner] this, and then we both just flipped out. We didn't know what to do at all. He was really upset, I was really upset. I didn't think to question him ... Even if I was 13 weeks it was still possible. This didn't even hit me then ... It didn't make me angry for about one or two years later. Thinking that first he kind of made me confused as to the dates and then he told me that it wasn't possible. He didn't mention that, well, other doctors will do it past this time ... I'm sure he's a perfectly okay person and I'm sure he's a good person, but that one or two minutes in his life, being this busy doctor, probably affected many, many young girls' lives, to a great extent. Like, for the rest of their lives. (Darla)

Darla's last statement speaks to the impact that a brief visit with a busy doctor can have on one's decision-making and life course. She is still angry that the doctor did not seek other avenues for her, and she lives, today, with the effects of that visit. Corinne had negative experiences with physicians she saw at the hospital, including those who were performing the procedure.

> *One doctor's telling me, 'Well, it just looks like a little piece of liver,' when he was putting in the laminaria tent. I [said], 'How big is it?' He [said], 'Oh, it just looks like a little chunk of liver.' I didn't really need to hear that.* (Corinne)

> *I never had the same [doctor]. That was awful. Some doctors were rough and some weren't ... I find there are two kinds of gynaecologists - the kind that are slow in explaining [things] to you and the kind that think the faster it's over with the better. And I never had any of the slow ones [laugh]. They didn't talk to you. And they made me feel like I was that type of girl. Not that they said anything but [thinking], 'I see a million cases like you everyday.'* (Corinne)

Corinne had both of her abortions at the hospital. In some cases, a woman may not see the same doctor for the appointments (consultation, laminaria insertion, and procedure), which hinders continuity of care. As Corinne recalled, "I was a number, more like an assembly line ... The doctors really left something to be desired." Eve had the same doctor perform all three abortions, with no problems. She did not have as much to say about the doctor as much as the other staff she encountered. Iris felt uncomfortable when she went for a physical to determine gestation, but not because of the doctors actions:

> *I went to my family doctor but I didn't see my family doctor because I just went walk-in ... Actually it was quite bad. [The doctor] walks in and she is huge. She's pregnant ... She was like seven months or something. And she was, like, huge. And she knew what I was in there for, so I kind of felt very uncomfortable ... Here she is, about to have this baby, and I'm going to go get rid of one.* (Iris)

Availability of Providers

Access to abortion services is dependent on the availability of physicians willing to perform them. Many physicians are unwilling because of the fear of harassment and violence from anti-abortion advocates. Of those who are willing to perform abortions, their availability can be precarious. A woman may discover that she is pregnant at nine or ten weeks gestation, but cannot get an appointment with a provider for three weeks. At that point, there are fewer doctors willing to perform the procedure. Another barrier is scheduling appointments with doctors, which can be difficult enough, but when one or two providers are unavailable, a woman's options are restricted further.

Darla is bothered by the fact that access to the procedure is dependent on doctors' willingness to perform abortions, and the gestational limits that doctors set:

> *I think I'm more angry with the arbitrariness and that it's all up to the doctor's discretion, I think that gives the doctor too much power in the first sense. And I think that they have too much already, because people automatically tend to take a doctor's word as rule or law.* (Darla)

In every sense, women are at the mercy of physicians when it comes to their access to abortion: if they will provide the service; who can access it; how easily; how soon; how late; at what cost; and where.

In Manitoba, surgical procedures performed on minors normally require consent by a parent or guardian. Many girls under 18 faced with an unplanned pregnancy do not wish to inform their parents. Aside from the private clinic, there are very few options available to minors seeking abortion services. If only one or two physicians are willing to perform the procedure without parental consent, the waiting period may

be longer. Or, if those physicians are unavailable to do the abortion, she must seek other services, either at the private clinic or out of province.

Harassment and Violence Against Providers

A potential barrier to access, and a barrier for physicians, is the threat of harassment and violence. At present, there is minimal protest activity in Winnipeg. However, the recent shooting of Dr. Fainman has sparked increased interest in security around the facilities where abortions are provided. Two women in this study encountered picketing by protesters, or its aftermath:

> *I also remember being in the counselling room and them talking about the picketers, because at that time there were a lot of picketers outside ... I think it was both days actually. I think that year [1990] it was a very active time for them ... They were when I was there, with the whole sticks [holding placards with the word] 'Murder!' People with very strong views out there. They mentioned something in the room when I went into that little counselling session, about the picketers being out there, and [they said to me] 'If they do anything, we can call the police.' ... I don't think [the protesters] did [say anything to me]. I think I would remember that. They just sort of walked around with their signs ... There's still the harassment of the signs, having them out there, and having them as a reminder ... I don't even think I read what the signs said. I just sort of walked by them.* (Heidi)

> *When we went to [the private clinic] for the first time, that first appointment ... there were tomatoes and eggshells ... all over the cement.* (Betsy)

Corinne did not personally experience harassment when she sought her abortions, but commented on the experience of someone she knows who is a gynaecologist: "His house has been picketed, and they've followed his children to school." Anna recalled a time when picketing was quite active outside the clinic:

> *At one point they had ... sponsor pickets. When they showed up they'd fundraise for us. You threw in a buck every time this one showed up, so we*

were sort of fundraising off the pickets. It's called 'Sponsor a picket,' and they heard about it. They realized that [the picketing] is not effective. (Anna)

Both Corinne and Heidi had these comments on the harassment of picketers, and billboards:

I saw [the protesters] outside! One time I was passing by - I was with my boyfriend - and I was going to go back and tell them off. I really was. Like, [I wanted to tell them], 'Do you know how difficult a decision it is anyway? How dare you put your views on me. I know where you're coming from, and do you think that anybody who has an abortion doesn't think about that?' ... But this bombing clinics thing, and doctors being killed, I mean, 'Oh, we kill one life to save many'... you're just obviously obsessed and not all together [laugh]. That's really what I think of them because they don't, to me they're not making their point anymore. People look at them and it's crazy ... (Corinne)

There are a lot of billboards, 'Don't stop a beating heart' or whatever. You see it at the bus stop, on the bus, like, huge billboards. I think it's wrong to put somebody's else's views on you. Especially like that, with a huge billboard. (Heidi)

The harassment, threats, and acts of violence against providers is another barrier which makes them less likely to perform abortions. Clinics are easier targets for harassment and violence because they are often free-standing facilities. The lack of providers willing to perform abortions is becoming more of a barrier as violence and threats of violence increase.

Gestational Limits

Although abortion services are available in Manitoba, there are limits on the gestational period that physicians will perform the procedure. Some doctors will only perform abortions up to ten weeks gestation, whereas others will up to 16 weeks. Most abortions performed are in the first trimester, but sometimes women may not

realize they are pregnant until ten or more weeks. With the waiting period for appointments being anywhere from one week at the private clinic to four or more weeks at a hospital, a woman may be well past twelve weeks gestation when the procedure is performed. Women with irregular periods may not suspect a pregnancy:

> *It was three months before I even knew to even go to [a pro-choice clinic]. I just kind of thought that it was irregular [periods] ... I guess it was like 12 weeks or something like that [when] I had found out.* (Heidi)

Anna has spoken to many women faced with unplanned pregnancies. Fear, denial, and lack of 'self-awareness' can be cause for delay:

> *I mean, I speak to so many women [and ask them], 'How long have you known?' [They tell me] 'I've known for six weeks.' 'I've known for a month.' 'I've been too afraid, I just wanted to forget.' So, I guess, realizing that you've only got a specific time frame, it seems like the women that are out of the loop really think you can just come in and get [an abortion] at six months. Lots of misinformation. ... I've seen a couple of exotic dancers whose pimps won't let them out of their sight, so they can't get into the clinic. Or students who have no time. [They] have jobs, or they're going to school all day and working all night, and physically don't have ten minutes to get in for an appointment.* (Anna)

In Darla's case, a combination of misinformation and gestational limits led to her decision to continue the pregnancy. When she was able to access pro-choice counselling services, Darla discovered that her pregnancy was too far along to have an abortion in Manitoba, because of gestational limits and the waiting period for appointments. Darla's situation is an example of these limits being a major barrier to access.

Waiting Period

Another barrier identified by some of the women in this study is the waiting period to have an abortion. Once a woman has made the decision to have an abortion, appointments are scheduled. Through a private physician or the hospital, the wait can be three or four weeks or more. Usually a woman can have an abortion quicker through the private clinic, but the waiting period can still be two weeks. Betsy was fortunate. She found out that she was pregnant at approximately ten weeks gestation:

> *The day I found out was Monday, the day I had the abortion was Friday ... I had to move. I know that sounds a bit awful. I knew I had to move fast [because of the stage of the pregnancy] ... I was not getting it done in a hospital simply for the fact that it would take too long.* (Betsy)

Betsy did not want to wait any longer than those five days. As she said, "it was driving me crazy ... [I]t's like waiting for a grade, you know?" For some women, any waiting period can be too long. Fiona found out she was pregnant before eight weeks into the pregnancy. She initially chose the private clinic because she thought the abortion would be performed sooner. Abortions are typically not performed before the eight week period, because the tissue is too scant. Fiona ended up having the abortion at a hospital because "I found out I had to wait anyway." Gloria felt really "stressed" and "hysterical" because:

> *I was eight and a half weeks pregnant, and I couldn't get in to have my abortion until the following week ... So when [my friend who worked at the clinic] told me that she wasn't sure if she could get me in the following week, I kind of lost it. I said, 'You know, you don't seem to understand, this has to happen soon.' So she fortunately enough managed to fit me in.* (Gloria)

Anna was fortunate to have the procedure performed rather early into the pregnancy. She did not have to wait very long.

Well, actually, it was very quick. [I had the procedure] just within two weeks [after contacting my doctor] ... I think I was barely seven weeks [pregnant] when he did it. He did it as early as he could legally, ethically do it. I was feeling a bit anxious about it, just that I wanted to get it over with. (Anna)

Anna actually considered seeking a menstrual extraction,[14] which would have meant a trip to the United States.

Trying to keep the pregnancy and the abortion a secret, while under the stress many women feel, can make the waiting period very difficult.

I couldn't be around my mom, I couldn't be around my family. It was too stressful, [pretending that] life's just great, everything's wonderful ... I had to put on an act and I didn't want to [do that anymore], so [my partner and I] actually stayed at hotel rooms. I told my mom, I said, 'Mom, I'm going to the lake for a week' ... [my partner] has a cottage and we have a cottage. So I said 'We're going to his lake' and he told his mom he was going to my lake so it worked out. We, we actually hung out at a couple of hotels, just to be together. We could talk freely ... (Betsy)

Physicians willing to perform the procedure have limited surgery time, and may only do abortions one day a week. It may be anywhere from two to five weeks before a woman can see the doctor for the initial consultation. Occasionally, circumstances may arise and an appointment may be available in a shorter period of time.

Well, I was lucky, actually. I phoned [the hospital] and they got me in. I think it was two weeks [later] that I got in for my first initial appointment. And then they had a cancellation, so I was able to do it the very next day. So I was actually really lucky. I don't know how it happened, because it didn't happen that way the other times. (Eve)

For most of the women in this study who sought abortion services through a hospital, the wait was much longer. Eve waited four weeks before she had the second abortion.

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[14]Menstrual extraction is an experimental self-help method normally used to eliminate menstrual flow and cramps (see Efforts to Improve Access).

Darla was told she would not be able to get an appointment at a hospital for two or three weeks. She was in a difficult position because the pregnancy was further along (15 weeks). Even at the private clinic, Darla was told that she could not get in for an appointment before the 16 week limit.

Some women find out that they are pregnant quite early - before eight weeks - so the wait can be even longer. For the first pregnancy, Corinne found out at six weeks, and had to wait another six weeks for the procedure. She said the wait for the second procedure was "kind of shorter," just over one month from the time she discovered she was pregnant until she had the abortion. Corinne said of the waiting period:

> *Waiting for it? ... [Y]ou have all this time to change your mind. But, again, it's a good thing you have all that time to change your mind. You have all that thinking about it to do before. I guess it goes both ways. Maybe at [the private clinic] I would've felt more rushed.* (Corinne)

Corinne had to wait several weeks for both abortions, but her circumstances allowed for this:

> *There was, of course, waiting time. For the first one and for the second one I was in school ... The [doctor's office] wasn't open past four, [but] I could miss school. I didn't work full time so there really wasn't any problem for me.* (Corinne)

Making the multiple appointments that are often involved when seeking an abortion can be even more difficult for women who are employed or are in school during the day, as most appointments are during business hours. Time away from school, work, or other obligations in one's life may not be possible.

Choice of Facility

As noted previously, in Manitoba abortion services are provided through a private clinic and hospitals. The routes differs in terms of the number of visits, the waiting period, and the cost. When the women in this study accessed abortion services, the procedure cost approximately $350 at the private clinic. Accordingly, accessing services through the clinic can be a major barrier. Some women ruled out the private clinic as an option early on, for financial reasons:

> *I couldn't have afforded to go the [private clinic]. [It] was never really something I thought about going to, because it cost money.* (Corinne)

> *Yeah, I did [know about the private clinic], but it was a question of money ... I would never go [there] and it's because I don't have the money. Because I found out [about the pregnancy] early on, I was able to wait. It's the money issue with [the private clinic]. It's a huge money issue.* (Eve)

> *I figured that I was going to have to go to the hospital. I thought there's no way that I can afford to go to a private clinic, because it's pretty expensive.* (Iris)

Gloria knew a staff member at the private clinic and wanted to have the procedure performed there. As she remembered, it was a time of "chaos": "They were all booked up solid, and at this point I was really stressed out, hysterical because I wasn't sure how I was going to pay for this ..." An unplanned pregnancy can be stressful enough, and the added barrier of cost or difficulty getting an appointment only exacerbates the situation.

Heidi's only option was the private clinic, but she found it difficult to come up with the money.

> *It was very difficult for us to obtain funds towards it, because of our age. [We were] selling off Nintendo games. I had a friend that lent me like a hundred*

dollars, and things like that. At that age, you can't work, and the only income is babysitting or paper route or whatever it is. Even after the money we had gotten together or whatever, [my partner] actually forced me to ask my friends. When I wasn't even sure about it. When I wasn't even sure about the decision. (Heidi)

Darla made inquiries into having the procedure in Fargo, North Dakota:

We were trying to think of where we could get the money ... I think it was approximately, maybe $900 ... just because, I know now they go by the weeks [gestation that] you are ... and I know they [performed the procedure] up to about 24 weeks and it was kind of an exorbitant amount, in the $800 or $900 range. (Darla)

Others chose a particular facility for reasons such as the desire to protect privacy.

Anna and Betsy said:

There was a couple of reasons [that I went through a private physician]. First of all, because I knew everybody [at the private clinic]. I just didn't want to go [there], it's just a little close. Also, I knew that my doctor was an abortion provider, so I was very comfortable going to the hospital even though I'm a firm believer in free-standing clinics ... (Anna)

I knew you could have [an abortion] at [the hospital], but my mom's in the health profession, so she knows a lot of people. I thought, the last thing I need is for anyone to know anything. (Betsy).

