REPRODUCTIVE JUSTICE ON CAMPUS: FEMALE STUDENTS' EXPERIENCES SEEKING AND ACCESSING HORMONAL CONTRACEPTION IN NORTHERN BRITISH COLUMBIA

by

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ABSTRACT

Problem: Access to hormonal contraception is a critical component of reproductive autonomy, yet structural and social barriers persist. Undergraduate students experience unique considerations around contraceptive decision-making related to service availability, campus culture, and lifestyle changes. While the implementation of universal contraception coverage in British Columbia (BC) has removed financial obstacles, the lived experiences of students indicate that challenges beyond cost remain. This study explores undergraduate students' experiences of seeking and accessing hormonal contraception in northern BC to better understand the factors shaping reproductive decision-making and service utilization.

Methods: Using a feminist relational discourse analysis (FRDA) framework, this study examines the interplay between individual experiences and societal discourse to uncover power dynamics that influence contraceptive decision-making and engagement with sexual and reproductive health (SRH) services. Semi-structured interviews were conducted with five undergraduate students from the University of Northern British Columbia (UNBC), each of whom had sought or accessed hormonal contraception from a healthcare provider within the past year. The study employed poststructuralist discourse analysis to identify recurring themes, discourses, and discursive patterns, followed by voice-centered analysis to center participant narratives within broader sociopolitical contexts.

Findings: Findings reveal that participants valued reproductive agency, yet their decisions were shaped by intersecting influences, including gender norms, misinformation, patient-provider interactions, and accessibility of services. Two key discursive patterns emerged: *a uterus is a credential a man cannot acquire: gender concordance as a driver of trust*, which highlights students' preference for female healthcare providers based on perceived

experiential knowledge and greater empathy; and *my body, my choice ... but also my responsibility: negotiating the gendered division of labour in contraception,* which reflects the internalized societal expectation that pregnancy prevention is primarily the responsibility of women, despite the recognized inequity in this burden. Participants described difficulties navigating contraceptive counselling, concerns about procedural pain management, and lack of comprehensive SRH education, all of which contributed to gaps in knowledge and barriers to care.

Conclusions: This study concludes that while financial access to contraception has improved with universal coverage, significant relational, educational, and systemic obstacles remain. Postsecondary institutions and healthcare systems must take proactive steps to challenge the feminization of contraceptive labour, improve SRH education, and engage in shared decision-making during contraceptive counselling. By addressing these barriers and centering the voices of contraception users, institutions can move toward genuine reproductive justice, ensuring that students have the autonomy and support to make informed decisions about their reproductive health.

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GLOSSARY

Hormonal Contraception: medications or devices that contain estrogen and/or progestin, including: the oral contraceptive pill (OCP), long-acting-reversible contraceptives (LARCs; i.e. intrauterine devices [IUDs] and subdermal implants), injection (medroxyprogesterone acetate), vaginal contraceptive ring, or transdermal patch

Contrapuntal Voices: contrasting or competing voices and narratives within each participant's story; tensions and negotiations within the individual's own sense of self

Discourse: statements which describe a theme in similar ways and that collectively represent a particular version of reality related to that theme, often reflecting taken-for-granted knowledge; a relational, socially situated practice that not only reflects but also constructs identities, power relations, and social meaning

Discursive Pattern: broader and recurring configurations of meaning that emerge when multiple discourses converge, overlap, or contradict each other within and across stories

Discursive Realms: how power and subjectification are considered in conjunction with previous research to understand how these patterns function in broader social, historical, and ideological texts

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CHAPTER ONE

Introduction and Background

Clinically, reducing unintended pregnancy rates through contraception access is a priority. Unintended pregnancies (UPs), meaning pregnancies that occurred earlier than was desired or that were not desired at all, carry an increased risk of adverse health outcomes for both the birth parent and the infant compared to intended pregnancies (Public Health Agency of Canada, 2009). In cases of UP, prenatal care is more likely to be delayed or underutilized (Heaman et al., 2014). Further, there is a higher prevalence of risky health behaviours early in the pregnancy, such as smoking, alcohol consumption (Han et al., 2005), and inadequate intake of folic acid (Cheng et al., 2009). Collectively, these factors can increase the risk of poor birth outcomes for the infant, including abnormal physiological development. Among people who give birth, UPs can increase the risk of mental health problems, such as postpartum depression (Cheng et al., 2009; Mercier et al., 2013).

Although a national survey of sexual and reproductive health (SRH) indicators is under development, SRH data is not routinely being collected in Canada on a national scale, which means the rates of UP in Canada are unknown (Statistics Canada, 2024). Estimates of UP are based on data collected around induced abortions, or the medical termination of a pregnancy[1]. According to the Canadian Institute for Health Information (CIHI, 2025), there were 101,553 reported induced abortions in Canada in 2023, which is a 13.7% increase since 2021. The highest rates of reported induced abortions were in the 18 to 29-year-old age categories. However, abortion statistics are not necessarily representative of the true number

[1]When referring to the choice to end a pregnancy, the word "termination" is commonly used in current discussions; however, the term "induced abortion" is still used in the national data.

of UPs, as many Canadians do not have access to abortion services, not all UPs end in abortion, and the trajectory of the maternal experience after UP is unclear (Black et al., 2015).

The total direct cost of UP in Canada in women[2] aged 20 to 29 years is estimated at $175 million per year, with 82% of this cost ($143 million) attributable to imperfect contraceptive adherence (Black et al., 2015). UPs may result from lack of contraception use, incorrect contraception use or contraceptive failure (Black et al., 2015). The most recent data indicates that 40.8% of sexually active 15- to 24-year-old youth who are at risk of pregnancy did not use contraception the last time they had sexual intercourse (Statistics Canada, 2020). Reducing rates of UP requires increased uptake of effective contraception.

