

**University of Wisconsin-Madison  
Consent to Participate in Research  
and  
Authorization to Use Protected Health Information for Research**

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**Study Title:** Wisconsin Abortion Consideration and Seeking Trajectories (WI-ACT) Study

**Lead Researcher:** Jane Seymour, PhD, MPH, 608-890-0216, 1300 University Avenue, Medical Sciences Center 1530, Madison, WI 53706

**Institution:** *University of Wisconsin - Madison*

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**Key Information**

The information in this section is to help you decide whether to be a part of this study. You can find more detailed information later in this form.

**Why are researchers doing this study?**

You are invited to participate in a research study about pregnancy options and your experiences with pregnancy. You have been asked to participate because you are pregnant and live in Wisconsin. The purpose of the research is to understand the experiences of people in these states who are exploring pregnancy options. We hope that the findings from this work will be used to improve the experiences of pregnant Wisconsinites.

**What will I need to do in this study?**

The research team will ask you to complete one online survey, then another survey four months later. After the second survey, you may be invited to complete an in-depth interview.

We expect that the surveys will take roughly 20 minutes each and the interview would last up to 90 minutes, for a total of 130 minutes over a roughly five-month period.

You can find detailed information about the study procedures in the section called, “**If I take part in the study, what will I do?**”

**What are some reasons I might – or might not – want to be in this study?**

| <b>You may want to be in this study if you are:</b>                                                                                                                                                     | <b>You may NOT want to be in this study if you:</b>                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Comfortable having researchers ask questions about your pregnancy experiences.</li><li>• Willing to answer two surveys for the study over six months.</li></ul> | <ul style="list-style-type: none"><li>• Want to be in a study that might help improve your own health.</li><li>• Are not willing to provide your phone number or email address to receive a follow-up survey.</li><li>• May not have time to complete study questionnaires.</li></ul> |

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| <ul style="list-style-type: none"><li>• Interested in contributing to scientific knowledge even though you won't benefit directly from the study.</li></ul> |  |
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### **Do I have to be in the study?**

No, you do not have to be in this study. Taking part in research is voluntary. If you decide not to be in this study, your choice will not affect your healthcare or any services you receive. There will be no penalty to you. You will not lose medical care or any legal rights. You can ask all the questions you want before you decide.

### **Detailed Information**

The following is more detailed information about this study in addition to the information listed above.

### **How is research different from health care?**

When you take part in a research study, you are helping to answer a research question. Study tests and procedures are not for your health care.

### **Who can I talk to about this study?**

If you have questions, concerns, or complaints, or think that participating in the research has hurt you, talk to the research team by email at [wiaact\\_obgyn@wisc.edu](mailto:wiaact_obgyn@wisc.edu) or by phone at

If you have concerns about your rights as a research participant or have complaints about the research study or study team, call the confidential research compliance line at 1-833-652-2506. UW Staff who are not part of the study team will work with you to address concerns and assist in resolving any complaints.

### **If I take part in the study, what will I do?**

If you decide to participate in this research, you will be invited to complete a confidential survey about your reproductive health experiences, including considering options for your pregnancy, such as abortion. You will be invited to take up to one additional survey, which will take place six months later. All surveys will be delivered to you via email or SMS text, and you can complete the survey on your phone, a computer, or other electronic device.

The first survey will last approximately 15 to 20 minutes. The follow-up survey, could take 10 to 20 minutes. You will be paid for completing each of these surveys.

In addition to surveys, you may have the opportunity to participate in a 60–90-minute interview about your experiences considering options for your pregnancy, such as abortion. via video call with a study team member about your experience.

As part of the study we will collect audio recordings of you during the interview procedures to help the researchers remember what you said and understand your

experiences. Recordings will not be used for purposes outside of the study or in any papers or publications. A written copy (transcript) of the recordings will be made for use in the research.

### **Protected health information (PHI) used in this study**

Protected health information, also called PHI, is information about your physical or mental health that includes your name or other information that can identify you, like your date of birth or medical record number. To do this study, we will use the following kinds of PHI: things you tell the researchers about your health

### **What happens if I say yes, but I change my mind later?**

You can leave the research at any time. If you choose to leave the study, your choice will not affect your healthcare or any services you receive. No matter what decision you make, and even if your decision changes, there will be no penalty to you. You will not lose medical care or any legal rights.

Your authorization for researchers to use your protected health information (PHI) does not have an end date. However:

- You can choose to take back your authorization for researchers to use your health information. You can do this at any time before or during your participation in the research.
- If you take back your authorization, information that was already collected may still be used and shared with others, but the researchers will no longer be able to collect new information about you.
- If you take back your authorization, you will not be able to take part in the research study.
- To take back your authorization, you will need to tell the researchers by writing to the Lead Researcher, Jane Seymour, at 1300 University Avenue Medical Sciences Center 1530, Madison, WI 53706.