For Betsy, and many other women, a family member working in a hospital or with other connections to the health care professions can cause concern over privacy and anonymity. This becomes a problem for women who wish to keep the abortion a secret. Their only other option may be the private clinic, which they may not be able to afford. Some of the women had heard stories about abortions at a hospital, and were discouraged from that route:

And the nurse [at the hospital where I went for the ultrasound] sat down beside me ... I said 'If I were to get an abortion through a hospital how long do you think I'd have to wait?' She said, 'My dear, if you want to get this over with as fast as possible I'd suggest [the private clinic], because here [at the hospital], it

depends what nurses you get, what doctors you get and how accepting they are of the procedure.' She said, 'People will know. Not everyone will know your procedure that you've had, but the nurses, they know, they talk, and a lot of them have preconceived ideas about how they feel about it and how they're going to treat you.' She says, 'I've heard horror stories from patients. You don't need the extra emotional burdens, so if I were you, I'd go to [the private clinic]. You're going to have to pay, but it's faster ... [Y]ou're looking at a three to four week wait [to have an abortion at the hospital ...' (Betsy)

[My partner] said ... 'No, I don't want you to go to the hospital, I want you to go to one of those clinics' because he had heard at hospitals they treated you kind of like crap. He said that he had friends that went [to a hospital] and they treated them kind of slutty. Like, 'Oh, you shouldn't have done this, or you brought this on yourself.' So he just said, 'No, there's no way. You're going to have to go to one of those clinics.' So then I had to go back and say to [the counsellor], 'Don't set it up at the hospital. I'll set it up at the clinic.' So he ended up paying for it. (Iris)

[The counsellor] told me [the private clinic] was more homey, and it was in a house, [and] that it was more relaxed feeling than in an actual hospital ... [T]he impression was given that it was more of a relaxed feeling rather than ... going to the hospital. (Heidi)

In Heidi's situation, because she was a minor, there were few options available. There were only a few doctors in the city who would perform the procedure without parental consent. She was referred to a private physician through a local clinic, but had a very negative experience. As she said: '[T]here was no way I'd ever go to [the hospital] just [because of] the experience that I had [with that doctor].' So her only option was the private clinic.

At that moment, when I was in the office there, I think the decision [about where to go for the abortion] almost had been made for me. [The counsellor] started talking about who I could go see, because I was a minor at the time, who would actually do it, and I had to make an appointment. I still wasn't sure [about my decision at that point] ... (Heidi)

The name of the private clinic was a deterrent for some women:

> *There's just something about the word 'Morgentaler.' You just visualize the day you have to go in there's going to be protesters. That someone's going to egg you.* (Fiona)

> *I just went to [the hospital]. It really didn't occur to me. Even if I would have had the money, it really didn't occur to me to go to [the] [private clinic]. I think the name of it, too, might have kept me away. There's so much with 'Morgentaler.' Maybe that was a little bit of a piece of it.* (Corinne)

Even though she did not have the abortion, Darla had a similar impression of the clinic. She had always heard that, 'You didn't go [there] because it's a butcher kind of thing. I didn't think it was a bona fide clinic.' Darla's statements are reflective of anti-abortion rhetoric. She no longer holds this view of the private clinic. However, the power of these discourses in framing abortion - and the facilities they are performed in - persists.

Privacy

With the stigma surrounding abortion, most women wish to protect their privacy. The choice of facility was sometimes based on this. Betsy said this about the private clinic: "[I]t's so private. [You] come in the back, [you] leave through the back. It's shady but at least it's private." Gloria said, "I didn't even want to think about going to [the hospital], just because I wanted it to be more private and discreet." A free-standing clinic affords women more privacy than a large hospital. Eve recalled her experience at the hospital:

> *Every time somebody picked up my chart I just cringed. Because about 20 different people pick up your chart ... It's not like one person picks up your chart and looks at it. Ten nurses picked it up, then you sit in the hallway waiting for your procedure, and three orderlies pick it up. Everybody's looking*

through your chart. Sure there's a sense of confidentiality and anonymity ... But, at the same time, 15 people looked at my chart [laugh]. You know? (Eve)

Corinne commented that she would rather have had the abortions in a private doctor's office instead of a large hospital, "feeling like everybody knows why you're there." The women went to different lengths to ensure that their privacy was protected.

> .... *[W]hen I went for counselling, I would park my car about four streets away, just in case anybody saw my car.* (Betsy)

> *It is quite confidential [at the private clinic], but it was even a big step to park near the place and walk over, because I was thinking, what if somebody drives by and sees me? I know it looks like a house, and you don't know what it is, but people do know what it is. What if somebody was driving by, and they see me go in here and stuff like that. That was one of my difficulties, I believe.* (Iris)

> *I had to work the next day [after the procedure] ... But I couldn't phone in sick. I didn't want anyone to know what was going on. I felt terrible and I was bleeding, but there was no way I was phoning in sick. Oh, anything to make everyone think that everything was cool.* (Betsy)

> *My dad came to pick me up [from the hospital] ... I told my parents I was getting laparoscopy, through the belly button. I made up this whole story about the possibility of endometriosis or some sort of thing, and that I had to go through all these appointments and do all this stuff ...* (Eve)

Multiple appointments can be difficult to explain if a woman is trying to protect her privacy. She may feel pressure to explain her whereabouts, particularly if there are three or four visits. Iris went to the private clinic, but commented on how privacy would be a concern with the multiple visits required at a hospital:

> *Like, I think when you go to the hospital you have to go one day and they do some kind of dilation thing ... And then the next day you go back, which is kind of a hassle when you're trying to keep it a secret, having to go somewhere twice.* (Iris)

The desire for privacy and confidentiality, and the difficulties encountered while trying to protect one's privacy have been identified by the women in this study as another barrier to access. A woman may be limited to certain options by geographical location, stage of the pregnancy, age, and cost, only to have privacy become an added concern. Many women in this study remarked that they chose to have an abortion at the private clinic because they felt there would be more privacy, but the clinic is potentially more visible because it is a free-standing facility, and because people are aware of the building and its purpose. For girls under 18, protecting privacy is even more difficult.

Access for Minors

The private clinic does not require parental consent to perform abortions on minors. However, most private physicians who provide abortions, and the hospitals, do require parental consent. This greatly reduces the options available to young women, particularly if they live with parents or guardians and wish to keep the abortion a secret. Heidi was 15 and 17 at the times she had abortions, and found access to be difficult. She said:

> *I would say the first time it was quite difficult. Very difficult ... accessing it, knowing where to go, doctors, how I'm going to go about getting there, parents, you know, worrying about school. Is the school going to call and say I'm missing? So many things more to think about [at 15] than when you're 17 and you're able to drive a car there, you know? You know more [at 17 years old]. And maybe I know more just because I had an experience beforehand. It might have been different if I only had one experience, and it was at 17. I think it depends, but I think at a very young age it's very difficult.* (Heidi)

Heidi recalled a visit to her family doctor, an appointment her mother arranged for her because Heidi was so sick. Already aware of the fact that she was pregnant, Heidi said:

> *If you can imagine going to the doctor's [office], knowing what your problem is, and the doctor [asks], 'Well, what's wrong?' I just broke out crying. [I said], 'Well, I know what's wrong. I'm just wasting your time just because I won't tell my mother.'* (Heidi)

This doctor helped Heidi protect her privacy by assuring her he would tell her mother that she was ill from the flu, and that he would be her doctor whether she terminated or continued the pregnancy.

For minors, appointments mean missing school. Heidi said, "I skipped school, and [the abortion] wasn't a thing that I could write a note for and use." Simple things that most people take for granted, such as transportation, can prove daunting for a 15 year old. Heidi recalled: "[W]e took the bus there [laugh], you know what I mean?" Following an abortion, facilities require that someone is able to take the woman home, as she may still be feeling the effects of the anaesthetic. The bus does not offer much privacy.

Trying to keep an unplanned pregnancy and an abortion a secret can be difficult under the best of circumstances. For minors, and anyone living with parents or guardians, privacy becomes a real concern. Iris was 18 at the time of her abortion, but found it difficult to protect her privacy in her parents' home:

> *I think it would be difficult also if, like me, you have the parental strictness. That was really hard ... trying to figure out when I could go [for the appointments], how to do all this stuff, and living at home. And having your period for two weeks. Well, my mom would be sure to notice, you know?*

There's stuff in the garbage. So, I was pretty good about it, but that's just like an added pressure, trying to keep it secret from everybody. (Iris)

Access in Rural Areas - A Case Study

For women who do not live in Winnipeg, access to abortion services is difficult. I spoke with a woman in a rural town in Manitoba about her daughter's experience accessing abortion services three years previously. I'll call her Jenna. Jenna was 16 years old when she discovered she was pregnant. When she took the pregnancy test, Jenna was eight and a half weeks pregnant. At the time, she lived with her mother and one sibling. Jenna's mother was on social assistance at the time, so finances were tight. Jenna would have to travel to Winnipeg to have an abortion. Fortunately, Jenna's step-father resided in Winnipeg at the time, so there was somewhere to stay. She was able to get an appointment at a hospital about two weeks later, which was fairly quick. Jenna was very fortunate that her mother was supportive and could give consent for the procedure. Jenna's partner was also supportive.

There were two trips involved, one week apart, and Jenna's mother found it difficult to obtain funds from social assistance for travel to Winnipeg. The first trip was for the pre-abortion counselling. The second trip involved at least one overnight stay, as the dilation was one day, and the procedure the next. Travel is not recommended immediately following an abortion, so any women from outside of Winnipeg can expect a two or three day stay.

Jenna expressed resentment to her mother about the barriers to access she encountered. For the abortion, Jenna was left alone on a stretcher, which she found scary.

Jenna was living in a community which was not supportive of abortion. She was quite ill with the pregnancy, and had to take two trips out of town for appointments, so others at her school found out. Jenna was harassed at school, and called a 'murderer.' She ended up leaving the school and now lives in another province.

This case reveals many of the barriers faced by girls and women living in rural or northern areas of the province where there is no access to abortion services. Not only are the services not available, but the dynamics of a smaller community can make hiding a pregnancy - and abortion - difficult. Further, many rural communities are more conservative in their thinking, and this creates added pressure for girls and women.

Although the nine women interviewed for this study about their abortion experiences were living in Winnipeg at the time they had the procedure, some commented on the difficulty accessing abortion faced by girls and women living in areas. At the time of the interview, Gloria was living in a rural community where there was no access to abortion services. I interviewed her in her community. She said:

> *You know, I often think if I would have been here [in this community], and that [the pregnancy] would have happened, where do you go? There is nowhere to go. And I think if you were like a young woman in this community ... and if you don't have any friends in the city, and if you don't have any support, and if you*

don't have the money or any sort of access, you're SOL. You're stuck becoming a mother, or you have a difficult decision of giving it up for adoption. (Gloria)

Fiona grew up in rural Manitoba, and commented on how difficult it would have been if she had been pregnant while living in her home community. She even considered whether or not she would have had an abortion in her community, if the services were available.

I'm thinking, even if I was living in _____ [when I found out I was pregnant], would have I have done it there? Not on your life. You know every nurse ... And just for anonymity, there's no way. (Fiona)

Darla and Heidi commented on how difficult it would be if a woman lived in an area where abortion services were not available.

Especially people who live in a small town. What are they going to do? First they have to come into Winnipeg, just for tests and it probably takes a day just to see a counsellor and to talk to someone and to make the appointments. They have to come in [to Winnipeg], and explain their whereabouts and stuff like that. So I think it must be really hard. (Darla)

I live in Winnipeg. It's not like I had a travelling experience like some of the people that I met at the clinic ... [Some] were from another province, even ... In that respect, I guess I'm lucky where I live ... I don't know what I would have done at 15. How do I afford a plane ticket? ... It was hard enough just to go away [from home, in the same city] and be dilated, you know? (Heidi)

For Aboriginal women, the barriers may be even more pronounced. Most reserves are isolated communities, some not even accessible by vehicle year round. Further, Band Councils control much of the reserve finances. Gloria and Eve both knew Aboriginal women who had sought abortions:

If you're coming all the way down from Oxford House ... and you're eighteen years old, and you have not very much money, where do you stay when you're [in Winnipeg]? How do you get out there? Where do you get the money to get your bus ticket? I think, too, for Aboriginal women, especially if you're a woman from the reserve, you're not going to get a whole lot of support from

your community. A lot of Aboriginal communities are very much against abortion ... (Gloria)

Well, a lot of [Aboriginal women] don't have time to come down here and spend four weeks [for appointments]. They have one plane that comes out and takes them down here, and it leaves in a day ... And that takes money. The reserves don't have that kind of money, to keep on flitting back and forth ... [If you ask them to consider], 'Well, what about [the private clinic] ... aren't you covered under your treaty, as a Band Indian, aren't you covered under the treaty?' [And they will say], 'Well, we have to go in front of the council, and we have to tell the council [why we need the money].' So it is an issue of a native woman in a reserve having to go in front of her entire reserve and tell them that she's pregnant and that she wants an abortion, and wants the council to subsidize it for her so she can get it in one day. As opposed to going through the freer system ... [at] the hospitals. It's free, but at the same time it can take anywhere from three to four weeks before you actually get your abortion, and these people don't have the resources to come down here that many times ... Women up north, and I'm not just talking about native women, I'm talking about women up north in general, have this real problem. (Eve)

Access to abortion services for women living in rural and northern areas is fraught with barriers. Lack of access denies those women the freedom to make their own choices about their reproductive lives. That hospital boards do not permit abortions being performed in their facilities is reflective of the reluctance to ensure that hospitals provide abortion services - a sentiment common to anti-abortion, legal and medical discourses.

This chapter presented the barriers to access identified by the nine women who participated in this study. To summarize, what these women found to be least helpful were: judgmental and unsupportive health care personnel; inaccurate and unavailable information about services; pressure and lack of support from persons close to them; cost; waiting periods; the difficulty protecting one's privacy; and the shame and stigma

attached to abortion. These same difficulties have been reported in other research (Ryan et al., 1994; Bowes, 1990; Sachdev, 1993).

Some women experienced fewer barriers than others. Anna was fortunate to have plenty of knowledge about available information and services, a personal connection to her provider, a stable, secure relationship, and a brief waiting period. Despite being virtually barrier-free, her experience is important to illustrate what can make access to abortion services easier. Darla's experience of not being able to access an abortion due to barriers she encountered shows the opposite extreme. Many women faced with an unplanned pregnancy may not receive accurate information about services that are available. The views of the other women provide a mixture of barriers to access and services which made the experiences easier. It is important to present both of these types of findings.

II. Improving Access to Abortion Services in Manitoba

Efforts to improve access

The numerous barriers to abortion services across Canada and in the United States have prompted the drive to find ways to ensure that women can access safe abortions. Prior to the legalization of abortion, both in the United States with the decision in *Roe v. Wade*, and in Canada with *Morgentaler, Smolling and Scott v. the Queen*, there were efforts by feminist groups to improve women's access to abortion services. "Technical barriers" are not as lofty when women "seize the means of reproduction" and become their own providers (Roth cited in Lamanna, 1991:14). One

example of such underground methods was the abortion collective known as "Jane." Tired of the danger and deaths resulting from illegal abortions, a group of women in Chicago decided to take access into their own hands. What began as a counselling and referral service in 1969 grew into an "illegal, floating, feminist, underground abortion service, run by women for women" ("Jane," 1990:93). It lasted until 1973. Initially, the doctor hired to perform the service operated on a fee-for-service basis, but then he became a salaried employee. This increased the availability of the procedure to lower income women. Eventually, the unlicensed doctor was terminated, and the women of "Jane" performed the abortions themselves. What this effort essentially succeeded in doing was to "demystify medical practice" ("Jane," 1990:99).

Another attempt to improve access to reproductive freedom is the technique of menstrual extraction. The procedure is done "most commonly to eliminate the general nuisance of menstrual flow and to relieve menstrual pain ... It can also be used to reduce the need for abortion" (Punnett, 1990:101-102). Unlike conventional surgical abortion, menstrual extraction involves women as active and controlling participants. A woman does not do the menstrual extraction herself, but instead relies on a network of other women in a menstrual extraction group. The procedure is done once a month, whether or not a pregnancy has occurred, using a syringe or other non-vacuum device. Other "early abortion-type" procedures - which are performed and controlled by a physician on a passive woman patient - include endometrial aspiration, pre-emptive abortion, menstrual induction, mini-suction, or early uterine evacuation (Punnett, 1990:103). As Punnett (1990:102) notes: "Given the always-tentative legal status of

abortion in [the U.S.], it becomes preferable to develop our own technology and health systems as an alternative to dependence on men (law-makers, doctors, priests, etc.) for access to abortion."