Hormonal Contraception

Hormonal contraception refers to medications or devices that contain estrogen and/or progestin, including: the oral contraceptive pill (OCP), long-acting-reversible contraceptives (LARCs; i.e. intrauterine devices [IUDs] and subdermal implants), injection (medroxyprogesterone acetate), vaginal contraceptive ring, or transdermal patch. Hormonal contraception methods vary in effectiveness at preventing pregnancy, with LARCs being the most effective at over 99%, and injection, OCP, vaginal ring, and patch at 97% to over 99%, depending on the user (World Health Organization [WHO] & Johns Hopkins Bloomberg School of Public Health Center for Communication Programs Knowledge for Health Project, 2022). Emergency contraception (EC), often referred as the “morning after pill,” contains

[2] As the terms "female" and "woman" are frequently used in the literature on contraception, these terms will be used in this thesis to reflect the terms used in the respective studies; the author acknowledges that binary language does not accurately reflect the spectrum of contraception users.

either ulipristal acetate, levonorgestrel, or a combination of ethinyl estradiol plus levonorgestrel. EC is up to 95% effective and is intended for use as a single-dose method of contraception after intercourse, rather than consistent daily use (WHO, 2021). All forms of hormonal contraception are more effective at preventing pregnancy than non-hormonal forms of contraception, such as condoms, diaphragms, or fertility awareness-based methods (WHO & Johns Hopkins Bloomberg School of Public Health Center for Communication Programs Knowledge for Health Project, 2022). For the purposes of this paper, "contraception" will be broadly used to refer to contraceptive methods that contain estrogen or progestin and require a visit to a health care provider (HCP) who is authorized to dispense or prescribe contraception.

Although over-the-counter hormonal contraception is becoming increasingly available around the world, many countries, including Canada, require hormonal contraception to be prescribed by an HCP (Grindlay et al., 2013). This requirement contrasts with non-hormonal contraceptive options, such as condoms, which are widely available for purchase without medical consultation. Due to this distinction in accessibility, this study will focus solely on hormonal contraceptive methods that require interaction with a prescriber, which influences individuals' ability to seek and access these methods. Non-hormonal methods, including condoms and fertility awareness-based strategies, do not require individuals to engage with healthcare services, and therefore fall outside the scope of this study.

Understanding Canadian healthcare infrastructure and policies around contraception will allow for development of SRH improvement initiatives that will reduce the social and economic costs of UP.

Contraception Access Across Canada

Canada has a decentralized, universal, and publicly funded health care system. Health care is funded and administered primarily by provinces and territories, each with its own insurance plan and service delivery approach (Tikkanen et al., 2020). While all citizens and permanent residents receive medically necessary hospital and physician services at no cost, outpatient prescription drugs are covered by a patchwork of over 100 public insurance plans and over 100,000 private plans throughout Canada (Health Canada, 2019).

Most forms of hormonal contraception require a prescription in Canada. Emergency contraception (EC) is the exception, as it is often held behind the counter, and to access it, one must speak with the pharmacy staff. In British Columbia (BC), a pharmacist must prescribe EC to receive it for free under the universal contraception policy. As EC and other forms of hormonal contraception share similar access points, EC is included in this study. Physicians remain the primary prescribers of contraception in Canada. Several provinces, including Alberta, Saskatchewan, Nova Scotia, and Québec, have also given pharmacists contraception prescribing abilities to varying degrees (Canadian Pharmacists Association, 2020). Other provinces, including BC and Québec, have implemented protocol-based contraception management by allowing Registered Nurses (RNs) to dispense contraception without an order from a physician (Guilbert et al., 2016; British Columbia College of Nurses and Midwives [BCCNM], 2024).

Provincial and territorial health care plans often cover the cost of prescription drugs for seniors, recipients of social assistance, and those with conditions associated with high drug costs (Government of Canada, 2021). Indigenous people receive prescription drug coverage under the federal Non-Insured Health Benefits Program (Government of Canada,

2023). With few exceptions, the remainder of the population either pays for prescription drugs out-of-pocket, receives subsidized contraception through sexual health clinics or income-based provincial drug coverage programs, or receives coverage under a private pharmaceutical insurance plan through their employer or as the dependent of an employee with private coverage (Di Meglio & Yorke, 2019). A significant portion of the public has neither public nor private insurance; an estimated 200,000 to 500,000 people in Canada are uninsured (Barnes, 2016).

Recent Changes to Contraception Policies in British Columbia

As of April 1, 2023, BC became Canada's first province to implement universal contraception coverage for its residents, including EC (British Columbia Ministry of Finance, 2023). Prior to the implementation of this policy, a provincial survey conducted by Norman et al. (2017) indicated that 40% of pregnancies among females who had a pregnancy within the past five years were unintended, and 63% of all respondents were at risk for UP based on fertility, intention, and sexual activity. Among those at risk for UP, 56% of respondents who were not using permanent contraceptive methods reported using a method with higher than 10% pregnancy rates per year, or no method. Income was the most significant determinant of effective contraception use, followed by education beyond high school, and older age. As BC is the first jurisdiction to offer free contraception to all residents, further investigation is warranted to ascertain the impact of this policy.

Undergraduate Students and Contraception

The above data suggests that young adulthood (ages 15 to 29) is a period of high risk for UP related to low contraception use and/or use of ineffective contraception methods (Statistics Canada, 2020), and high rates of induced abortions (CIHI, 2025). Among this

demographic, undergraduate students, typically aged between 18 to 28 years, are of particular interest, as they are in a stage of newfound autonomy and freedom that accompanies emerging adulthood. Previous inhibitions about health-risk behaviours, such as unprotected sex, may weaken with reduced adult supervision and the perception that sex is a normative adult behaviour, and even a rite of passage (Arbour-Nicitopoulos et al., 2010). For some young people, there can be compounding factors that challenge autonomy, risk-taking, and UP, specifically sexual safety.

Over the last decade, there has been widespread public discussion around campus sexual violence in the media, awareness campaigns, social movements, and on-campus events (Albert & Perry, 2024; Gabriele & Naushan, 2020). According to Statistics Canada (2020), 11% of Canadian post-secondary students who identify as women were sexually assaulted in a post-secondary setting in 2019, and 71% of all students surveyed had witnessed or experienced unwanted sexualized behaviours, including inappropriate verbal or non-verbal communication, sexually explicit materials, and physical contact or suggested sexual relations. Nonconsensual sexual contact, including rape, is more prevalent at post-secondary institutions when compared to other crimes, with 26.4% of females experiencing sexual assault (Cantor et al., 2020). Although the correlation between campus sexual violence and UP among students is unclear, the threat of sexual violence may have an impact on students' reproductive decision-making. Concerns about autonomy and safety may influence contraceptive choices, and survivors may seek EC as a precautionary measure.