### **Will being in this study help me in any way?**

Being in this study will not help you directly. Your participation in the study may benefit other people in the future by helping us learn more about how to support pregnant Wisconsin residents considering their options.

### **What are the study risks?**

*The risks of this study are that some questions might make you feel emotional. You may become upset or have psychological discomfort when answering the questions. In addition, if your responses are revealed outside the study team, it could affect your employment or reputation, and you are at risk of revealing illegal behaviors. You may become fatigued or frustrated by the length of the questionnaire. There is also a risk of a confidentiality breach.*

**Who has access to the information collected for the research?**

We have strict rules to protect your personal information and protected health information (PHI). We will limit the use and disclosure of your personal information, including research study and medical records, as described in this consent form. However, we cannot promise complete confidentiality. We will share information with individuals or organizations identified in this consent form. Federal or state laws may also permit or require us to show information to university or government officials responsible for carrying out or monitoring this study. This includes University of Wisconsin and its representatives and affiliates, including those responsible for ensuring compliance, such as the Human Research Protection Program.

We may have to tell appropriate authorities, such as child protective services or health care providers, if we learn during the study that you or others are at risk of harm (for example, due to child or elder abuse, or suicidal thoughts).

Authorizing the research team to use your PHI means that we can release it to the people or groups listed in this form for the purposes described in this form. Once we share your identifiable health information outside UW-Madison, the HIPAA Privacy Rule may no longer protect it. However, we try to make sure that everyone who sees your health information keeps it confidential.

**Will information from this study go into my medical record?**

None of the information we collect for this study will go into your medical record. The researchers are not required to release health information to you if it is not part of your medical record.

**Will my information be used in other research?**

This study is collecting information from you. We would like to make your information available for other research studies that may be done in the future without additional consent from you. The research may be about experiences like those examined in this study. However, research could also be about unrelated experiences, or other types of research. These studies may be done by researchers at this institution or other institutions, including commercial entities. Your information may be shared with researchers around the world. Our goal is to make more research possible. We plan to keep your information indefinitely. To get your information, future researchers must seek approval from this institution and review by an IRB may be required.

Your name and other information we think could identify you, such as your date of birth or medical record number, will be removed from any information you provide before it is shared with other researchers. Researchers cannot easily link your identifying information to the information. However, there remains a possibility that someone could identify you. There is also the possibility that people who are not supposed to might access your information. In either case, we cannot reduce the risk to zero.

Participating in this study means you agree to share your information. You can change your mind later, but researchers might still use your information if it has already been shared or has been de-identified and can't be removed. If you do not want your information used for other research studies, you should not participate in this study. We may share survey responses and transcripts of interviews with researchers at other institutions. We will remove direct identifiers about you, such as your name, date of birth and other information we think could be used to identify you. However, we cannot guarantee there is no risk you could be identified. Information in free text fields such as those in survey responses and transcripts of interviews may contain details that could be used with other available information to identify you (such as an employer name, job title or rare diagnosis).

### **Can I be removed from the research without my agreement?**

The person in charge of the research study or the sponsor can remove you from the research study without your approval. Possible reasons for removal include:

- You do not follow the study rules or no longer meet the requirements to be in the study
- The study is stopped by the sponsor or researchers

### **What else do I need to know?**

#### **Will I receive anything for participating?**

If you agree to take part in this research study, we will pay you \$30 for your time and effort for completing the first study. You will receive \$50 if you complete the second survey, and \$100 if you complete the interview.

We reserve the right to withhold compensation and discontinue your participation in the study if any of the information you provide indicates that you are ineligible or providing inconsistent (or fraudulent) responses.

### **Permission to communicate about the study by email and text message**

You must provide your email address and/or phone number so we can provide a gift card for your participation and send you the follow-up survey and an interview invitation if you are eligible. Email and text messaging are generally not a secure way to communicate about your health as there are many ways for unauthorized users to access email and text messages. You should avoid sending sensitive, detailed personal information by email or text message. Email and text messages should also not be used to convey information of an urgent nature. If you need to talk to someone immediately, please contact Allison Hung, Research Coordinator, by phone at 608-262-7738 or by text message at 608-292-4067.

### **How many people will be in this study?**

We expect about 675 people will be in this research study.

### **Who is funding/supporting this study?**

This research is being funded by a private foundation.

You do not have to agree to click “yes” below. If you refuse to say “yes,” however, you cannot take part in this research study. If you click “yes” below, it means that:

- You have read this consent and authorization form.
- You have had a chance to ask questions about the research study, and the researchers have answered your questions.
- You want to be in this study.
- You give authorization for your protected health information to be used and shared as described in this form.

\_\_\_\_\_ Yes, I agree to participate

\_\_\_\_\_ No, I do not agree to participate