Without legislation pertaining to abortion in Canada, wrangling occurs on numerous other fronts; in some cases to restrict abortion, and in others to improve access. Some of the more notorious cases involve provincial decisions to limit the activity of anti-abortion protesters outside abortion clinics and hospitals providing the service. Recent incidents of violence in both Canada and the United States have no doubt prompted such measures. Following the shooting of Dr. Garson Romalis in Vancouver, the British Columbia government passed the Access to Abortion Services Act in September, 1995. The legislation, which essentially set up "bubble zones" around clinics, defined protests outside these facilities as offences. On January 23, 1996 a British Columbia provincial judge ruled that the legislation was in violation of the *Charter of Rights and Freedoms*, and charges were dismissed against Maurice Lewis, the first person to be charged under the Act. In August 1994, an Ontario court ruling ordered protesters to stay 20 metres from abortion clinics and physicians' offices, and 160 metres from physicians' homes in Toronto, Brantford, Kingston, and London. The judge making the ruling, Justice George Adams, suggested in a written statement that such protest activity amounted to a "public nuisance," "criminal harassment," and was in violation of the right to security of the person as guaranteed in the *Charter of Rights and Freedoms* (cited in LeBourdais, 1995:930).

RU 486

The women in this study who accessed abortions in Manitoba had standard surgical abortions. Another contentious option which would improve women's access to abortion is the French abortion pill, RU 486, a form of medical (or drug-induced) abortion. Developed in 1980 by Dr. Etienne-Emile Baulieu and manufactured by Hoechst Roussel (and its U.S. subsidiary Roussel-Uclaf), the drug consists of a synthetic anti-progestin known as mifepristone (taken orally), in combination with a prostaglandin (taken orally or by vaginal suppository or injection). Pregnancy requires progesterone. Mifepristone inhibits the action of the body's progesterone, weakening the lining of the uterus and bringing on menstruation. When taken alone, the drug is about 80 percent effective in terminating pregnancy within a few days after taking it (Claire, 1995:137). Beyond eight weeks gestation, the body's natural progesterone is more plentiful, rendering RU 486 ineffective. About two days after taking the anti-progestin, a prostaglandin, which induces uterine contractions, is administered. The oral dose (Cytotec) has less side effects than the vaginal. When used together, the mifepristone (RU 486) and misoprostal (Cytotec) are about 95 percent effective if used within 49 days of the last menstrual period (Claire, 1995: 136-37).

To date, the drug is not available in Canada, even for testing purposes. RU 486 is legal in France, England, Sweden and China, with efforts underway to legalize it in other countries. In 1996, RU 486 was approved for use as an abortifacient in the United States after several years of testing. Roussel-Uclaf has five criteria which must be met before the drug can be marketed in any other country: abortion is legal;

abortion is accepted by medical, public, and political opinion; a suitable prostaglandin is available; distribution is strictly controlled; and patients agree to written informed consent, and to surgical abortion if RU 486 fails. As Mullen et al. (1994:64-65) note, Canada meets these criteria: a majority of Canadians are pro-choice; there is no law restricting abortion; a universal health care system could ensure that distribution is controlled; and informed consent processes are included in common law. A prostaglandin which is used to treat ulcers is available in Canada. At present, there is an impasse as the Canadian government awaits application from Roussel-Uclaf, and Roussel-Uclaf is waiting for assurances from the government that harassment and potential boycotts will not impede distribution (Mullen et al., 1994).

The implications of RU 486 are numerous. Availability of medical abortions would improve both choice and access, especially for women who may be intimidated by anti-abortion protests and harassment outside facilities that perform surgical abortion. Further, women in rural settings and other locales which do not have approved facilities will have greater access. However, "the new medical technology ... will increase access only if the numbers and geographic distribution of providers are expanded..." (Harvey, Beckman, Castle, and Coeytaux, 1995:203). While, in theory, a medical abortion could be administered by general practitioners, doctors with less experience in gynaecology may wish to refer rather than take the risk of error (Claire, 1995:139)

As Mullen et al. (1994:64) claim: "[A]ttempts by the anti-abortionists to frame the issue as one of medicalized genocide have been largely ignored by the media, and

supplanted by emphasis on RU 486 as a matter of women's choice, scientific freedom and justice." Despite the fact that one of the purposes of RU 486 is as an abortifacient, other uses of the drug include treatment of breast and other cancers, AIDS, endometriosis, Cushing's Syndrome, and brain tumours (Mullen et al., 1994:66). Moreover, though the impact of such measures is debatable, Mullen et al. (1994) suggest that potential boycotts could threaten the political and economic structure of the country, particularly because there is still strong opposition to abortion in areas with largely agricultural-based economies.

As with other efforts to improve access, the future of RU 486 is dependent on a host of legal, political and social factors. The conditions imposed by Roussel-Uclaf which require that public opinion support the distribution of the drug in a given country speaks to the power of public discourses in relation to access to abortion services. In fact, "the importance of media in framing public understanding and opinion may prove a key element in the evolution of public and political will to make RU 486 available in Canada" (Mullen et al., 1994:66). Like surgical abortion, RU 486 has a place in moral discourse; the French Minister of Health and Social Welfare declared the drug "the *moral* property of women" (cited in Lamanna, 1991).

Although RU 486 is not presently available,[15] there are alternative measures being explored in Canada and elsewhere. A combination of the drugs methotrexate (which has been approved for use to treat cancer) and misoprostal (which has been

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[15]A Toronto physician has admitted to illegal use of RU 486. See "Toronto doctor admits illegal RU 486 use," *Vancouver Sun*, 30 May, 1994.

approved for use to treat gastrointestinal ulcers) has been tested in the United States and in Canada. The drugs are widely available in Canada, but approval for their use as an abortifacient has not been granted. Methotrexate was first used as an abortifacient in Brazil in 1952 (Thiersch cited in Claire, 1995:136). Other uses include the treatment of intact tubal pregnancies, some malignancies, leukemias, rheumatoid arthritis and psoriasis (Claire, 1995:136). A Vancouver physician has admitted to prescribing the drugs as an abortifacient ("Safer abortions," *Winnipeg Free Press*, 5 March, 1995). Unlike RU 486, which on its own can terminate a pregnancy within a few days of administration, methotrexate works slowly. The drug interferes with DNA synthesis, repair, and cellular replication thus preventing foetal cell development. Taken alone, methotrexate can take three to four weeks for bleeding to begin, whereas in combination with vaginal misoprostal, it is 95 percent effective at terminating a pregnancy in a shorter period of time (Claire, 1995:137).

The women in this study were asked how they felt about RU 486. Some women were not clear on the nature of the drug, and thought it referred to emergency contraception, or the 'morning after pill.' Fiona and Iris offered reasons why this method would be something they would consider:

> *I think a lot of [women] work in denial, or they wait for the next period, 'Oh, I must have just missed one,' right? [They might think], 'Maybe I should check this out, because I can do this itsy bitsy pill thing, or I can go through this whole other experience [surgical abortion] which sounds pretty horrible'... [For me, I would have chosen the drug method because] I wouldn't have had to wait. I could have done it immediately ... [but] I guess they have to be careful how they regulate it.* (Fiona)

That would be a good way to do it more privately. Like I said, I was uncomfortable in the waiting room, especially. I guess that would be a good way, as long as it's safe. (Iris)

Concern for the safety of a medical, drug-induced abortion was common. The history behind use and misuse of contraception and new reproductive technologies invites caution. Most of the women commented on the need for testing and regulation of such drugs.

The only hope that I have is that it is tested. I'm hoping that women don't use it as a form of birth control, but if they do find themselves doing that, that they are lucky enough not to have any terrible side effects or anything terrible happening to them physically in the future. (Gloria)

Another problem I have is the politics of birth control in general. Who's making them, who's making money off of them, where are they distributing them, who's taking them, who's testing them? So, I find that women are caught in this catch-22 where, in order to have reproductive rights, they have to surrender themselves to transnational corporations and big money pharmaceutical companies that are destroying the earth and destroying other people. I mean, look what they did when the pill came out and they took it to Brazil ... we use it as the morning after pill now. Doesn't that say something? We're caught in this sort of rock and a hard place where you want to take it ... I mean [look at] the female condom. Here we are, the one thing that men do to prevent pregnancy, STDs and HIV, the condom, [and] they turn it around and make it number 37 item for women to use. So, philosophically, I find women in this sort of bind where they want their reproductive rights and they want the reproductive choices, but whose making the birth control? Where are they sending it? Where are they distributing it? Who is making the money? Who is testing it? (Eve)

Well, I'm for [RU 486], I guess. It's a person's decision. You know, as long as it's not really detrimental to somebody ... I don't know what kind of research has been done on it. And what are the effects, years later, of it? If it's a new drug. I guess it would just be another method [of abortion] ... (Heidi)

The availability of RU 486 or any other prostaglandin method of abortion would not eliminate the need for surgical abortion. Medical abortions are only effective up to approximately seven or eight weeks gestation (49 to 56 days after the beginning of the

last menstrual period). Many women do not know that they are pregnant until this time or later. Further, in the event that a medical abortion fails, a surgical abortion would need to be done because it is not known what, if any, long term effects the drugs may have on the foetus. Darla wondered about the feasibility of RU 486:

> *I agree that the abortion pill should be legalized here. I think, of course, it won't be for years and there'll be heavy restriction and debate ... It's hard to use anyway because you have to know before you're seven or eight weeks, and most women don't know until they're seven or eight weeks* ... (Darla)

For women who find out they are pregnant earlier on, and do not wish to wait until eight weeks for a surgical abortion, RU 486 may be beneficial. The procedure is less invasive than surgery, there is no anaesthetic, no risk of injury to the uterus or cervix, and recovery is usually faster. For some women, a medical abortion offers them more control over their own bodies and the process of terminating a pregnancy (Claire, 1995). Concerns over side effects and regulation aside, some women prefer a surgical abortion to a medical one because often the products of conception are expelled at home during a drug-induced abortion, and this can be traumatic. As well, pain and cramping from the uterine contractions may last longer and be more intense. Further, this procedure still requires medical supervision, and several visits to a doctor's office, leaving abortion in the hands of the medical profession.

CHAPTER SEVEN: Stigma and Silence

> Abortion is chosen and therefore tends to carry a stigma. (Davies cited in Timpson, 1996:781)

One of the most striking themes in this study is the silence and stigma surrounding abortion. Peterman (1996:6) states that: "Regardless of the secrecy of abortion in individual women's lives, abortion today is a very public phenomenon and the meaning of abortion is highly contested." Ironically, abortion is 'public' in dominant discourses but remains a shameful secret for many women. This silence only further stigmatizes abortion. The challenge to create new discourses which allow women to define abortion for themselves is hampered by the stigma. As Weedon (1997:107) notes: "[I]n order to have a social effect, a discourse must at least be in circulation." This may be one of the most significant barriers for women as it operates to keep women silent about their experiences which, in turn, perpetuates other discourses.

The social stigma placed on abortion is an important factor in a woman's decision to share that experience and who she shares it with. With an issue so contentious as abortion, even sharing one's personal opinion can be threatening. Elisabeth Noelle-Neumann (1974) explored the formation of public opinion on controversial issues. Noelle-Neumann refers to the "spiral of silence" and suggests that:

> .... [P]ublic opinion arises from an interaction of individuals with their social environment ... by assessing the distribution of opinions for and against [her] ideas, but above all by evaluating the strength (commitments), the urgency, and the chances of success of certain proposals and viewpoints. (Noelle-Neumann, 1974: 43-44)

The "spiral of silence" makes women afraid that someone may find out about the abortion. The measures taken to protect one's privacy are examples of the power of stigma. Betsy spoke of the "hyper vigilance" she felt about the word "abortion," and her fear that someone may think she had one:

> *At the back of this magazine, I was looking through it and I saw this [article]. It says something and [then] it says 'abortion' with a big question mark. I saw it and I didn't want anyone on the treadmills behind me to see I was reading this. I took it and I flipped it over so they wouldn't see the word 'abortion.' I started to read it and I thought, somebody saw it, so I can't read this whole article, so I'm just going to flip [the pages] like it doesn't mean anything to me.* (Betsy)

Many of the women in this study referred to the stigma surrounding abortion. Betsy felt it when she was calling for information.

> *It's such a taboo subject, I guess. No one wants to talk about it. They don't want to admit it even exists. In their eyes it's just, 'go somewhere else.'* (Betsy)

> *I mean even I'd admit that there's stigma ... I've got hangups about how I'm, perceived. You know what I'm saying?* (Anna)

> *That was one of my uncomfortable moments, was just walking in there [to the clinic], not because of who was inside, but who would see me walking in there. Because it's a stigma of some type.* (Iris)

Darla felt stigmatized by her family doctor when she went to see him after finding out she was pregnant.

> *I think what bothers me as well with that whole thing [is] I think [the doctor] looked at me as a 19 year old girl who was being foolish and stupid. [I felt that he] really wanted to say, 'Oh no. Not again.' And I really think that kind of attitude is what made him appear that way and say those things and do those things. And that really bothers me.* (Darla)

Women facing an unplanned pregnancy may feel stigmatized on many fronts. Looks or words of judgment can be one way, but simply the fear of judgement can silence women about their experiences.

> *The message that abortion is wrong comes across stronger than [the message that] it's okay. And I think, even today, I wouldn't go around and tell some of my friends that I had one, just because of judgement reasons. I don't believe it really makes me the full person who I was, [but] I think something like that is still judged in today's society.* (Heidi)

Despite personal relationships, people often hold very strong opinions about abortion. As Heidi said:

> *And even though someone can be a really good friend of yours, there's a limitation because you can't really share this experience, because of fear of where the person stands ... and how they may judge you.* (Heidi)

The fear of judgement is closely related to what abortion represents. There is an assumption that women who have abortions are promiscuous, or that they are irresponsible. The women themselves held similar judgements about other women who have abortions.

> *I think about [the three pregnancies] and feel, I'm not that kind of girl, I'm not that type of girl. I don't go off and get pregnant ... I think, my God, I've had three pregnancies already under the age of 21, you know? If I heard of someone else doing that, what would I think about them? ... I was an honour roll type of person, never got into trouble, never did drugs, anything like that. I guess I look on that type of promiscuous person going around getting pregnant using abortion as birth control ...* (Corinne)

With stigmatized behaviour, there is a separation between 'us' and 'them.' Corinne's statement, "I'm not that kind of girl" illustrates this. After her abortion, Fiona said that she felt "I'm one of *them* now." The women in this study were very aware of the

stigma attached to abortion, and their fear of discovery and reluctance to talk about abortion are connected to a fear of isolation. As Noelle-Neumann (1974:44) states:

> Voicing the opposite opinion, or acting in public accordingly, incurs the danger of isolation. In other words, public opinion can be described as the dominating opinion which compels compliance of attitude and behaviour in that it threatens the dissenting individual with isolation.

Although abortion itself is stigmatized, women who have had more than one abortion face added stigma.

Multiple Abortions

There is little research which explores the experiences of women who have had repeat abortions. What is available is usually statistical in nature. Millar, Wadhera and Henshaw (1997) explored repeat abortions in Ontario between 1975 and 1993. For that period, 20 percent of women who had obtained abortions had at least one previous abortion. There were variations among different age groups. In 1993, the 'repeat rate' was four times the first-abortion rate for ages 15 to 19. In other age groups, the repeat rate was two to three times. From their findings, the authors discovered that women who have had an abortion are more likely to have another, as compared to women who have never had an abortion are to have a first (Millar et al., 1997). In Manitoba hospitals in 1995, one-third of the abortions were performed on women who had previously had an abortion (Statistics Canada, 1997). These figures illustrate that repeat abortions are not that uncommon, yet they do not suggest that these women are using abortion as their form of contraception.

> .... [F]ew if any women are long-term users of abortion as a primary method of birth control. A fecund, sexually active woman relying only on abortion would need to have 35 abortions during her lifetime if she wanted no children. (Millar et al., 1997:23)

Heidi commented on this assumption.

> *I think a lot of people see it as being an easy access to contraception. It's not consciously that I was thinking when I was having sex that, 'Hey, if I get pregnant, I'll just have an abortion.'* (Heidi)

Three women in this study had more than one abortion. Corinne had two, Eve had three, and Heidi had two. They are conscious of the stigma.

> *Not that many people know that I've been pregnant four times ... [H]aving more than one abortion is a pretty prevalent thing here. It makes it very difficult when you have more than one. People look at you very differently.* (Eve)

Eve has personally felt the stigma attached to multiple abortions. She is very aware of the reactions of others, and is careful about what she tells others.