Historically, decision-making around accessing contraception for students was influenced by type of insurance coverage. Undergraduate students often have mandatory health insurance coverage, either through their educational institution or as a dependent on

their parent's health insurance. In the case of dependents, a report detailing all pharmaceutical claims is made available to the primary policy holder (often a parent), reducing confidentiality (Di Meglio & York, 2019). The recent implementation of universal contraception coverage theoretically removes this barrier to access, however, students' awareness and understanding of the new policy is currently unknown, which may affect uptake.

Students in rural areas may face additional barriers to accessing contraception and sexual health services, such as transportation, limited service availability, and concerns about confidentiality (Johnston et al., 2015). Substantial lifestyle changes experienced during emerging adulthood, combined with high rates of sexual activity and low rates of contraception use, make undergraduate students an ideal population for health promotion and education efforts related to sexual health and contraception use.

Female post-secondary students have consistently expressed a strong desire to prevent pregnancy, as pregnancy is often viewed as incompatible with, or a significant barrier to, meeting educational and career goals (Hickey & White, 2015; Cabral et al., 2018; Payne et al., 2016). However, when considering hormonal contraception, female students also highly value fertility and the ability to have children when they choose (Payne et al., 2016; Sundstrom et al., 2015). The fact that UPs and induced abortions are occurring at a high rate despite the desire to prevent pregnancy illustrates the need for evaluation of factors that affect access to and choice of contraception for young adults, specifically undergraduate students.

Research Question

Contraception and abortion are feminist issues, as the extent to which these resources are available directly impacts the freedom and autonomy of an entire subgroup: any person who can become pregnant. Historically, reproductive autonomy, or the power to independently make decisions around contraception, pregnancy, and reproductive health has been withheld from women (Espey, 2015). There continues to exist a complex web of power structures that influence who can make reproductive decisions, how confidently such decisions can be made, and under what circumstances (Le Guen et al., 2021). Further, the emphasis on the secondary health benefits of hormonal contraception (i.e. acne treatment, menstrual symptom relief) combined with the minimization of patient concerns around risk and the drive to prescribe contraception based on effectiveness, does not equate to reproductive justice. While these benefits may enhance the appeal of hormonal contraception, their promotion can inhibit true contraceptive autonomy, or the power to make fully informed decisions about one's reproductive health. If HCPs frame contraception primarily around its efficacy in preventing pregnancy rather than presenting a balanced discussion of risks, alternatives, and patient values, they may inadvertently reinforce power structures that limit reproductive choice (Le Guen et al., 2021).

Currently, supporting and preserving contraception access is a high-priority issue as reproductive rights are in an international state of flux. Recent events have highlighted how political structures and power dynamics influence the reproductive autonomy of individuals. Events such as the recent ruling by the Unites States (US) Supreme Court to overturn *Roe v. Wade*, which protected the rights of the individual to decide whether to continue or end a pregnancy (*Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health*

v. Jackson Women's Health Organization, 2022) have global repercussions. Speculation and fear around funding, government support, and potential criminal consequences of offering abortion care may result in fragmentation of SRH services and HCP shortages within the US government (Coen-Sanchez et al., 2022). The current narratives around abortion and the reinforcement of oppressive policies by the US have significance for women globally as the gap between who can, and who can not, assert their reproductive autonomy, widens.

Although abortion was decriminalized in Canada in 1969, no laws exist to protect the right to abortion, although it has been argued that abortion can be considered a de facto right under the Canadian Charter of Rights and Freedoms, which protects the right to life, liberty, conscience, and privacy (Abortion Rights Coalition of Canada, 2018). However, as recently as 2023, there have been bills introduced in Canadian Parliament to amend the Criminal Code to restrict or criminalize abortion, but these have not been passed (Abortion Rights Coalition of Canada, 2023).

According to the Sexual and Reproductive Initiative study by Statistics Canada (2024), stakeholders and data users (including the government, advocacy and civil society organizations, clinicians, administrators, medical and service delivery organizations, and academic researchers) expressed that "most policies focus on women's ability to breed the next generation rather than women having the choice of when and how to become pregnant" (p. 8). Although national statistical research is underway, it is important to gather the perspectives of contraception users to avoid perpetuating androcentric policies that situate women as "breeders" and instead, support Canadian young people's desire, and human right, to decide freely the number, spacing, and timing of children, or to have children at all (WHO, 2022).

The following study sought to answer two research questions:

1. *What are undergraduate students' experiences of seeking hormonal contraception in northern BC?*
2. *What are undergraduate student's experiences of accessing hormonal contraception in northern BC?*

The objectives of this study were to: (a) uncover power dynamics that influence undergraduate students' contraceptive decision-making and engagement with SRH services; (b) identify barriers and enablers for undergraduate students who are seeking and/or accessing hormonal contraception; and (c) amplify the voices of often marginalized and underrepresented groups. The findings of this study can assist researchers, HCPs, and university administrators in tailoring SRH services to students' needs and dismantling existing oppressive power structures, with the goal of increasing uptake of these services, and ultimately, improving the overall health and well-being of students of reproductive age who can become pregnant, particularly those in northern BC.

This thesis explores undergraduate students' experiences seeking and accessing hormonal contraception. Chapter 2 provides a comprehensive literature review, summarizing existing research on contraceptive access and decision-making among post-secondary students. Chapter 3 details the study design, data collection methods, and analytical framework, grounding the study in feminist and reproductive justice perspectives. After an overview of the findings in Chapter 4, the findings are presented in detail across three chapters that reflect the structured approach of Feminist Relational Discourse Analysis (FRDA). Chapter 5 discusses the results of Phase 1 of data analysis, Chapter 6 offers a short "discursive interlude" that will transition the findings of Phase 1 to that of Phase 2, which are

discussed in Chapter 7. Chapter 8 critically examines these findings, situating individual experiences within broader social and institutional contexts, and offers recommendations for policy, healthcare practices, and future research to enhance equitable and autonomous contraceptive access for students.