> *I'm not embarrassed to tell people that I've had an abortion, but I'm certainly embarrassed to tell them I've had three. Telling them I've had an abortion is not a big deal.* (Eve)

This screening process speaks to the depth of the stigma around multiple abortions. This stigma made the second and third abortions much more difficult for Eve. She was afraid of what others would think, so she did not tell anyone about them. Her current partner does not know she has had three abortions and four pregnancies. There is the silence associated with the fear, but also the self-blame from internalizing the stigma:

> *Nobody knew. I didn't know what to do. There was just no way that I was telling anybody. And I pulled it off. To this day only [my partner at the time] and I know that one. I wasn't naive to the outside reactions of the rest of society if you want to put it. I wasn't dumb. I knew, first one alright. Even people who are against [abortion] could even find some forgiving in the first one, but the second one? Nooo, definitely not, definitely not. So there was just no reason why a second one should happen, and I punish myself on that too.*

> *There's no reason why the second one should have happened. And even the third one, I punish myself even more, because here I was three times. You should've seen me by the fourth one.* (Eve)

Heidi had two abortions, and is also aware of the stigma.

> *Yeah, there is a lot of stigma, and not only the fact of one abortion, but there is more stigma if you've had two or three. I don't think people can really understand what a woman goes through. Okay, so she should have learned after the first time. But I don't think they realize all the other things that a woman goes through [when she] happens to get pregnant a second time and still makes that decision.* (Heidi)

The stigma attached to abortion, particularly for multiple abortions, is closely tied to sexual behaviour. Sexuality is very complex, as are interpersonal relationships. The reasons for an individual's sexual behaviour and contraceptive practices vary. It is naive to believe that education on sexuality and contraception will automatically translate into action. Despite the increase in cases of sexually transmitted infections and HIV/AIDS, people continue to engage in sexual activity without using protection. Negotiating contraception is complicated. Alcohol may be involved, or coercion, and even force. Low self-esteem and fear of rejection may also be factors. Further, contraceptive methods fail, even when used correctly. Corinne, Eve and Heidi revealed some of these complexities, and each woman talked about why they had more than one pregnancy. Corinne's situation was unique in that she wanted to be pregnant, but had the abortion out of fear and pressure. She did want to get pregnant the second and third times, engaging in 'contraceptive roulette' (Currie, 1988) as her partner did not want a pregnancy. However, her reasons for wanting to become pregnant again become more complex:

> *I guess, when I got pregnant one year later, I thought, here's my retribution, here's where I can renew myself. How deja vu can it be, why I have to have this baby ... And then when I got pregnant a few months later [after the second abortion], I was using condoms that I thought would break or did break on us before. The condom situation was usually up to me anyway ...so, I just used that condom and it broke and there I was.* (Corinne)

Although her partner told her he did not want her to get pregnant, he did not want to use condoms. As she said, the 'situation' was up to her. She still felt the need for 'retribution' at the time of the interview:

> *I do specifically want to have kids with him ... probably for retribution. There's other guys out there and stuff, and I know that, but I don't want to get pregnant by any of them, just him ... I want to make up for what I did. I figure if I have three, or two [children] or whatever, I could make up for what I did. Like when I got pregnant exactly a year later, 'Oh, I can make up for what I did.' And when I got pregnant only a few months after the second [abortion], 'Oh, I can make up for what I did.'* (Corinne)

Heidi, too, felt that she did not really arrive at a decision and had the abortions out of pressure. However, she did not express a *conscious* desire to become pregnant the second time.

> *I sort of felt guilty that it had happened again ... I had this feeling that I would get pregnant again, and have this child. I think subconsciously, that was the reason why I didn't take care of myself, protection wise. Because subconsciously I sort of wanted to be pregnant again.* (Heidi)

Like Corinne, Heidi now believes that these experiences kept her in relationships with the partner she was with at the time of the abortions:

> *I think after [the first abortion] I had this feeling that, I don't think it was a thing of wanting to be pregnant, but it was a feeling of wanting to make up for [the abortion] ... I think the reason I stayed for the other year was just this feeling that one day I would have this child that I didn't have ... I still think that's what made me cling to these relationships for so long, when they should have ended ... If I had a good understanding of this 'replacement' thing that I had going on in my head, of what that was, I don't think I would have gotten pregnant the second time.* (Heidi)

Eve's four pregnancies were with the same partner also. She did not say anything about a conscious or unconscious desire to be pregnant again, but did not use protection with her partner. She said that "it didn't matter" to her that they would have intercourse without protection:

> *For some reason there was this stupid block in my head. I don't know, I guess that's something for psychology, but for some reason it did not matter. But I knew I was pregnant. I knew I was pregnant even before I took a test.* (Eve)

Eve is now in a happy relationship and feels differently about contraception since those experiences. When discussing pregnancy with her current partner, she said: "I told him if I ever get pregnant, I have to have it." I asked her what caused her to arrive at that decision. She replied:

> *The fourth one. And I can't explain why and I can't explain how, me doing all the things I do, that's just my own rule now. I just can't do it anymore. So I said to him, 'You better be damn careful if you're not ready to have a kid because [laugh], I'll have to keep it!' I couldn't do it again. I could not do it again. Four times between the ages of 19 and 23 or 24 is just enough.* (Eve)

Other women in the study did not have more than one abortion, but had some views on multiple abortions:

> *My mother's big argument, or other pro-life activists, their big argument is if it's legal people are going to abuse it. And you're going to have these girls that are going out and getting five or six abortions and using it as a birth control method. Well, it's a hard enough decision already, I don't think people are going through it for the joy of it.* (Darla)

> *You know, you're supposed to learn from your mistakes. If you haven't got it by the fourth time, what's wrong with you? Is it, are you a sucker for punishment, do you like this? ... Whoopi Goldberg has had six. I read her story. She didn't understand, she didn't have any education at this time. She was 13, 14, 15. So, I mean, that's a little different, but still, 'You like this procedure, or what?' ... It's funny because I don't understand this myself, but I've always thought of, if someone told me they've had five abortions, I would have [thought], 'Are you ever an idiot.' One mistake, fine. Maybe even two, maybe, but five? You've*

> *got to be stupid. But yet, in my eyes it was okay for one. Which is silly ...* (Betsy)

Betsy views her own unplanned pregnancy as a 'mistake,' and feels some ambivalence about multiple abortions. When she went for post-abortion counselling, Betsy was preemptive:

> *[The counsellor] said to me, 'When did you have your abortion?' - I'd sought counselling probably two or three months after the abortion - and I said 'Well, I had it in June.' She said, 'Wow, that wasn't too long ago. You're already here,' and I said, 'Well, I've only had that one.' She didn't ask me [if I had more than one abortion], but I felt the need to clarify, so I jumped right in there. It made me feel better.* (Betsy)

The myths and assumptions about abortions are deeply ingrained in the psyches of many people. To some degree, it may be a form of 'othering.' By insisting that 'I'm not one of *them*,' a person can create some distance from the very stigma which bears weight on their own circumstances. As Gibbons (1986) suggests: "Attributing responsibility to stigmatized persons for their condition helps to distance the observer from those persons and from the stigma itself." Gibbons identifies three factors common to the general experience of stigma. The first is *morality*, the idea that stigmatized persons are held morally accountable for their condition. Second is *isolation*. The silence and secrecy, as well as segregation make interactions with others difficult. Third, is *ambivalence*. This characterizes the attitudes held by nonstigmatized persons toward those who are stigmatized, but also "the attitudes of some stigmatized persons who have internalized societal opinion of their own stigma and others who have it" (Gibbons, 1986:143).

Guilt and Self-blame

> So pervasive is the belief that conscientious women can avoid unintended pregnancies that the experience of failed contraception often [results] in self-blame. (Ryan et al., 1994:162)

For some of the women, the social stigma toward abortion was internalized. Many of the women reported feeling shame and embarrassment at the unplanned pregnancy. Self-blame was a common reaction to failed contraception, and to lack of use.

> *It takes two. I have no control over that part of my biology except for taking these drugs which aren't even one hundred percent effective. I mean, this terrible blaming mentality. That has got to be one of the hardest things to get rid of inside yourself, I think.* (Fiona)

Anna recalled feeling "silly" when faced with an unplanned pregnancy at 30 (despite taking oral contraception) because, "Everyone else I know did this when they were 15."

Eve commented on her feelings after the second, third and fourth pregnancies:

> *Actually, the funny thing is, now that I'm thinking about it, the same thing applied, embarrassment and things like that. I didn't tell anybody about that one.* (Eve)

> *[For] the one that I miscarried ... I got pregnant again and I thought, 'Oh my God, I can't believe it.' One of the first things that went through my mind was embarrassment ... I was embarrassed. I felt very stupid and irresponsible.* (Eve)

> *Well, after I beat myself up [laugh], [I felt] terrible. Terrible. You know, for the longest time before and after that happened I felt like the biggest loser, that if I couldn't have children then I deserved that, because that was just my fault and I was the stupidest person.* (Eve)

Eve's self-blame and feelings of guilt included feeling that she "deserved" it, if she could not have children in the future. Corinne and Betsy both felt pain during the abortion procedure and commented that they 'deserved' to feel pain:

> *That was for the laminaria tent, the next time. And I had that, and that was just awful. But even though it was just awful, I was relieved that there was pain involved, because I felt it shouldn't be pain free. At least physically [I felt] I should have to suffer ... And of course the guilt, you feel like, 'Oh I deserve this and so much more. It should be like this.'* (Corinne)

> *And then [I felt] the pain, and then I thought I deserve this pain. 'Don't give me anymore gas,' I said, 'I deserve this pain.' So, yeah, I said that to [the nurse], I said, 'Don't give me any more gas.' And she knew why. She knew why.* (Betsy)

This self-blaming mentality suggests that these women were internalizing anti-abortion discourses, and feeling the weight of the stigma.

Women may feel that an abortion will free them from the stigma of an unplanned pregnancy, only to be stigmatized by having an abortion (Sachdev, 1993:44). The shame of an unplanned pregnancy can be transferred to the abortion experience, or the feelings may be conflated. Although most women feel some sense of relief, and many women feel a multitude of emotions, some women feel guilt. The guilt can stem from many different places, and does not mean that a woman regrets the decision. For Heidi, she described feeling 'happy' walking out of the first abortion. Iris found that she was not thinking about the abortion very much. For these women, however, there was some guilt:

> *Months later or years later, I had this guilt of actually being happy about it. I guess it wasn't a guilt of feeling happy about it, but it was a guilt of not feeling guilty. I think that's the best way to put it.* (Heidi)

After that week I started feeling kind of guilty because I thought that I should be thinking about it even more than I was. I wasn't thinking about it that much, and I thought, this isn't good. I did this major thing in my life and I'm not even really thinking about it. I was feeling very guilty about not thinking enough about the baby and things like that. (Iris)

These feelings reflect the social expectations around abortion, and the associated stigma. This same feeling was identified by a counsellor in London, England who said: "A number of women have said to me that they feel guilty about not feeling guilty after deciding to have an abortion" (Butcher cited in Claire, 1995:19-20). Others felt guilt for other reasons:

I thought I had made the right choice and I started questioning it, started feeling guilty. Everywhere you go you see and hear propaganda about it. (Fiona)

I don't think of myself as an overly emotional person, but you become one. I mean, there's things I've thought that I never would have thought. When I found out that I had to have a cyst removed from my ovary and I had cervical dysplasia, and I had to go for surgery I thought, 'Oh good. This is what I deserve.' I really felt like I deserved jail time or something. I felt like I needed some form of punishment ... I felt guilty, I thought, 'Something so amazing just happened to me, becoming pregnant. Some people would die for this opportunity and here I'm going, get rid of it.' That really bothered me. (Betsy)

I felt so guilty that I was [happy with the third pregnancy], instead of feeling that tumultuous feeling [that I felt with the first two], I was so excited. Why didn't I feel that way with the other ones? I felt guilt towards them, but [the counsellor] said you have to look at all three differently because they were all different times they were three different pregnancies, they weren't two abortions and a miscarriage ... (Corinne)

Corinne did not want to terminate the pregnancies, particularly the second (which was a miscarriage) and the third. She felt that she did not have control over the decision-making process. Her guilt and 'need to replace' stem from this ambivalence. For

Corinne, there was some guilt, as she did not want to have the abortions, but for the second pregnancy, she questions the decision-making process:

> *I feel guilty about the first one and I feel guilty that I didn't feel enough flip-flopping and changing my mind for the second one. There were condoms that I knew broke easily and I did happen to use those more after the second pregnancy. I wanted to [get pregnant] but I didn't want to be at fault for it.* (Corinne)

This 'contraceptive roulette' is in fact a form of decision-making itself (Currie, 1988). Taking responsibility for a pregnancy, especially in a relationship where the partner may not wish to become a parent, is risky. Some women would rather leave the 'decision' about pregnancy up to 'fate.' This contributed to the ambivalence felt by Corinne when faced with the pregnancies.

Although some of the women in this study expressed feelings of guilt about the unplanned pregnancies and the abortions, Darla talked about feeling guilt and self-blame about the services and doctors she consulted.

> *There was a lot of guilt. Just thinking that I should have gone to another doctor and I should have gone to [the pro-choice clinic] sooner, and I should have gotten information ... I still have a lot of guilt about that, I think, being kind of naive and kind of invincible.* (Darla)

According to Eve, part of the stigma results from the fact that abortions are not uniformly included in health care:

> *At least have it on Medicare. I think right away the stigma would go. There would be no stigma. I think that women would be more aware. People would be more aware. It would be an 'out there' kind of issue, or just not even an issue anymore! You know, like, normalize the situation. Make it part of life and lets on move on.* (Eve)

For some of the women in this study, facing the stigma and keeping their experiences a secret were the most difficult. As Eve suggested, funding abortions in the private clinic might 'normalize' abortions, and take away the stigma. Betsy and Heidi felt uncomfortable with the idea of paying for the abortion.

> *[My partner] said, 'Well, can it be on my Visa? And [he] just felt just horrible. Paying for this. Then she said, 'There's a 15 dollar surcharge is that okay?' [He]'s like, 'Oh my God, a 15 dollar surcharge. Just take my Visa already.' Just take it already and shut up, okay?* (Betsy)

> *It was just like, even when you pay for the abortion, you're paying in front of all the other people that are in the room with you. It's just such a cold feeling* ... (Heidi)

In order to take away some of the stigma surrounding abortion, there needs to be an understanding of women's own experiences as well as granting the procedure more legitimacy by funding clinic abortions. Talking about their secrets provided these women with an opportunity to alleviate some of the stigma.

Talking About Abortion

For most of the women in this study, talking about their experiences was a relief. The stigma and silence force many women to keep these experiences a secret. I asked the women how they felt when talking about abortion. Betsy said:

> *It's legal. It's a legal procedure, and there's so much hush hush about it. None of my family knows. My brother found out by accident. He was looking for a pen in my drawer and he just welcomed himself in my drawer and I had a 'How to deal with abortion' book ... He said, 'I happened to find this' and I said, 'Well, I'm a little careless I guess.' He said, 'Do you want to tell me why you're reading this?' and I broke out into tears and I said, 'Because it's something I did.' Telling more people and talking about it makes you almost feel more relaxed and more at ease with it ... I think one day I actually told*

> *someone at work and I couldn't believe I told them. I was just so casual about it. I said, I'm so sick of hiding it. This is something I did, it's an experience I went through. I think I'm better for it. I'm stronger anyhow, and I said, 'You know, I had an abortion,' and [she said], 'mm-hmm, so? You don't have to justify it.'* (Betsy)

For Fiona, talking about her experience is becoming easier, and helps to take away the guilt. Talking about the abortions helps Corinne to gain some perspective, to reflect:

> *That's what blows my mind. It's hush-hush. More and more, I don't care. I think it helps me deal with it and I don't feel that guilt, that shroud of 'You're evil or you've done the sin of sins.' It's good to talk about it.* (Fiona)

> *[Talking about it] makes you think about it more. I don't think a day goes by that I don't. It makes you analyze more and put your feelings more into perspective, and lay it out better instead of a jumble of thoughts and mixed feelings.* (Corinne)

The stigma and silence of abortion can make the experience of seeking abortion information and services much more difficult than for other procedures. I chose to present this theme last because the stigma attached to abortion underscores how these women feel about their abortion experiences and it is an overarching barrier to access. In fact, the stigma and silence is the most significant barrier encountered by the women in this study.