CHAPTER TWO

Literature Review

An integrative review (IR) was conducted to capture and analyze the literature describing undergraduate students' experiences seeking and accessing hormonal contraception. An IR is a method of literature review that looks broadly at a topic of interest and is inclusive of diverse research to address the aim of the review. An IR uses a systematic approach to define concepts, review theories and evidence, and analyze issues of a particular topic. The following IR utilized Whittemore and Knafl's (2005) updated methodology, based on Cooper's (1998) framework, as it was designed to enhance the rigour of the IR method in nursing research. This five-step approach involves (a) problem identification; (b) literature search; (c) data evaluation; (d) data analysis; and (e) presentation, each of which will be described below.

Problem Identification

From the lens of a post-secondary educator and community health nurse, the current public discourse around reproductive rights across North America, along with recent changes to contraception policies in BC, sparked a curiosity around the implications for women and people assigned female at birth (AFAB)[3] in northern BC who were pursuing higher education. The "PCC" framework (Population, Concept and Context), as displayed in Table 1, was used to guide the formulation of the research question (Aromataris et al., 2024). The final research question was: What are undergraduate students' experiences of seeking and accessing hormonal contraception?

[3] To ensure consistency, the terms "women" and "female" will be used as encompassing terms in the proposed study to describe self-identified females and people assigned female at birth. The author acknowledges that not all contraception users will identify as women, and care will be taken to address participants using the pronouns they use.

Table 1

Population, Concept, Context (PCC) Framework

Population	Concept	Context
Undergraduate students	Experiences of seeking and accessing hormonal contraception	Countries with a Human Development Index (HDI) score of ≥ 0.8

Literature Search

A literature search was conducted using a comprehensive search strategy of health science databases along with purposive sampling of online search engines and grey literature. After expansive reading on the subject, inclusion and exclusion criteria for determining primary sources were selected based on relevancy and project scope, as depicted in Table 2. The original search was restricted from the years 2013 to 2023 to best capture relevant articles as health services, technology, and contraceptive methods are in a continuous state of shift. For the purposes of this study, articles were included from countries with a score of ≥0.8 on the HDI[29], which is a summary measure of life expectancy, education, and standard of living; a score of ≥0.8 indicates a country is within the highest tier on this scale. Countries in a state of political unrest were excluded. These geographical criteria were selected to limit results to studies conducted in countries comparable to Canada in terms of healthcare infrastructure and access to education. An age parameter of 18 to 29 years old was selected, as 18 is the lowest age at which people typically enter postsecondary education, and, among women aged 20 to 29, high rates of induced abortions and low rates of contraception use and/or use of ineffective contraception methods have been documented (Black et al., 2015). The search was repeated on April 13, 2025, using the same search parameters to capture any new literature that was published after 2023.

Primary sources were extracted from two electronic databases: Cumulated Index to Nursing and Allied Health Literature (CINAHL) and Medline with Full Text (EBSCO). The University of Northern British Columbia (UNBC) Health Sciences Librarian was consulted to refine the search strategy by guiding database usage and discussing strategic search terms to maximize yield of eligible articles. Two online search engines, Google and Google Scholar, were used to locate primary sources not captured by the databases searches and to identify relevant grey literature. Search terms and results can be found in Table 3.

Table 2

Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Undergraduate students between the ages of 18 and 28 who are female or assigned female at birth • Process of seeking or accessing contraception, including help-seeking, information-seeking, and decision-making behaviours pertaining to contraception, perceptions/knowledge of contraception, and seeking or accessing services that offer contraception • Conducted in a country with a Human Development Index (HDI) score of ≥ 0.8 • Academic journal article, thesis, or dissertation • Available in English • Published between the years 2013 to 2025	• Experience of using contraception • Only non-hormonal methods of contraception discussed • Properties and/or efficacy of contraceptive methods, devices, or agents

Table 3

Search Strategy

Date	Database/ Search Engine	Search Terms	Results	Limiters/ Expanders
November 16, 2023 April 13, 2025	CINAHL	((MH "Student Health Services+") OR (MH "Students, College+") OR (MH "Students, Undergraduate") OR (undergrad* OR college) N3 student*) AND ((MH "Decision Making+") OR (MH "Health Services Accessibility+") OR (MH "Help Seeking Behavior") OR (access*)) AND ((MH "Contraception+") OR (MH "Contraceptive Agents+") OR (MH "Contraceptive Devices+") OR (MH "Reproductive Health") OR (birth control) OR (contracept*))	79 14	**Expanders:** Apply equivalent subjects **Limiters:** Date of Publication: 20130101-20231231 20231101-20251231 **Narrow by Language:** English **Search modes:** Boolean/Phrase
November 16, 2023 April 13, 2025	Medline with Full Text (EBSCO)	((MH "Student Health Services") OR "undergraduate student*" OR "college student*" OR (undergrad* OR college) N3 student*) AND ((MH "Decision Making+") OR (MH "Help-Seeking Behavior") OR (MH "Health Services Accessibility+") OR (MH "Information Seeking Behavior") OR "access*")) AND ((MH "Contraception+") OR (MH "Hormonal Contraception") OR (MH "Contraceptive Devices+") OR (MH "Contraceptive Agents, Hormonal+") OR (MH "Reproductive Health") OR (MH "Sexual Health") OR "birth control" OR "contracept*")	64 16	**Expanders:** Apply equivalent subjects **Limiters:** Date of Publication: 20130101-20231231 20231101-20251231 **Narrow by Language:** English **Search modes:** Boolean/Phrase

November 13, 2023 April 13, 2025	Google Scholar	(undergraduate students or college students) and (hormonal contraception or hormonal contraceptive or oral contraception or oral contraceptive or birth control pill or intrauterine device or long acting reversible contraceptive)	3590 (screened first 50 results) 853 (screened first 50 results)	**Limiters:** Date of Publication 2013-2023 2023-2025
November 13, 2023 April 13, 2025	Google	(undergraduate students or college students) and (hormonal contraception or hormonal contraceptive or oral contraception or oral contraceptive or birth control pill or intrauterine device or long acting reversible contraceptive)	"About 120, 000)" (screened first 100 results) “About 2,190,000” (screened first 100 results)	N/A

Cumulatively, 173 studies were retrieved from the electronic databases: 143 from the original search in 2023 and 30 from the search in 2025. After duplicates were removed, 145 articles remained for screening. Articles were screened by title and abstract. After inclusion and exclusion criteria were applied, 36 articles were extracted. Following full-text screening, 26 articles remained that were included for analysis. The title and description of the first 50 results from Google Scholar and the first 100 results from Google were reviewed for relevance. Beyond this point, the search results appeared increasingly unrelated to the topic and were therefore excluded from further review. Of these 150 results, eight reports were retrieved for screening, all of which were included for analysis. Academic articles and grey literature were included at this stage.