CHAPTER EIGHT: Discussion and Conclusions

A major premise of this study has been that women are the experts of their own lives, and they define their experiences themselves. Women's stories have been silenced by dominant discourses and the stigma attached to abortion. In this study, women shared their experiences of accessing abortion services in Manitoba. This chapter discusses the women's experiences compared to the dominant discourses, the expansion of a subversive discourse, strategies for change, strengths and limitations of the study, and conclusions.

Although eight of the nine women obtained one or more abortions, their accounts reveal that access is neither unencumbered nor easy. How a woman feels about her abortion experience is directly affected by the information, services, and support that she may or may not receive. Lack of accurate information, lack of support from partners, friends and family members, pressure from others, barriers due to being a minor, waiting periods, financial concerns, attitudes of health care personnel, and the difficulty maintaining privacy are the main barriers to access that were encountered by the women in this study. All of these factors influenced how women interpret the experience of abortion, the barriers they encountered, and the stigma and silence imposed on them - the central themes that guide these analyses.

In order for women's experiences to be privileged, their own definitions and meanings need to be explored. Dominant discourses have defined abortion with little regard for the experiences of the women who have them. The women in this study reflected some of the dominant discourses in their own words. As Weedon (1997)

suggests, dominant ways of thinking exist before we acquire language. Nonetheless, the women in this study defined abortion as a personal choice which should not be hindered by legal, medical, or moral (anti-abortion) barriers. Several of the women in this study felt that abortion should be defined as a medical procedure, and would be 'normalized' if clinic abortions were funded by Medicare. Ryan et al. (1994:205) found, too, that the women and practitioners viewed abortion "as a medical procedure rather than a criminal or moral concern."

The support from partners, family and friends (or lack thereof) is an important element for these women. In fact, less tangible factors such as the support and attitudes of others had more of an effect than systemic barriers on how each woman viewed her experience afterward.

Throughout the interviews, the women expressed the desire to have others understand the abortion experience from the perspective of women who have had (or tried to access) abortions. They felt that politicians, the media, doctors, anti-abortion advocates, and the rest of society need to understand that women themselves must define the abortion experience for themselves.

The women in this study identified numerous barriers to accessing abortion services in Manitoba. The dominant discourses of medicine, law and morality contribute to and sustain these barriers, as does the stigma. The experience of seeking an abortion is a difficult process, and negotiating access can create added stress for women. 'Choice' is a complex concept. Women may have the legal (albeit negative) right to choose to terminate their pregnancies, but their choices are often limited by the

systemic barriers outlined in this and other studies, and by the pressure from and attitudes of persons they consult through the process.

The women in this study spoke loud and clear about the stigma and silence attached to abortion. Feelings of guilt and self-blame were sometimes internalized by these women, and made the experiences much more difficult. The women felt better participating in this study and talking about their experiences. This project is one opportunity for some women to break the silence that so often characterizes abortion.

Ryan et al. (1994) found that the separation of abortion from other forms of health care has contributed to the stigma women experience, and provides little or no incentive to policy and health care providers to create high quality, comprehensive, women-centred reproductive health care. Medical discourse can - but often does not - assist in removing some of the stigma from abortion by recognizing it as a legitimate, funded medical procedure. Abortion is one of many fertility control strategies used by women, and must be accepted as a fundamental aspect of women's health care.

Comparing the Discourses

One of the objectives of this research was to determine if the dominant discourses of law, medicine and morality reflected the needs and concerns of women seeking abortions. Chapters One and Two outlined the way these discourses have constructed abortion. For the women in this study, the dominant discourses are not congruent with their own experiences and understandings of those experiences. The essentialist assumptions of those discourses do not account for the experiences of

individual women. Each woman's story is unique, though they do share common experiences.

All of the women in this study identified themselves as pro-choice. To this extent, their words reflect pro-choice discourse. These women believe that abortion is an individual woman's choice. While there were occasional feelings of ambivalence about the experience of seeking abortion services, and the abortions themselves, these women feel that abortion should be accessible to women as part of their reproductive health services. Dominant discourses often equate 'pro-choice' with 'anti-motherhood.' For these women, this is not the case. Most of the women expressed a desire to pursue motherhood, or already have done so, and nearly all of them found the abortion decision to be a difficult one to have to make. There were several areas where the dominant discourses do not support access to abortion services.

Criminal legal discourses currently do not deprive women of abortion services, as there is currently no law in Canada. The solvent abuse case in Manitoba, which went to the Supreme Court of Canada in 1997, upheld the notion that the foetus does not possess rights. However, there is no law which guarantees safe, funded access to abortion services for Canadian women. The void left by the removal of restrictions on abortion from the *Criminal Code* allows competing discourses to define abortion. This leaves access in a precarious position. For example, the *Health Services Amendment Act* in Manitoba was passed to restrict funding of abortions to hospital facilities only. This legislation denies many women access to abortions at the province's free-standing clinic.

It is not always obvious how discourses create and sustain barriers to access, particularly when there are no legal restrictions placed on access to abortion. Several women in this study commented that abortion is 'legal,' and for that reason it should be accessible to women. This speaks to the influence of legal discourses on social attitudes; that is, the idea that if a practice is legal, it should be socially accepted.

Medical discourses somewhat reflect the needs of women seeking abortions. The Canadian Medical Association's position is that abortion should be accessible to all women. Some hospital boards have granted approval to have the procedure performed in their facilities and abortions are funded in those hospitals. This helps to make abortion accessible. At the same time, abortion is not accessible to all women. Medical discourses operate in concert with legal and moral discourses, and access is sporadic and centralized in Manitoba.

The medical profession currently retains control over abortion. Defining abortion as a medical procedure does make it more accessible, but control is not with the women who have them. The lack of drug-induced abortions means that abortion remains a surgical procedure. While drug-induced abortions would still be under medical supervision, they would grant women more control over the process.

Moral discourses, such as those espoused by anti-abortion advocates, do not reflect the needs and concerns of women seeking abortions. Some of the women in this study reflect the internalization of these discourses, and they are at the root of the guilt and self-blame women may feel after having an abortion. Women should not have to

feel any shame for seeking an abortion. The women in this study expressed their wish to have the stigma removed from abortion - to have it 'normalized.'

The women in this study do not privilege the foetus. Anti-abortion discourses have denied the presence and agency of women, and focused on the foetus and foetal rights instead. Women in other studies have also rejected the anti-abortion position (Ryan et al., 1994; Sachdev, 1993; Bowes, 1990). For the women in this study, abortion is a personal, moral decision in their own lives, but not morally *wrong* as anti-abortion advocates suggest. While some women expressed ambivalence about abortion, and there were feelings of loss and sadness, none of the women in this study regretted having the abortions. These experiences have been integrated into their lives.

The harassment, threats and violence against abortion providers in the name of religion do not reflect the needs and interests of women seeking abortions. The women in this study were steadfastly opposed to attempts by protesters to impose their views and definitions of abortion on others. Further, the language used by anti-abortion advocates did not reflect the views of these women, and in some cases angered them. These women were offended that anti-abortion discourses (and others) claim to understand the abortion experience.

There is an assumption in anti-abortion rhetoric that abortion is traumatic for all women. None of the women in this study define their experiences as 'traumatic,' though Corinne's abortions were both painful and she was admitted to the hospital with complications. She did not want to have the abortions, but did so under pressure, and this contributed to her feelings about those experiences. Despite the abortions being

'awful' for Corinne, she remains steadfastly pro-choice, and does not view abortion negatively. Ryan et al. (1994:198) found:

> The women with whom we spoke demonstrated that there is nothing inherently traumatic about abortion, however, every step of the process of accessing abortion services can be made traumatic by judgemental, or undermining treatment by others, including abortion providers.

In this study, negative feelings following an abortion were more the result of coercion, pressure, or lack of support from others rather than personal feelings toward abortion.

The myths about abortion need to be exposed and debunked. Assumptions about abortion and the women who have them only reinforce the stigma and silence women feel. Women need to be able to 'be honest' about their lives, as Anna said.

What the women in this study have done is to share their experiences of accessing abortion services, and their understandings of those experiences. Throughout the previous three chapters, the women talked about negotiating access to abortion services and some of the dominant constructions of abortion were reflected in what these women had to say. However, an important distinction has been made. The dominant discursive constructions do not privilege the women who have abortions. These discourses rely on totalizing, essentialist notions of 'women' and 'women's experience.' The unique experiences shared by these nine women *resist* (and subvert) those dominant constructions. They are individual constructions by women who have lived the experiences. At the risk of suggesting a 'hierarchy of truths,' the women's constructions of their experiences reflect *both* their experiential subjectivity and that which is discursively constructed - their understandings of those experiences - unlike the dominant discourses. This research shows that these dominant discourses both

create and sustain numerous barriers to access. As such, these discourses impact on both the experiences of the women, and their understandings of those experiences.

As the women in this study revealed, the dominant discourses of law, medicine and morality fail to reflect their needs and concerns with respect to accessing abortion services. Further, those discourses are not uniform in their constructions. As Weedon (1997:135) suggests, "[i]t is the conflict between competing discourses which creates the possibility for new ways of thinking and new forms of subjectivity." In this study, the experiences of these women, and their understandings of them, further point out conflicts and contradictions in the way the dominant discourses frame abortion. The 'space' that is created between the dominant constructions of abortion and the women's own experiences is a form of resistance (Weedon, 1997:109). In sharing their own experiences, these women are expanding the discourse of personal experiences of abortion.

Expanding the Discourse

> Reverse discourse enables the subjected [subverted] subject of a discourse to speak in her own right. (Weedon, 1997:106)

Feminist poststructuralism offers a theoretical framework which examines discourse as a form of power. Dominant discourses struggle to assign meaning to a particular phenomenon, and the struggle shifts over time. Abortion has been defined in legal, medical and moral (anti-abortion) discourses with little regard to the experiences of the women who have abortions. Access to abortion is contingent on a host of factors, particularly the power of law, medicine and morality. I felt that it was

important to explore how these discourses have defined abortion to illustrate the ways they create and sustain barriers to access. The voices of women who have accessed (or attempted to access) abortion services are rarely heard. This study provided an opportunity for the creation of a subversive discourse - *their own*. At times, the dominant discourses were reflected in the words of the women in this study. This was to be expected. We are not immune to the power of these discourses. Subjectivities are the effects of discourses (Weedon, 1997). Moreover, the exposure of these discourses and their attempts to define women's experiences for them offers a point of resistance. As Foucault (1978:101) suggests, discourse transmits and reinforces power, "but it also undermines it and exposes it, renders it fragile and makes it possible to thwart it."

Weedon (1997) suggests that resistance and change at the individual level is the beginning of the creation of reverse (subversive) discourse. How much 'change' is achieved depends on the "wider context of social interests" (Weedon, 1997:108). Feminist poststructuralist theory privileges women's active resistance to the power of patriarchy and its social construction (Gavey, 1989). Resistance to dominant discourses often takes "brave actions" (Weedon, 1997:108), and the way the women in this study spoke out about their experiences is very brave. The stigma and silence attached to abortion may be the most significant barriers to overcome in resisting dominant discourses.

The purpose of this research was to explore the experience of seeking an abortion in Manitoba. There has been little opportunity for women who have sought or

had abortions to speak up and define those experiences. As well as providing these women with a forum to express their views, I hoped that participating in the research would assist them in other, more personal ways. I asked each woman why she wanted to participate in the study. Some of the women said that they felt better talking about their experiences:

> *Well, it feels good ... to have it acknowledged. It's not a secret [anymore]. Someone's saying, 'Hey, this exists. If you've had one come talk to me. I want to share your experience.' And it feels good knowing I can talk about it ... Day to day I don't talk about it, and I try not to think about it too much. It's not some terrible sensitive thing where I'm going to break out in tears. I was like that. I'm not anymore, I've come to a different level of dealing with it. It's good to talk about it. It feels good knowing that I carry around this big secret and somebody else knows about it.* (Betsy)

> *It feels better to talk about it. Like I said before, we should have a voice instead of everyone else who has no idea what's going on. And it's kind of a purging thing, and not being judged. When you talk about it to your friends and they just want to console you ... you want to say, 'I'm not looking to be consoled anymore.'* (Corinne)

> *I think it's helping me deal with it when I talk about it ... Maybe it's selfishly just to make myself feel better ... if nothing else helping someone else, you know?* (Fiona)

The silence and stigma attached to abortion make it difficult to talk about it. All of the women in this study were very aware of the stigma. For Anna, she wanted people to know that women in their thirties who are married are sometimes faced with the same decisions as younger, single women, and that abortions - women taking control of their own reproduction - are 'everyday occurrences.'

> *I thought, 'Well, you're doing some really good work.' I don't really feel like I need to tell a story or anything, so it's not therapeutic for me to talk about it, but it's something I don't mind sharing ... Even I feel a sense [that] it would be great if we could all just be honest about our lives ...* (Anna)

Not only did these women feel better talking about their experiences of accessing abortion services for this study, but they wanted to share their experiences with others. This desire to expand their own discourses is another step toward subverting dominant constructions of abortion. Heidi and Eve both spoke of choosing to participate in this research to educate others about abortion. Darla, too, still upset by the fact that she was not given accurate information when she was seeking an abortion, hoped that her participation would help.

> *Anything that can educate women, anything that can give them information. And giving that human element to a situation that is so technical ...* (Eve)

> *I think that's one of the reasons why I figured, 'Okay, I'll go to this study just for education purposes' ... I feel, in society, that there's a lot of difficulty talking about the subject. People still need to be informed and that information needs to be out there. Not that I wanted to come here and share my experience or whatever, it was more to give information to other people. And if it helps in some way then hopefully the system will change [for] minors accessing it, and people geographically. I hope in some way that this will educate others in society to open their minds a little bit to what the topic is about. Not what they think, but personal experiences.* (Heidi)

> *Well, before, I think it didn't really bother me. I think because I was so busy after I decided to continue with the pregnancy. But after a couple of years, I sat down and thought about all these things and all these discrepancies. I remembered back and tried to piece together moments in time and remembered the doctor saying this to me, and it just made me really angry. It still makes me angry ... I think it [the ad for the study] just sort of sounded like me ... I thought well, maybe some good can come out of it. I thought I wasn't going to [participate]. I just kind of skipped over [the ad] until I saw 'even if you did not [have an abortion].'* (Darla)

Iris said that she felt good helping out with the research, and that she, too, had something to offer by sharing her experience.

> *I felt that I was well-informed, but I'm sure there's a lot of people who aren't, and there's people who have gone through bad experiences with trying to find*

information, or having the procedure. [I] might as well help out with what I thought was good for me. (Iris)

The nine women who participated in this research shared their deeply personal experiences of seeking an abortion. Through their words, they defined their experiences for themselves and shared their meanings, they broke through some of the silence and stigma, and told what it was like for them to go through the process of accessing information and services. In their wisdom, they offered insights into their own experiences, and suggestions to improve access to abortion services in Manitoba.

Strategies for Change

The nine women in this study learned a great deal from their experiences and are indeed the experts of those experiences. They cannot speak for all women who have sought abortion services in Manitoba, but they were able to offer suggestions for improving access.