After screening all sources, the makeup of the sample was as follows: 13 cross-sectional studies (Asdell et al., 2022; Bersamin et al., 2017a; Bersamin et al., 2017b; Chen et al., 2023; Fitzpatrick et al., 2014; Garrett et al., 2016; Hopkins et al., 2018; Lally et al., 2015; Lemay et al., 2025; O'Connell et al., 2020; Waltermaurer et al., 2013; Wagner et al., 2023; Yarger et al., 2021), 11 qualitative studies (Cabral et al., 2018; Cassidy et al., 2018; Claringbold et al., 2019; Hickey & Shedlin, 2017; Hickey & White, 2015; Lechner et al., 2013; Mann et al., 2020; Payne et al., 2016; Sundstrom et al., 2015; Szajbely & Neiterman, 2025; Vamos et al., 2020), one undergraduate thesis (Nearen, 2018), and one briefing paper (Institute for Women's Policy Research, 2020). The screening process is outlined in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram, which can be viewed in Figure 1.

Of the 26 sources included in the review, four studies took place outside of the US: two in Canada (Cassidy et al., 2018; Szajbely & Neiterman, 2025), one in Ireland (Lally et

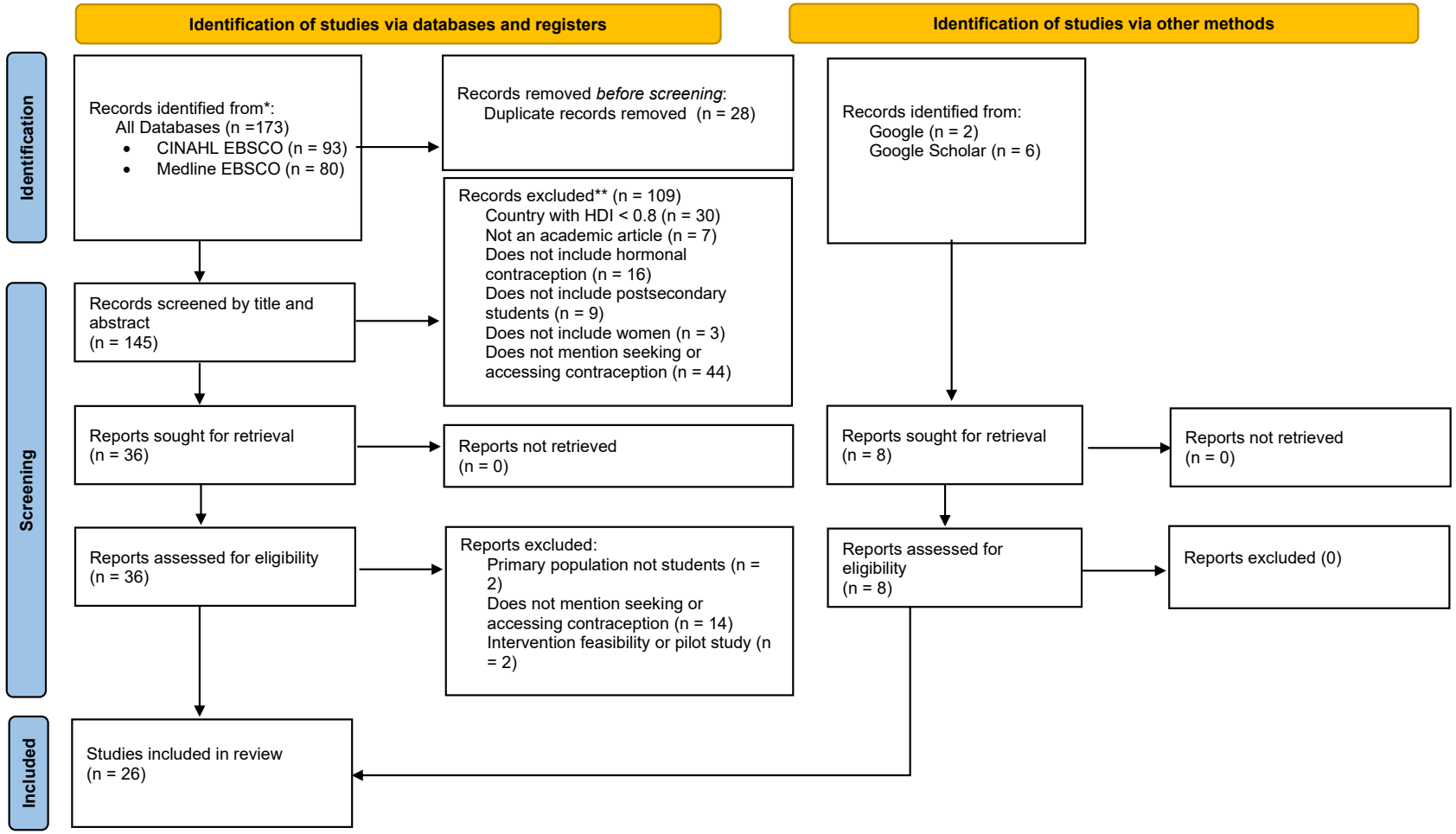
al., 2015), and one in Australia (Claringbold et al., 2019). Claringbold et al. (2019) was the only study that included students from a rural university in their sample. These countries differ in their health delivery models and contraception coverage policies, with all countries offering some level of contraception coverage. Australia, like most of Canada, employs a universal healthcare model with varying drug coverage policies; contraception cost varies depending on method of contraception and individual eligibility for subsidization (Services Australia, 2025). In 2022, Ireland implemented a free contraception coverage scheme, which has expanded to included women, transgender, and non-binary people aged 17 to 35, and covers the cost of consultations with HCPs, family planning, student health and primary care centers, and prescriptions for a wide range of contraceptive options (Government of Ireland, 2025).