I think doctors could be, regardless of what their religious or what their beliefs are, I think [my doctor] should have gone through some things with me. You know, [he could have said], 'Well, okay, I know this is a big shock, but these are your options. These are the things you can do. Think about all of them. This is what happens with this one.' [He could have given me] a booklet of some sort and just [said], 'Read this on your own time, [ask me] any questions.' That should have been [done]... He should have assessed more what my ideas were on how to handle the situation, and not let me listen to this heartbeat. (Betsy)

I wish that we would have maybe two or three clinics. Even two or three more women's health clinics so that information is more readily available ... [T]here's more access even that way ... (Darla)

I don't want to say promotion or advertising, but there needs to be some means for women to get the information ... [W]hether it's ads or, I don't know ... So many women finally get to [a pro-choice] clinic after being dicked around ...

but there's got to be some better way for women, out of the [pro-choice] movement, to find out. (Anna)

And the [Inter]net now, too. There's always that option. Yeah, I would [look for information there]. If right now, [another unplanned pregnancy] happened to me, I'd probably put it into the net. 'Abortion services'... Because when you think about it, that's a great anonymous way to find out something, you don't have to talk to anyone. (Fiona)

A common suggestion was to extend health care funding to the private clinic:

Put them [abortions] on Medicare. There's no reason why [the private clinic] should be charging. The only reason they're charging is their overhead is so high. They've got stuff to do ... they have to keep going ... [Some people say], 'Look at this, they're just making money off of abortions.' I highly doubt that, and if they just put it on Medicare [it would be easier] ... (Eve)

I think if [the private clinic] was funded, I don't think we'd need more than one clinic, because more people would go [to the private clinic] ... It wouldn't be such a long waiting time. (Darla)

It's the same procedure that's being done at the [private clinic] as [at the hospital]. They are just doctors as well as the doctors [at hospitals]. If that's the case, then I think both places should be paid for. And I think you should have the choice, as to where you want to go. I don't think the government should be making that choice for you then. (Heidi)

[I would like to see] therapeutic abortions ... covered under Medicare, even in private clinics, like they should be. (Gloria)

The nine women interviewed for this study all sought abortions in Winnipeg. However, some were aware of the situation in rural and northern areas of the province and commented on how access could be improved:

I think probably [access could be improved] geographically. I mean, I think basically in Manitoba it's just Winnipeg that people can go to [have an abortion] ... Geographically, it was okay for me, but I think in other situations [for rural women] it could really create a problem, especially financially. (Heidi)

If it was mandatory, if the provincial government passed some sort of legislation saying that every community that has a large general hospital, like for example,

Dauphin, I wouldn't expect small communities like Ste. Rose or McCreary, or Grandview that have small hospitals, but, you know, larger towns like Dauphin, or Brandon, or Thompson, or Flin Flon ... [should do] abortions, or [ensure that] abortions are allowed. And that they hire those people to work in those facilities, to make sure they are pro-choice and to make sure they are going to be supportive. (Gloria)

.... [I]f you put it in Brandon, then what about Thompson? What about Lynn Lake? I don't know how expensive it is. I don't know what the hospitals are like out there. If there's hospitals out there, yes they should be doing them at the hospitals ... because it's a medical procedure. (Corinne)

Change begins with ideas. I asked the women who they would take their ideas to. Gloria, Iris, Fiona and Darla said they would talk to a Minister of Health.

I guess maybe the Health Minister. And I would just remind him about [the] need for rural women [to have access], and rural women have different issues from urban women in regards to this, like transportation, the lack of an income, or the lack of money to access this. (Gloria)

I guess probably some sort of Minister of Health. First, I'll say who I'd talk to, those people at that horrible [anti-abortion] clinic [laugh]. I don't think they realize how they're not helping the situation. So that's probably what I'd just say [to them] ... But, the funding .... [Abortion] has to be more accessible ... or just [distributing] propaganda or something, or just the knowledge, get it out there to people. We don't want to advocate it, but just so it's there and the option's there, and people aren't waiting [to access these services] ... It gets more dangerous, I'm sure, as you get farther along [in a pregnancy]... (Fiona)

Probably the Minister of Health for the province, and for the federal government. Just to kind of compare the province's access ... There's only one other province that doesn't have a funded [private] clinic. I just don't really understand the logic there. (Darla)

These women felt that access might be improved if they could convince the Minister of Health to consider the need for funding, and to provide access across the province. Betsy did not have any comments about improving access, but said that she would talk to someone in the private clinic about the counselling process, which still bothers her. Heidi said that she would talk to another woman faced with an unplanned pregnancy

and provide her with information and resources that she knows about now. When asked who she would like to talk to, Eve did not have any one person in mind:

> *My issue wouldn't be with anybody in a higher standing. My issue wouldn't be with somebody who is considered able to change the way things are. I'm a very down-up person. I think that change comes from down as opposed to up, so if I had five minutes to gather a million women in a room [I'd] tell them, you know? Educate them. Quickly in five minutes, let them know what has to be done, what's going on, what can be done. I'm a big believer in power from the bottom up, not from the top down. So my five minutes would have me be with just women. Trying to get as many women as I can to change it [access] ... I think that it's the people who are doing it or living it, I think they have the power and they have the will to change it better than anyone else.* (Eve)

Empowering women, those most affected by access (or lack of) to abortion services, would do more to change the situation for Eve.

Corinne's response captures her desire to have women's discourses and experiences acknowledged, rather than being defined by others:

> *I'm so tired though of hearing about abortion from a medical standpoint and tired of hearing about abortions from a pro-life standpoint, and [the idea that] it's such a dirty word. I'd just like to put it out in the open. I guess I would talk to the media ... I feel awful about [the fact that I've had the abortions], and I didn't have to do it, but I don't feel as though I should have to keep it a secret. I'd probably talk to, I don't know, Ted Koppel. What would I say? Someone listen to us instead of everyone else ... Pro-lifers, medical, political, government, all that kind of stuff. Doctors that perform them. When is the last time a doctor had one, you know?* (Corinne)

A potential strategy for expanding this subversive discourse is to identify and form alliances with persons and groups in the community who are committed to improving access to abortion. From a policy perspective, physicians and others in the health care profession who support access can advocate for change. Pro-choice legal advocates could also assist in improving access. Sharing these women's experiences with organizations committed to access, such as the Canadian Abortion Rights Action

League, would increase lobbying power and help to further expand this subversive discourse. Most importantly, at a grassroots level, the words of these women (and others who share their experiences) should be shared with women who wish to help other women (pro-choice counsellors, service providers, and fellow advocates).

The stigma surrounding abortion and the standpoints of other dominant discourses have overshadowed the experiences of the women who have had (or tried to obtain) an abortion. Corinne stated that she felt 'awful' having to keep her abortions a secret. Other women in this study expressed similar sentiments. The stigma attached to abortion makes it very difficult for women to talk about those experiences, and that silence is perpetuated by other discourses. The women in this study hoped that this research would inform others about their experiences accessing abortion services in Manitoba, and what steps can be taken to initiate change.

Strengths and Limitations of the Study

It is important to discuss the strengths and weaknesses of this research. Perhaps one of the strongest points is that the voices of the women are given priority. This was possible through the use of qualitative research methods. The depth of the interviews for this study provides a more rounded understanding of women's experiences accessing abortion services than a survey. Surveys are useful to capture a larger, albeit surface, picture of a particular experience. Satisfaction surveys which ask clients to evaluate the service they received do provide important information with respect to service delivery, but nuances such as those expressed by the women in this and other

qualitative studies are minimal. In order to assess what is needed to improve access to abortion services in Manitoba, the voices and stories of women were needed. Despite the small sample of women in this study, they offer detailed, informative accounts of their experiences.

The sample size in this study is small and very limited in generalizability. The scope of this research and the difficulty in sampling has contributed to this. The generalizability of these findings are also limited by the process of self-selection. Attempts were made to attract a broad cross-section of women in Manitoba, but a self-selected, non-probability sample does not permit one to choose participants.

The voices of women from different ethnic backgrounds, particularly Aboriginal women, are missing from this study. Their experiences would have greatly enhanced the research. Some Aboriginal women may feel differently about abortion for personal and/or cultural reasons, and the feminist perspective which informs this study may not reflect their own views (as may be the case with many women). Advertisements were posted at several Aboriginal women's agencies and student centres, and a presentation was done at one agency, but with no response. Immigrant women's experiences are also missing, and would have illuminated the unique barriers faced by women from other countries, and the cultural and linguistic challenges faced in a new country, but no immigrant women responded to advertisements for this study. The experiences of women of different abilities are also absent from this study.

Another limitation is the fact that all of the women who participated in this study have some post-secondary education. At the time of their abortions, most of the

women had completed some post-secondary education, and as a result, these woman may have had more resources and skills at their disposal when seeking information and abortion services.

It was more difficult than anticipated to sample women who had travelled from rural and northern Manitoba to Winnipeg for the procedure. Two sets of ads were aimed at this group of women. When there was no response with the first ad (Appendix C), a second was circulated, in which the heading was changed from "volunteers needed" to "access to abortion" (Appendix D). Women who responded to the original ad in the fall/winter 1996/97 (Appendix B) noted that the word "abortion" in the heading was what caught their attention (one agency in northern Manitoba agreed to post the original ad for two weeks on the condition that the bold heading with the word "abortion" be removed). Extra effort went into posting the advertisements at university residences which house students from outside the city of Winnipeg. Identifying women who had to travel from rural or northern Manitoba may be more difficult as many of these women may still reside in their home communities.

My own views on abortion have influenced this research. I am pro-choice and this was a significant factor in my decision to pursue this study. This is an issue that I have felt strongly about for quite some time. Research done by humans will invariably have some degree of bias, stated or otherwise. In keeping with a feminist qualitative methodology, I did not hide my views from the women who participated in this study. I engaged in focused conversations with the women, but listened to their experiences as they wished them to be told. They are the experts of their own lives. Their views

occasionally encouraged me to further re-examine my own feelings about abortion. Further, I have a greater understanding of the complexities of unplanned pregnancies and the process of negotiating access to abortion services in Manitoba. I will do what I can to share the women's views with others.

Notwithstanding the limitations of this study, the experiences of the women interviewed provide both common and diverse experiences of accessing abortion services in Manitoba. Both the free-standing clinic and public hospital experiences are reflected in these interviews. One woman was a minor and high school student when she sought abortion services. Three women had undergone more than one abortion procedure. Three women had experienced a miscarriage as well as having one or more abortions. Six women were living with parents at the time they sought abortion services. One woman attempted to access an abortion, but continued with the pregnancy after facing numerous barriers. The support from partners, family members and friends were varied and had a significant impact on each woman's experience.

This study is unique for several reasons. To date, it is the first qualitative study in Manitoba to explore women's experiences in accessing abortion services. Their views on abortion and the services they encountered offer valuable information on how access can be improved in the province. Studies which have explored barriers to access (Ryan et al., 1994; Bowes, 1990) have conducted their research in a climate where there are criminal restrictions placed on abortion - one of the most obvious barriers. By exploring access at a time when abortion is *not* illegal, more insidious (yet powerful) barriers emerge.

Most of the barriers identified by the women in this study have been identified in other studies (Peterman, 1996; Ryan et al., 1994; Sachdev, 1993; Bowes, 1990), but the lack of information and the proliferation of misinformation about abortion and abortion services are significant barriers which need more attention. This study explores this area in-depth. Further, the stigma and silence attached to abortion have been explored to a degree in other studies, but this theme was so pronounced in the interviews that I felt it warranted lengthy discussion. This may be the most under-acknowledged barrier to accessing abortion services. It can be argued that the stigma surrounding abortion underscores most, if not all, of the other barriers. Other studies have explored the experiences of women who have had multiple abortions, but rarely as in-depth as this study. The complex issues of sexuality and relationships are very closely tied to the women's reproductive decision-making. As well, despite the small sample size, the experiences and backgrounds of the women in this study were quite diverse.

Future research into women's experiences accessing abortion services should explore the views of Aboriginal women and women of colour. Further, in-depth interviews with women living in areas where there is no access to abortion would prove invaluable. Research in provinces where these issues have not been explored is also needed. Prince Edward Island has no facility which performs abortions, so women must leave the island for the procedure. Interviews with providers and other health care personnel in Manitoba would reveal how the dominant discourses operate from

their perspective. Revealing how these discourses operate, in many contexts, is another step toward challenging their power.

Conclusions

The heartfelt honesty and openness of the women who agreed to be interviewed for this study provide insights into experiences that are rarely talked about. As the title of this study suggests, dominant discourses have been 'subverting women' by not privileging their experiences of accessing abortion services in Manitoba. Also, the women in this study can be 'subverting women' in that they challenge dominant constructions of abortion which do not reflect the realities of their own lives.

How does this research contribute to social change? Sharing the experiences of the women who participated is one step toward removing the silence and stigma which clouds this issue, and is a way of sharing with other women who may not have much opportunity to discuss these deeply personal experiences. Further, this research offers alternative perspectives to the dominant discourses - a subversive discourse. New ways of understanding the abortion experience have been revealed, from the experts themselves. These stories are an asset to the literature on women's experiences accessing abortion services.

This research can facilitate social change in other ways. Dispelling the myths and assumptions about abortion helps diffuse their power. Accurate information on abortion services should be made available to girls and women. Schools should ensure

that guidance counsellors and family life classes educate students on safer sex, birth control, and options that are available in the event of an unplanned pregnancy.

Medical and nursing students should be educated about the abortion procedure. Ryan et al. (1994:205) state that optional training further stigmatizes abortion as 'immoral' for those who choose not to provide them. No physician can be forced to perform the procedure, but the training should be incorporated into the curriculum.

Health care personnel should be educated and sensitized to the circumstances of women seeking abortions, regardless of their beliefs and personal opinions. Further, if an individual is personally unable to assist a client seeking abortion services, then an adequate referral and information process should be utilized. Too often women encounter health care personnel who fail to offer this information because of their personal opposition to abortion, or lack of awareness about the client's needs. What happened to Darla should not happen to others.

Safety measures for providers need to be ensured. Harassment, threats and violence against providers may deter some physicians from providing abortion services. Particularly while the procedure remains a surgical one, doctors should be given incentives to provide this necessary service.

Abortion should be a publicly funded procedure, regardless of the facility, and should be available to women in rural and northern areas. Safely administered medical abortions should be available to women with early pregnancies. These measures will decrease the waiting period for abortions, help to make the procedure more accessible to women, and normalize abortion.

Most importantly, society needs to begin to understand that women will continue to define their own reproductive lives. Worldwide, an estimated 20 million women risk their lives, and about eighty thousand die annually from illegal, unsafe abortions ("Unsafe," 1998). Abortion will continue to be used to control fertility here and around the world, and measures need to be in place to ensure that the procedure is safe, legal, and accessible. Perhaps, as Eve suggested, change can occur from the bottom up. While we can hope that politicians, clergy, and the medical profession will begin to shift their thinking, women themselves can share their own views without shame, and expand the discourse. In doing so, more voices emerge to challenge the assumptions and discourses of others who claim to 'speak' for this group of women. As Weedon (1997:168) notes, "power is invested in and exercised through [those] who speak."

BIBLIOGRAPHY

Ainlay, Stephen C., Gaylene Becker and Lerita M. Coleman (eds.) (1986). *The Dilemma of Difference: A Multidisciplinary View of Stigma*. New York: Plenum Press.

Alberta Report, 5 December, 1994.

Alcoff, Linda and Elizabeth Potter (eds.) (1993). *Feminist Epistemologies*. London: Routledge.

Armsworth, M. (1991). "Psychological Response to Abortion," *Journal of Counselling and Development*, 69(4): 377-79.

Army of God (1992). *99 Covert Ways to Stop Abortion*.

Ashton, John (1980a). "Experiences of Women Refused National Health Service Abortion," *Journal of Biosocial Science*, 12(2): 201-210.

Ashton, John (1980b). "Patterns of Discussion and Decision-Making Amongst Abortion Patients," *Journal of Biosocial Science*, 12(3): 247-260.

B'Nai Brith Canada (1994). "The Extreme Right: International Peace and Security at Risk." Unpublished manuscript.

Bagley, Gordon (1992). "Bombing of Toronto Abortion Clinic Raises Stakes in Bitter Debate," *Canadian Medical Association Journal*, 147(10): 1528-1533.

Bart, Pauline (1987). "Seizing the Means of Reproduction: An Illegal Feminist Abortion Collective - How and Why it Worked," *Qualitative Sociology*, 10(4): 339-357.

Becker, Howard (1963). *Outsiders: Studies in the Sociology of Deviance*. New York: The Free Press.

Bonavaglia, Angela (1991). *The Choices We Made: Twenty-five Women and Men Speak out About Abortion*. New York: Random House.