Data Evaluation

As multiple types of evidence were included in the sample, each source was evaluated for quality using the Joanna Briggs Institute ([JBI], 2025) critical appraisal tools, according to study design. Each tool is comprised of questions pertaining to quality criteria, prompting the reviewer to provide one of three responses: yes, no, or unclear. "Yes" indicates that the article meets the quality standard, whereas "no" or "unclear" denotes a flaw in the quality of the study or the criterion was not addressed in the report. A summary of the critical appraisal results can be found in the data matrix in Appendix A. While studies varied in quality, all studies met the majority of criteria according to the JBI critical appraisal tools, and no report was omitted during the data evaluation stage. Articles were analyzed with attention to bias and how each piece of research contributes to the construction of knowledge and reality.

Figure 1

PRISMA Flow Diagram



Note. This PRISMA flow diagram depicts the process of identifying, screening, and including studies in this integrative review.

Data Analysis

Using Whittemore and Knafl's (2005) method, data analysis was conducted in four phases: data reduction, data display, data comparison, and conclusion-drawing and verification. This systematic approach promotes a "thorough and unbiased" (Whittemore & Knafl, 2005, p. 550) interpretation of sources and synthesis of the data; however, as feminist theory acknowledges that even a rigorous approach to data analysis is subject to bias, the following steps were taken with the aim of trustworthiness and credibility.

Data Reduction

In the data reduction phase, the sources were first divided into subgroups based on the type of evidence to create a manageable framework. Pertinent data from each source was then extracted and organized into a data matrix based on predetermined categories, which can be viewed in Appendix A.

Data Display

In the data display phase, repetitive words and phrases were identified within each primary source, which were then collapsed into broader concepts, themes, and categories. Two overarching concepts emerged: contraception and sexual and reproductive health services, each with several subcategories. The extracted data from the data matrix was reconfigured into two data displays based on these categories (see Appendix B), facilitating the "visualization of patterns and relationships…and serve as a starting point for interpretation" (Whittmore & Knafl, 2005, p. 551). Only the data pertaining to each category from each source were included in this display.

Data Comparison

The data comparison phase is an iterative process in which the data displays are examined, compared, and grouped in order to extract key themes (Whittemore & Knafl, 2005). During this phase, the results of the data display were reconstructed into concept maps that were drawn and re-drawn until key relationships emerged (see Figure 2).