Bowes, Nancy (1990). *Telling Our Secrets: Abortion Stories from Nova Scotia*. Halifax: Canadian Abortion Rights Action League (CARAL).

Breckenbridge, Joan (1995). "The Last Gasp?" *Globe and Mail*, 28 January.

Brodie, Janine (1992). "Choice and No Choice in the House," in Brodie, Gavigan and Jenson (eds.) *The Politics of Abortion*. Toronto: Oxford University Press, pp. 57-116.

Brodie, Janine, Shelley A.M. Gavigan and Jane Jenson (1992). *The Politics of Abortion*. Toronto: Oxford University Press.

Canada. Statistics Canada (1997). *Therapeutic Abortions*. Ottawa: Minister of Supply and Services.

Canadian Medical Association (1988). *Policy Summary: Induced Abortion.*

Canadian Abortion Rights Action League (CARAL) (1997). *Factum of the Intervener, The Canadian Abortion Rights Action League (CARAL).*

Chisholm, Patricia (1996). "Does a Fetus Have Rights?" *Maclean's*, 19 August.

Claire, Miriam (1995). *The Abortion Dilemma: Personal Views on a Public Issue*. New York: Plenum Press.

Coeytaux, F.M., A.H. Leonard and C.M. Bloomer (1993). "Abortion," in M. Koblinsky, J. Timyan and J. Gay (eds.), *The Health of Women: A Global Perspective*. San Francisco: Westview Press.

Colker, Ruth (1994). *Pregnant Men*. Indianapolis: Indiana University Press.

Comack, Elizabeth (forthcoming). "Producing Feminist Knowledge: Lessons from Women in Trouble," *Theoretical Criminology*.

Comack, Elizabeth (1998). "Do We Need to Syndromize Women's Experiences?: The Limitations of the 'Battered Woman Syndrome,'" in K. Bonnycastle and G. Rigakos (eds.), *Unsettling Truths: Battered Women, Policy, Politics, and Contemporary Research in Canada*. Vancouver: Collective Press.

Cossman, Brenda (1986). "The Precarious Unity of Feminist Theory and Practice: The Praxis of Abortion," *University of Toronto Law Review*, 44(1): 85-108.

Currie, Dawn (1992). "Abortion Law Reform: A pendulum that swings one way," in D. Currie and Brian D. MacLean, *Rethinking the Administration of Justice*. Halifax: Fernwood Publishing, pp. 65-80.

Currie, Dawn (1991). "Feminist Encounters with Postmodernism: Exploring the Impasse of Debates on Patriarchy and Law," *Canadian Journal of Women and the Law*, 5: 63-86.

Currie, Dawn (1988). "Re-thinking What We Do and How We Do It: A Study of Reproductive Decisions," *Canadian Review of Sociology and Anthropology*, 25(2): 231-253.

Dagg, P. (1990). "The Psychological Sequelae of Therapeutic Abortion - Denied and Completed," *American Journal of Psychiatry*, 148(5): 578-85.

Dauphin Regional Health Centre (1995). *Therapeutic Abortion Guidelines*.

Denzin, Norman K. and Yvonna S. Lincoln (eds.) (1994). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications.

Diamond, Irene and Lee Quinby (eds.) (1988). *Feminism & Foucault: Reflections on Resistance*. Boston: Northeastern University Press.

Dresser, Rebecca S. (1994). "Freedom of Conscience, Professional Responsibility, and Access to Abortion," *The Journal of Law, Medicine & Ethics*, 22(3): 280-285.

Dunphy, Catherine (1996). *Morgentaler: A Difficult Hero*. Toronto: Random House of Canada Limited.

Edmiston, Susan (1990). "Here Come the Pregnancy Police," *Glamour*, (August): 202-205, 263-266.

Ferris, Lorraine E. and Margo McMain-Klein (1995). "Small-area Variations in Utilization of Abortion Services in Ontario from 1985 to 1992," *Canadian Medical Association Journal*, 152(11): 1801-1807.

Foucault, Michel (1978). *The History of Sexuality: Volume 1*. New York: Pantheon Books.

Gavey, Nicola (1989). "Feminist Poststructuralism and Discourse Analysis," *Psychology of Women Quarterly*, 13: 459-475.

Gavigan, Shelley A. M. (1992). "Beyond *Morgentaler*: The Legal Regulation of Reproduction," in Brodie, Gavigan and Jenson (eds.) *The Politics of Abortion*. Toronto: Oxford University Press, pp. 117-146.

Gavigan, Shelley (1984). "The Criminal Sanction as it Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion," *Journal of Legal History*, 4: 20-41.

Gerber-Fried, Marlene (ed.) (1990). *From Abortion to Reproductive Freedom: Transforming a Movement*. Boston: South End Press.

Gibbons, Frederick X. (1986). "Stigma and Interpersonal Relationships," in Ainlay et al. (eds.) *The Dilemma of Difference: A Multidisciplinary View of Stigma*. New York: Plenum Press, pp. 123-144.

Gilligan, Carol (1982). *In A Different Voice*. Cambridge: Harvard University Press.

Ginsburg, Faye D. (1989). *Contested Lives: The Abortion Debate in an American Community*. Berkeley: University of California Press.

Gold-Steinberg, Sharon (1994). "Personal Choices in Political Climates: Coping with Legal and Illegal Abortion," in Carol E. Franz and Abigail J. Stewart (eds.), *Women Creating Lives: Identities, Resilience and Resistance*. Boulder: Westview Press.

Gordon, C. (1980). *Michel Foucault: Power/Knowledge*. Brighton: Harvester Press.

Greenglass, E. (1981). "A Canadian Study of Psychological Adjustment After Abortion," in P. Sachdev (ed.), *Abortion: Readings and Research*, Toronto: Butterworths, pp. 76-90.

Greschner, Donna (1990). "Abortion and Democracy for Women: A Critique of *Tremblay v. Daigle*," *McGill Law Journal*, 35: 634-670.

Grindstaff, Laura (1994). "Abortion and the Popular Press: Mapping Media Discourse from *Roe* to *Webster*," in Jelen and Chandler (eds.) *Abortion Politics in the United States and Canada: Studies in Public Opinion*. Westport, CT: Praeger Publishers, pp. 57-88.

Grosz, Elizabeth (1993). "Bodies and Knowledges: Feminism and the Crisis of Reason," in Alcoff and Potter (eds.) *Feminist Epistemologies*. London: Routledge, pp. 187-216.

Harvey, S. Marie, Linda J. Beckman, Mary Ann Castle and Francine Coeytaux (1995). "Knowledge and Perceptions of Medical Abortion Among Potential Users," *Family Planning Perspectives*, 27(5): 203-207.

Henshaw, Stanley K. (1995). "Factors Hindering Access to Abortion Services," *Family Planning Perspectives*, 27(2): 54-59.

Hook, K. (1963). "Refused Abortions: A Follow-up Study of 249 Women Whose Applications Were Refused by the National Health Board in Sweden," *Acta Psychiatrica Scandanavia*, 39, supplement 168.

Hopkins, Nick, Steve Reicher and Jannat Saleem (1996). "Constructing Women's Psychological Health in Anti-Abortion Rhetoric," *Sociological Review*, 44(3): 539-564.

Huberman, Michael A. and Matthew B. Miles (1994). "Data Management and Analysis Methods," in Denzin and Lincoln (eds.) *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications, pp. 428-444.

Hunter, James Davison (1994). *Before the Shooting Begins: Searching for Democracy in America's Culture War.* New York: The Free Press.

Hutchison, Penelope (1997). "A Feminist Approach to Post-Abortion Counselling," *Herizons*, (Summer): 23-24.

Imber, Jonathan (1986). *Abortion and the Private Practice of Medicine*. New Haven: Yale University Press.

Jackman, Martha (1993). "The Canadian Charter as a Barrier to Unwanted Medical Treatment of Pregnant Women in the Interests of the Foetus," *Health Law in Canada*, 14(2): 49-58.

Jacobson, J.L. (1990). *The Global Politics of Abortion*. Washington: World Watch Institute.

Jansson, B. (1965). "Mental Disorders After Abortion," *Acta Psychiatrica Scandanavia*, 41: 87-110.

Jelen, Ted. G. and Marthe A. Chandler (eds.) (1994). *Abortion Politics in the United States and Canada: Studies in Public Opinion*. Westport, CT: Praeger Publishers.

Jenson, Jane (1992). "Getting to *Morgentaler*: From one representation to another," in Brodie, Gavigan and Jenson (eds.) *The Politics of Abortion*. Toronto: Oxford University Press, pp. 15-56.

Jones, Deborah (1996). "Guns and Money: The New Abortion Wars," *Chatelaine* (May).

Kellough, Gail (1996). *Aborting Law: An Exploration of the Politics of Motherhood and Medicine*. Toronto: University of Toronto Press.

Kellough, Darlene G. (1992). "Pro-choice Politics and Postmodern Theory," in William Carroll (ed.), *Organizing Dissent: Contemporary Social Movements in Theory and Practice*. Toronto: Garamond Press, pp. 81-100.

Klinkenborg, Verlyn (1995). "Violent Uncertainties," *Harper's* (January), pp. 37-52.

Korcok, Milan (1995). "Physicians Targeted as Abortion Debate in US Turns Violent," *Canadian Medical Association Journal*, 152(5): 727-730.

Lamanna, Mary Ann (1991). "Who Makes the Abortion Decision?: Law, Practice, and the Limits of the Liberal Solution," in Dorothy C. Wertz (ed.), *Research in the Sociology of Health Care*, 9(2): 9-20.

Lamanna, Mary Ann and Nancy Langworthy (1989). "Talking to Teens: A New Understanding of Adolescent Women's Sexual and Reproductive Decision-making," Paper presented at the annual meeting of the National Council on Family Relations, New Orleans, 7 November.

Law Reform Commission of Canada (1989). *Crimes Against the Foetus* (Working Paper #58).

LeBourdais, Eleanor (1995). "Potential for Violence Causing Fear Among Canadian Doctors Who Perform Abortions," *Canadian Medical Association Journal*, 152(6): 927-932.

Luker, Kristin (1984). *Abortion and the Politics of Motherhood*. Berkeley, CA: University of California Press.

MacGuigan, Mark (1994). *Abortion, Conscience & Democracy*. Toronto: Hounslow Press.

Martin, Michel (1992). "Canadians' Access to Abortion Still Limited, Activists Argue," *Canadian Medical Association Journal*, 15 August, 147(4): 497-499.

Martin, Sheila (1989). "Using the Courts to Stop Abortion by Injunction: *Mock v. Brandanburg*," *Canadian Journal of Women and the Law*, 3(2): 569-583.

McConnell, Moira L. (1994). "Abortion - Provincial Legislation - Control Over Health Care: *R. v. Morgentaler*," *The Canadian Bar Review*, 73: 417-430.

McConnell, Moira (1989). "Capricious, Whimsical and Aborting Women: Abortion as a Medical Criminal Issue (Again)," *Canadian Journal of Women and the Law*, 3(2): 661-666.

McConnell, Moira and Lorenne Clark (1991). "Abortion Law in Canada: A Matter of National Concern," *The Dalhousie Law Journal*, 14: 81-89.

Millar, Wayne J., Surinder Wadhera and Stanley K. Henshaw (1997). "Repeat Abortions in Canada," *Family Planning Perspectives*, 29(1): 20-24.

Miller, Fiona (1996). "The Legal Intervention in Winnipeg is Wrong," *The Globe and Mail*, 8 August.

Morton, F.L. (1992). *Pro-choice vs. Pro-life: Abortion and the Courts in Canada*. Norman: University of Oklahoma Press.

Mullen, Michelle A., Barbara Slater and Raisa Debber (1994). "Politics, Principles and a Pill: Public Policy, Ethics and RU486," *Health Law in Canada*, 14(3): 63-68.

Naffine, Ngaire (1987). *Female Crime: The construction of women in criminology*. Sydney: Allen & Unwin.

Noonan, Sheila (1989). "Protection of the Foetus: Denial of the Woman," *Canadian Journal of Women and the Law*, 3(2): 667-672.

Oakley, Ann (1981). "Interviewing Women: A Contradiction in Terms," in H. Roberts (ed.), *Doing Feminist Research*. London: Routledge and Kegan Paul Inc., pp. 30-61.

Olesen, Virginia (1994). "Feminisms and Models of Qualitative Research," in Denzin and Lincoln (eds.) *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications, pp. 158-174.

Ontario Coalition for Abortion Clinics (1988). "State Power and the Struggle for Reproductive Freedom: The Campaign for Free-standing Abortion Clinics in Ontario," *Resources for Feminist Research*, 17(3): 109-114.

Osofsky, J and H. Osofsky (1972). "The Psychological Reaction of Patients to Legalized Abortion," *American Journal of Orthopsychiatry*, 42 (January): 48-60.

O'Reilly, Michael (1992). "When the protest comes home: Ontario doctor latest victim of anti-abortion picketing tactic," *Canadian Medical Association Journal*, 147(10): 1526-1528.

Petchesky, Rosalind Pollack (1987). "Fetal Images: The Power of Visual Culture in Politics and Reproduction," *Feminist Studies*, 13(2): 263-289.

Peterman, Jean P. (1996). *Telling Their Stories: Puerto Rican Women and Abortion*. Boulder, CO: Westview Press.

Peterman, Jean (1990). "The Abortion Decision: Women Tell Their Stories," unpublished master's paper, Department of Sociology, University of Illinois at Chicago.

Petersen, Kerry A. (1993). *Abortion Regimes*. Brookfield, Vermont: Dartmouth Publishing Company.

Petrillo, Lisa (1993). "Selling Babies is a Big Business for Bogus Abortion Clinics," *Ms.* (September/October): 92-94.

Planned Parenthood Manitoba, Inc. (1990). "Barriers to Accessing Health Services."

Powell, Marion G. (1997). "Ensuring Access to Abortion in an Era of Cutbacks," *Canadian Medical Association Journal*, 156: 1545-47.

Punnett, Laura (1990). "The Politics of Menstrual Extraction," in Gerber-Fried (ed.) *From Abortion to Reproductive Freedom: Transforming a Movement*. Boston: South End Press, pp. 101-112.

Ristock, Janice L. and Joan Pennell (1996). *Community Research as Empowerment: Feminist Links, Postmodern Interruptions*. Toronto: Oxford University Press.

Rodman, Hyman, Betty Sarvis, and Joy Bonar (1987). *The Abortion Question.* New York: Columbia University Press.

Rubin, Beth (1997). "Forced Fetal Rights are Wrong," *Winnipeg Free Press*, 1 February.

Ryan, Lyndall, Margie Ripper and Barbara Buttfield (1994). *We Women Decide: Women's Experience of Seeking Abortion in Queensland, South Australia and Tasmania 1985-1992*. Women's Studies Unit, Faculty of Social Sciences, Flinders University.

Sachdev, Paul (1993). *Sex, Abortion and Unmarried Women*. Westport, CN: Greenwood Press.

Sachdev, Paul (1989). *Unlocking the Adoption Files*. Lexington, MA: Lexington Books.

Sachdev, Paul (ed.) (1988a). *International Handbook on Abortion*. Westport, CN: Greenwood Press.

Sachdev, Paul (1988b). "Canada," in P. Sachdev (ed.), *International Handbook on Abortion*, pp. 66-97.

Sachdev, Paul (ed.) (1981). *Abortion: Readings and Research.* Toronto: Butterworths.

Scheidler, Joseph (1985). *Closed: 99 Ways to Stop Abortion.* Lewiston, New York: Life Cycle Books, Ltd.

Schulman, J. (1996). *Winnipeg Child and Family Services v. D.F.G.*, 13 August.

Simon, Nathan M. (1981). "Women Who are Refused and Who Refuse Abortion," in Paul Sachdev (ed.) *Abortion: Readings and Research.* Toronto: Butterworths, pp. 91-109.

Simpson, John H. (1994). "The Body in Late Capitalism: An Introductory Sketch," in Jelen and Chandler (eds.) *Abortion Politics in the United States and Canada: Studies in Public Opinion.* Westport, CT: Praeger Publishers, pp. 1-14.