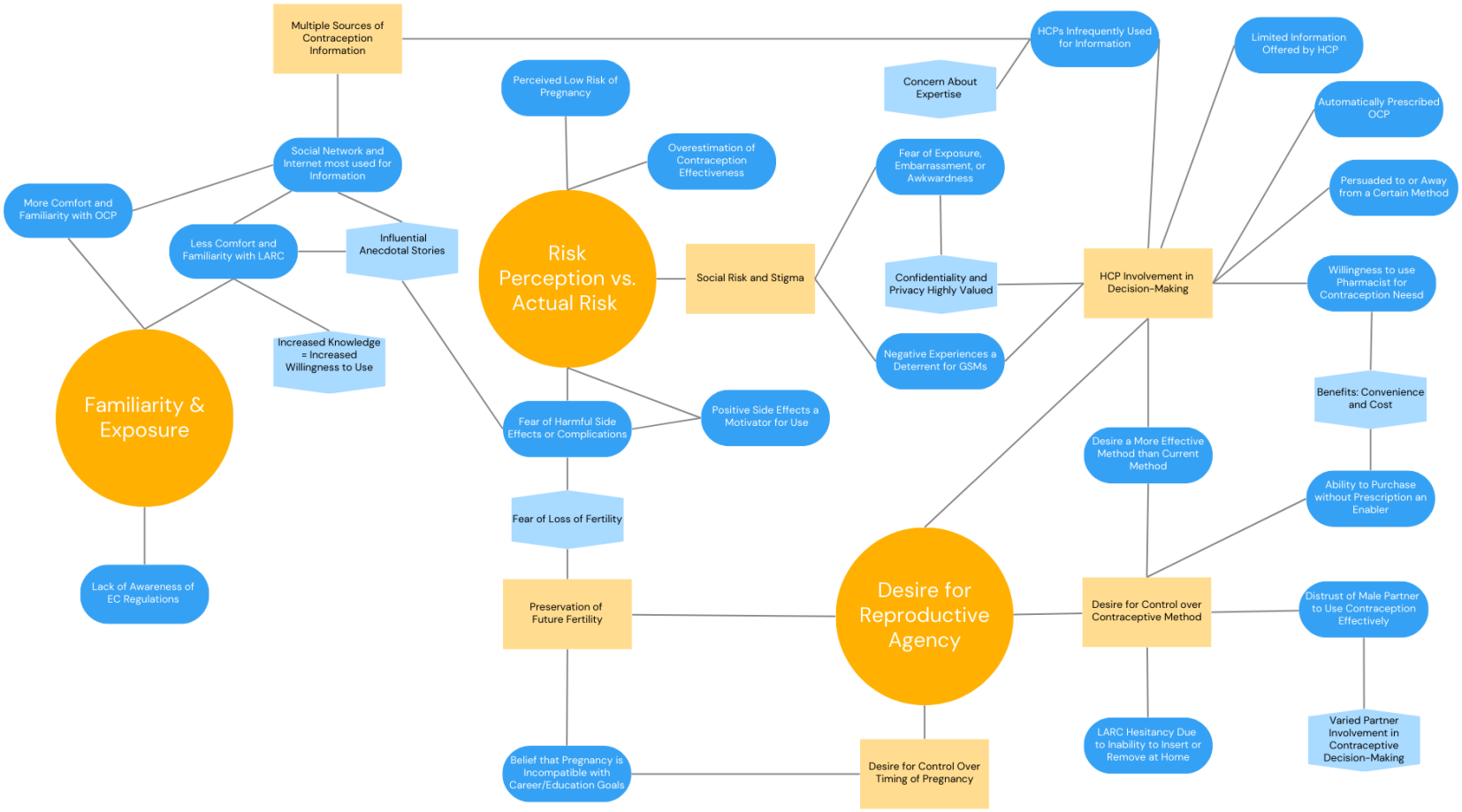
Conclusion Drawing and Verification

In the final phase of data analysis, conclusion drawing and verification, individual patterns and relationships are abstracted into encompassing concepts and themes, which are revised until as much data as possible can be included under this set of these generalizations (Whittemore & Knafl, 2005). After the data was organized, displayed, and mapped, three key themes emerged in this phase: 1) desire for reproductive agency, 2) the influence of familiarity and exposure on contraceptive decision-making, and 3) incongruity between risk perception and actual risk. The following sections will discuss each of the three themes and associated sub-themes.

Desire for Reproductive Agency. The theme of agency, or the capacity to act on one's own goals and interests, was a common thread throughout the literature. In the context of seeking and accessing hormonal contraception, reproductive agency refers to the capacity to decide when, and if, to have children, and the means by which to achieve these goals. In relation to reproductive agency, topics of preserving fertility for the future, the involvement of HCPs, and partner involvement arose.

Figure 2

Data Comparison Concept Map



Note. The data comparison phase involved reconstructing the results of the data display to identify key relationships.

Fertility and the Future. The desire for reproductive agency among women enrolled in post-secondary education emerged through discussions around planning for the future. In four studies, the perceived incompatibility between childbearing and pursuing educational and career goals, or the notion that childbearing was reserved for a later phase of life, was mentioned as a reason for using contraception (Cabral et al., 2018; Hickey & Shedlin, 2017; Hickey & White, 2015; Mann et al., 2020). Of note, a qualitative study of community college students of all genders found that, while many female participants reported a strong fear of pregnancy and its potential negative impact on their lives, a group of male students expressed the belief that an unintended pregnancy would provide motivation to work harder and would not negatively affect their academic or career success (Cabral et al., 2018). This gender difference in perception of pregnancy during post-secondary education was not mentioned in any of the other articles; however, studies that only included male participants were not included.

Despite the common desire to prevent pregnancy among students, fertility was a major concern; in three studies, preserving fertility for the future was a priority when choosing contraceptive methods (Cabral et al., 2018; Payne et al., 2016; Sundstrom et al., 2015). LARC methods were mentioned as being less desirable due to their long-lasting nature and the inability to insert or remove them independently (Claringbold et al., 2019; Sundstrom et al., 2015), limiting the LARC user's level of control over their fertility. LARC methods were also perceived to be a threat to fertility due to the risk of complications, such as uterine perforation, regardless of the actual likelihood of such complications (Asdell et al., 2022; Payne et al., 2016; Sundstrom et al., 2015).

HCP Involvement. When choosing a contraceptive method, the role of the prescribing HCP was frequently discussed. Participants across studies described receiving limited information about contraception methods (Hickey & White, 2015; Payne et al., 2016; Sundstrom et al., 2015), automatically being prescribed OCP (Payne et al., 2016) or being persuaded toward or away from using certain contraceptives (Claringbold et al., 2019; Payne et al., 2016). HCPs were an infrequently used source for information (Hickey & Shedlin, 2017; Vamos et al., 2020), and some students expressed concern about the level of expertise of HCPs at on-campus clinics (Hickey & White, 2015). In a study by Hopkins et al. (2018), 69% of female students across three community colleges in a southern US state wished to use a more effective method of contraception, defined in this study as injectables, OCPs, the patch, ring, implant, or IUD. Despite 59% of these students having access to a prescriber, autonomy in contraception choice was limited. In this way, the clinician as a gatekeeper to contraception was a recurring motif. However, the potential of the clinician to empower contraceptive users was also described; in studies by O'Connell et al. (2020) and Lemay et al. (2025), 73% and 76% of college students, respectively, reported they would be likely to obtain contraception from a community pharmacist if this option were available. Reported advantages of accessing contraception through a pharmacist were: convenience (less time needed, easier to access, and extended hours of operation), and lower cost, all of which increase the ability of the student to access contraception at a time and place of their choosing.

Wagner et al. (2023) described a lack of awareness of EC regulations, including whether or not age restrictions existed, if identification was needed, and if pharmacists could restrict EC access, all of which are potential barriers to seeking EC. Similarly, Szajbely &

Neiterman (2025) found that participants felt uninformed prior to EC use. One study found that ease of availability was the most discussed facilitator in EC use (Hickey & Shedlin, 2017), while another study reported that knowing that EC can be purchased without a prescription was a significant predictor of female college students' intention to use EC (Fitzpatrick et al., 2014). If EC is perceived as being difficult to acquire, even if this is a misconstruction, students may be less likely to access EC. In this way, EC access and use among students may hinge on their level of agency and ability to independently decide to seek this option with or without HCP involvement, or overcome erroneous beliefs that EC is difficult to access.

Partner Involvement. Romantic and sexual partner involvement in contraceptive decision-making was only discussed in three articles (Claringbold et al., 2019; Hickey & Shedlin, 2017; Vamos et al., 2018). In an Australian study by Claringbold et al. (2019), women expressed a lack of trust in their male partners to appropriately use contraception, and they desired to have control over their contraceptive method. Participants in a study by Vamos et al. (2018) expanded on this idea by reporting that the level of partner influence on contraceptive decision-making was dependent on the length and seriousness of the relationship, but that the final decision must ultimately be their own. Contrary to these studies, Hickey and Shedlin (2017) found that the majority of participants reported partner involvement in decision-making and actual purchase of EC. The decision-making process may differ between the use of preventative contraception and the use of backup contraception, as one is an ongoing decision, and the other is a one-time decision.