Smart, Carol (1995). *Law, Crime and Sexuality: Essays in Feminism.* London: Sage Publications.

Smart, Carol (1992a). "The Woman of Legal Discourse," *Social & Legal Studies*, 1: 29-44.

Smart, Carol (1992b). "Disruptive Bodies and Unruly Sex: The Regulation of Reproduction and Sexuality in the Nineteenth Century," in Smart (ed.) *Regulating Womanhood: Historical Essays on Marriage, Motherhood and Sexuality.* London: Routledge, pp. 7-32.

Smart, Carol (1989). *Feminism and the Power of Law.* London: Routledge.

Smart, Carol (1986). "Feminism and Law: Some Problems of Analysis and Strategy," *International Journal of the Sociology of Law*, 14: 109-123.

Supreme Court of Canada (1997). *Winnipeg Child and Family Services (Northwest Area) v. D.F.G.*, 31 October.

Tesch, Renata (1991). *Qualitative Research: An Analysis of Types and Software Tools.* Bristol, PA: The Falmer Press, Taylor and Francis, Inc.

The Feminist Majority Foundation (1994). *1994 Clinic Violence Survey Report.* Arlington: The Feminist Majority Foundation.

Timpson, Joanne (1996). "Abortion: The Antithesis of Motherhood?" *Journal of Advanced Nursing*, 23: 776-785.

"Toronto Doctor Admits Illegal RU 486 Use," *Vancouver Sun*, 30 May, 1994.

"Unsafe Abortions Placing Millions of Women at Risk," *Winnipeg Free Press*, 21 March, 1998.

Warner, Judith (1993). "The Assassination of Dr. Gunn: Scare Tactics Turn Deadly," *Ms.* (May/June): 86-90.

Waters, Wendell W. (1976). *Compulsory Parenthood: The Truth about Abortion*. Toronto: McClelland and Stewart.

Weedon, Chris (1997). *Feminist Practice and Poststructuralist Theory (Second Edition)*. Oxford: Blackwell Publishers.

Weedon, Chris (1987). *Feminist Practice and Poststructuralist Theory*. Oxford: Basil Blackwell Ltd.

Willis, Ellen (1990). "Putting Women Back into the Abortion Debate," in Gerber-Fried (ed.), pp. 131-138.

Wilmoth, G., M. Alteriis and D. Bussell (1992). "Prevalence of Psychological Risks Following Legal Abortions," *Journal of Social Issues*, 48(3): 37-66.

Winnipeg Free Press, 12 November, 1997.

Winnipeg Free Press, 17 February, 1996.

Winnipeg Free Press, 5 March, 1995.

Winnipeg Free Press, 4 October, 1994.

Winnipeg Free Press, 12 September, 1994.

APPENDIX A

ABORTION STUDY

Are you a woman who has sought abortion services in Manitoba in the last 8 years? There has been little research which explores women's experiences in order to determine how access can be improved. I am a graduate student researching access to abortion in Manitoba. If you would like more information or you would like to participate, please call (phone number). All conversations are confidential.

Are you a woman who had to travel from rural or northern MB to Wpg. to access abortion services since 1988? Female grad student at UofM would like to hear about your experience for Master's thesis. Confidential (phone number).

APPENDIX B

.ABORTION STUDY.

Are you a woman who has sought abortion services in Manitoba in the last 8 years?

I am a graduate student researching the topic of access to abortion in Manitoba and would like to hear your story.

Despite the lack of legislation regarding abortion in this country, there are many barriers that women encounter because access is not universal. Also, there has been very little research on abortion which has focused on the voices and experiences of women.

If you have tried to access abortion services in Manitoba and underwent the procedure, or even if you did not, your experiences will be very valuable in determining what Manitoba women feel is needed to improve access. If you should choose to participate, your anonymity and confidentiality is guaranteed. This project has been given approval by the Department of Sociology Ethical Review Committee, University of Manitoba.

If you would like to find out more information about the project or you think you might be interested in sharing your experience, please give me a call at: (204) and ask for Brenda. Any and all conversations are confidential.

APPENDIX C

VOLUNTEERS NEEDED

A graduate student at the University of Manitoba would like to talk to women who travelled out of town to obtain an abortion in Manitoba sometime in the last 9 years.

Your participation will provide information on women's experiences accessing abortion, and feedback on services in the province.

If you are interested in participating or would like more information, please call (204) in Winnipeg, or leave a message and I can return your call if you wish. I am willing to travel to your community to speak with you.

All conversations are completely confidential. Your anonymity is guaranteed and will be protected at all stages.

This project has been granted ethical approval by the Department of Sociology Ethical Review Committee, University of Manitoba.

APPENDIX D

Access to Abortion

♀♀♀

Are you a woman who had to travel from rural or northern Manitoba to Winnipeg to obtain an abortion in the last 9 years? A female graduate student in Sociology would like to hear your story.

Your participation will provide information on women's experiences accessing abortion, and feedback on services in the province.

If you are interested in participating or would like more information, call Please leave a message if I am not available, and I will return your call as soon as possible.

•*All conversations are completely confidential. Your anonymity is guaranteed and will be protected at all stages*•

This project has been granted ethical approval by the Department of Sociology Ethical Review Committee, University of Manitoba.

APPENDIX E

THE UNIVERSITY OF MANITOBA Department of Sociology

CONSENT FORM

Subverting Women: Access to Abortion Services in Manitoba

I, _____, agree to participate in the research project "Subverting Women: Access to Abortion Services in Manitoba." I have read the attached information sheet on this study. I understand that in agreeing to participate, my interview will be audiotaped, and that once transcribed by the researcher, the tapes will be destroyed. I understand that, if I wish, I will be provided with a copy of the transcript for review and to make any alterations to that record. Any information provided by me will be kept in strict confidence.

I understand that I am free to refuse to answer any questions I do not wish to answer. I agree to participate in this study voluntarily and may withdraw participation at any time should I wish to do so.

I understand that any information provided by me may be included in the report and that it will be presented in such fashion that neither my identity nor those of persons I mention can be identified. I understand that information provided by me will be reported in the researcher's Master of Arts thesis, in partial fulfillment of the requirements of a Master of Arts degree, and possibly in other scholarly publications.

Please check the appropriate responses:

[] I wish to receive a copy of the transcript for review
[] I do not wish to receive a copy of the transcript for review

[] I wish to receive a copy of the final report
[] I do not wish to receive a copy of the final report

_____ _____
Date Participant's Signature

_____ _____
Date Researcher's Signature

THE UNIVERSITY OF MANITOBA Department of Sociology

Subverting Women: Access to Abortion Services in Manitoba

Thank you for taking the time to participate in this study. The purpose of this research is to explore the experiences of women in Manitoba who have attempted to access abortion services. Little attention has been paid to the voices of women themselves and their suggestions to improve access. Your participation will provide valuable information about access in Manitoba. The interview will be approximately 1-2 hours in length, and with your permission will be audiotaped. Throughout the study, your identity and those of any persons you mention in the interview or questionnaire will never appear in print to protect your confidentiality. You are free to refuse to answer any questions you do not wish to answer, and to withdraw from the study at any time.

The interviews will be transcribed by myself and the tapes will be destroyed once transcription is complete. You will be assigned a code which will ensure your anonymity and confidentiality. The results of this study are to be reported in a Master's thesis, in partial fulfillment of the requirements for a Master of Arts degree.

This study has been approved by the Department of Sociology Ethical Review Committee, University of Manitoba. Any questions or comments about ethical procedures should be directed to the Head of the Department of Sociology at 474-9260.

If you have any questions feel free to contact myself or my advisor, Dr. Karen Grant.

Thank you again!

Researcher
Brenda Comaskey

Thesis Advisor
Karen Grant

APPENDIX F

INTERVIEW GUIDE

GENERAL BACKGROUND

Can you tell me about your family background (where you grew up, family members/siblings)?
What was your family like - ethnicity/religiosity?
Can you tell me about yourself and your current family situation (age/ethnicity/religiosity)?
How about your educational background/employment or economic situation?
How long have you lived in Winnipeg?
Can you tell me a little bit about your contraceptive history?
Can you tell me about your reproductive history (previous pregnancies, children, etc.)?

THE DECISION-MAKING PROCESS

Thinking back to that pregnancy (go through each one if more than one - keep track), please tell me what you were thinking and feeling?
How old were you at the time? Were you living in Winnipeg?
Family situation/economic/
What was going on in your life at the time?
How did you arrive at your decision?

(Probes)
What were your circumstances when you first discovered you were pregnant?
What was your initial reaction? The reaction of those around you?
What options did you consider?
How did you feel about abortion at the time? Why? (if politically involved - what led to that involvement?)
Did you know abortion was legal?
Who was the first person or where was the first place you went for information? Why?
How was the decision-making process for you?
Were there other persons involved in the decision-making process?
How did others around you feel about the decision?
What advice, if any, did your doctor or other health professional offer you?
What factors contributed to your decision?

What information did you seek to help make your decision? Were you satisfied with your decision? With the input of others?

ACCESSING ABORTION SERVICES

Thinking back to the time you attempted to access abortion services, what was that like for you? What is your general feeling toward that experience?

(Probes)
Was information readily available to you?
How did you know who to contact or where to go?
Services consulted - did you seek counselling or were you asked to attend?
What types of facilities did you consult?
What was the reception like at the places you contacted or the people you talked to?
What did you find most helpful in accessing information?

The Abortion Experience: (note: if a woman attempted to access services but did not go through with the procedure, these questions will be omitted)

How did you feel in the period between the time you decided to terminate the pregnancy and the actual procedure?
How far along in your pregnancy were you at the time of your appointment?
Did you have to wait long before getting an appointment?
Can you describe the hospital or clinic environment?
What were the reasons you chose the facility that you did?
Did you feel you had enough information before you had the procedure?
Can you tell me about the nurses/provider/other staff and how they made you feel?
What was the experience like for you?
How did you feel afterward?
Did you have a post-abortion check-up? How was that for you?
What services and/or persons did you find most helpful?
What services and/or persons did you find least helpful?
Was it easy for you to obtain an abortion (cost, location, etc.)?
Would you make the same decision or go the same route again?
What would you do differently the next time around and why?
Did this experience affect you in any particular way? If so, how? (views on abortion, experience of motherhood, relationships, etc.)

IMPROVING ACCESS TO ABORTION SERVICES IN MANITOBA

Views on Barriers:

Do you think that it is fairly easy or difficult to obtain an abortion in Manitoba?
What do you think makes it easy or difficult for a woman to obtain an abortion?
How do you feel about public debates around abortion?
(delays, repeat visits, violence against providers, travel, costs, RU 486)?

Suggestions to Improve Access in Manitoba:

Do you feel access in Manitoba needs improvement? Why?
In what ways do you think access in Manitoba could be improved?
In what ways do you think Manitoba has good access?
How about Canada?

If you could have 5 minutes to talk to someone about access to abortion in Manitoba, who would that person be, and what would you say?

*Can you tell me why you wanted to participate in this study?
*May I contact you if I have any questions or things that need clarification?
*How do you feel about the questions asked today?
*Any other questions you think I should be asking?

APPENDIX G

Department of Sociology
University of Manitoba
WINNIPEG, MB
R3T 2N2
(204)474-9260 FAX (204)261-1216

The research project titled

Subverting Women: Access to Abortion Services in Manitoba

Proposed by Principal Investigator(s)

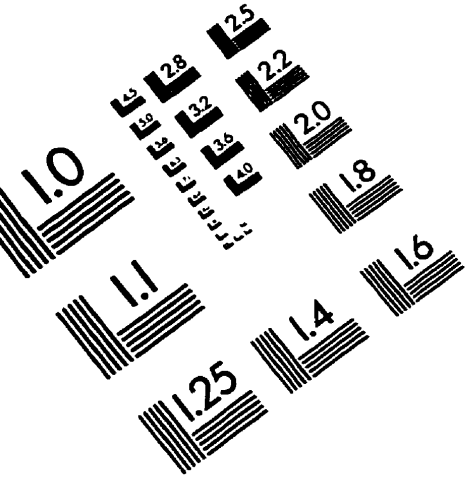
Brenda Comaskey, M.A. candidate

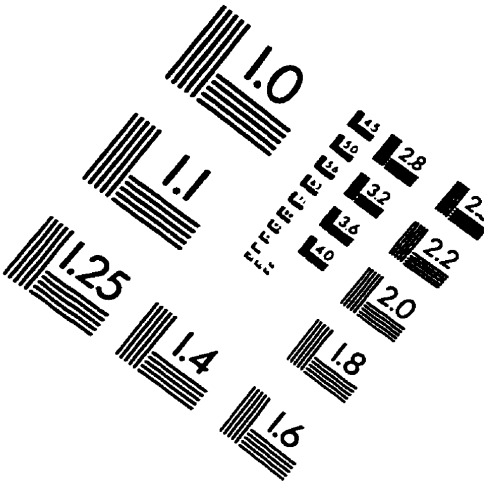
has been reviewed and found to be ethically acceptable.

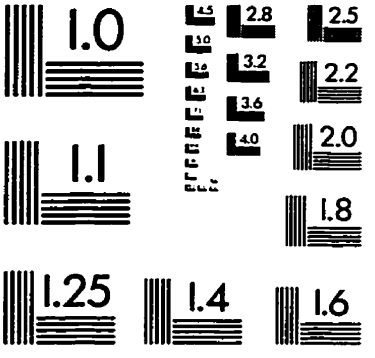
Good luck with the project.

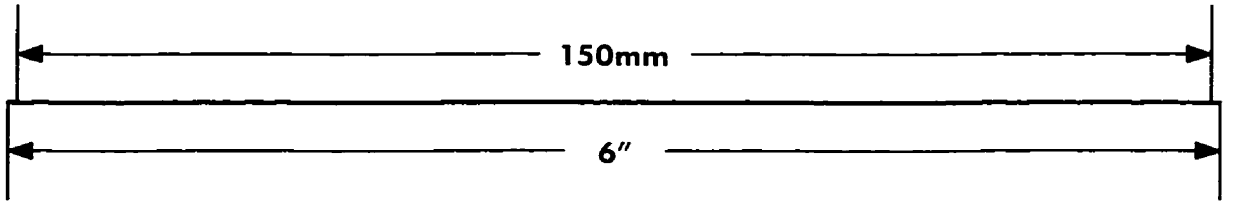
Chair, Ethical Review Committee — Date: Nov. 18/96

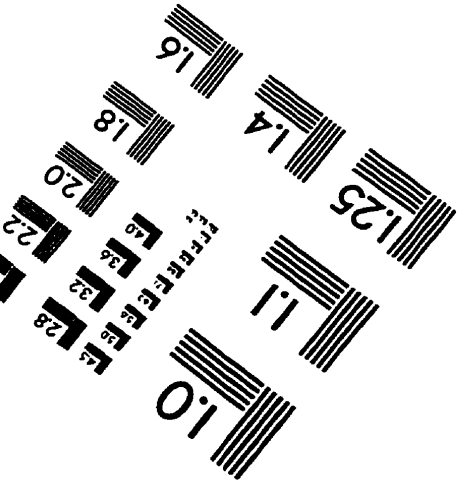
IMAGE EVALUATION
TEST TARGET (QA-3)

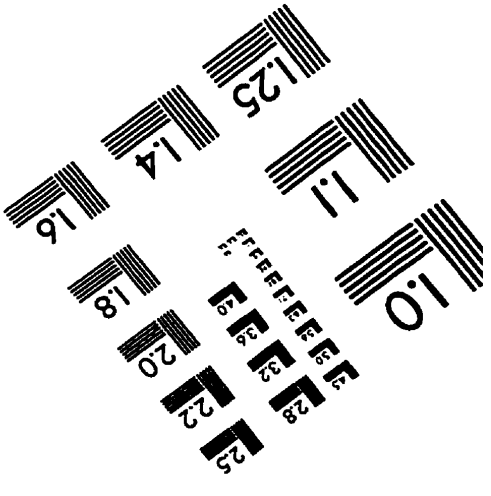












APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989