Familiarity and Exposure. A common theme throughout the literature was the influence of familiarity and exposure, or how exposure to contraceptive options influenced

students' contraceptive decision-making. Familiarity, or lack of familiarity, with different contraceptive methods, was identified as a consideration when choosing contraception (Cabral et al., 2018; Payne et al., 2016; Sundstrom et al., 2015). Students became familiar with different types of contraception through a variety of means, including the Internet or media, their social network, HCPs, secondary school sex education classes, student services, or a combination of these (Claringbold et al., 2019; Garrett et al., 2016; Hickey & Shedlin, 2017; Hickey & White, 2015; Lally et al., 2015; Payne et al., 2016; Szajbely & Neiterman, 2025; Vamos et al., 2020).

The Power of the Social Network. While there was some variability between studies, students widely reported the Internet and their social network as their main sources of information on contraception (Garrett et al., 2016; Hickey & Shedlin, 2017; Payne et al., 2016; Szajbely & Neiterman, 2025; Vamos et al., 2020). In a study by Claringbold et al. (2019), 50% of the students interviewed had decided on a method of contraception before their appointment with their HCP. This finding was echoed in Vamos et al.'s (2020) study, in which participants reported using friends and family to gather information, and to reinforce their contraceptive decision once it had been made.

Discussions about contraception with friends were also described as a means of connecting with and supporting one another (Claringbold et al., 2019). Observed experiences with contraception, or the testimonies of others, were reported as being highly influential when selecting, or rejecting, certain contraceptive methods (Claringbold et al., 2019; Mann et al., 2020; Payne et al., 2016; Sundstrom et al., 2015; Vamos et al., 2020). Anecdotal stories of contraception were powerful motivators even when students knew the source was unreliable (Hickey & White, 2015).

OCP versus LARC: Seen and Unseen. The observability of OCP versus LARC methods was persuasive in selecting a contraceptive method. In four studies, lack of visibility of LARC users, or spread of misinformation through social networks about risks of LARCs, contributed to negative beliefs about LARCs and discomfort with the idea of using this method (Claringbold et al., 2019; Mann et al., 2020; Payne et al., 2016; Sundstrom et al., 2015). On the contrary, familiarity with the OCP made this method more acceptable to students, as students deemed it a safer option (Mann et al., 2020; Sundstrom et al., 2015). These narratives around contraception, perpetuated by social networks, may be related to lack of knowledge around contraception and its risks among undergraduate students, which will be discussed below.

Incongruity Between Risk Perception and Actual Risk. The literature consistently found incongruities between undergraduate students' perceived risks of pregnancy or contraception use and the actual risk of either. These perceived risks had an impact on students' contraceptive decision-making. In addition, students considered potential social risks associated with using various services, such as campus health clinics or clinics that offer solely SRH services, when considering whether to use these services.

Perception of Pregnancy Risk. While pregnancy was consistently viewed as an undesirable event by students, concern about pregnancy did not necessarily drive contraceptive decision-making. Many students did not consider themselves at risk for unintended pregnancy (Cabral et al., 2018; Hickey & Shedlin, 2017) or overestimated the effectiveness of their contraceptive methods (Cabral et al., 2018). Vamos et al. (2020) found that participants accessed SRH services only when considering sexually transmitted infection (STI) prevention, rather than pregnancy prevention. In a study of 482 college women, worry

about pregnancy increased consideration of EC use by approximately 30%, but actual EC use remained unaffected (Waltermaurer et al., 2013). In addition, the decision to use contraception was, at times, driven by the desire for positive side effects, such as acne reduction or menstrual cycle management (Cabral et al., 2018; Claringbold et al., 2019; Sundstom et al., 2014).

Underestimated Risks of OCP and Overestimated Risks of LARCs. Although pregnancy risk was perceived as low by students in several studies, many students reported fear of complications as a reason for preferring one contraceptive method over another. In several studies, students perceived the OCP as carrying fewer risks compared to LARC methods (Mann et al., 2020; Payne et al., 20165; Sundstrom et al., 2015), which reflects the theme of the familiarity and exposure.

Knowledge about contraceptive methods was investigated in 11 studies (Asdell et al., 2022; Cabral et al., 2018; Claringbold et al., 2019; Fitzpatrick et al., 2014; Lally et al., 2014; Mann et al., 2020; Nearen, 2018; Payne et al., 2016; Sundstrom et al., 2015; Vamos et al., 2020; Wagner et al., 2023). Out of eight studies that discussed LARCs methods, seven studies found that students feared potential complications or negative side effects of LARCs (Asdell et al., 2022; Cabral et al., 2018; Claringbold et al., 2019; Mann et al., 2020; Nearen, 2018; Payne et al., 2016; Sundstrom et al., 2015), and the word "unnatural" appeared in five studies when students described LARCs (Cabral et al., 2018; Claringbold et al., 2019; Mann et al., 2020; Payne et al., 2016; Sundstrom et al., 2015). Perceived risks of LARCs included infertility (Cabral et al., 2018; Nearen, 2018; Payne et al., 2016; Sundstrom et al., 2015), damage to reproductive organs (Mann et al., 2020; Nearen, 2018; Payne et al., 2016), and death (Nearen, 2018; Sundstrom et al., 2015), which were deterrents to using LARCs

regardless of the likelihood of these events. Of note, Asdell et al. (2020) found that the average score on a 10-item LARC knowledge assessment that was administered to female undergraduate students, graduate students, and resident physicians was 4.8/10. There was a statistically significant difference in both willingness and intent to use a LARC method in the future between students scoring above and below the mean, with students who scored higher being more willing to use, or intending to use, a LARC method in the future.

Five studies investigated knowledge of EC (Hickey & Shedlin, 2017; Hickey & White 2015; Lally et al., 2015; Szajbely & Neiterman, 2025; Wagner et al., 2023). Similarly to LARC methods, students demonstrated low knowledge of EC, particularly around effectiveness, side effects, and timing (Hickey & White, 2015; Hickey & Shedlin, 2017; Lally et al., 2014; Szajbely & Neiterman, 2025). Wagner et al., (2023) also found that many students were unaware of methods of EC other than levonorgestrel. Ultimately, misinformation about contraception was prevalent among undergraduate students, and under- or over-estimation of risk factored into contraceptive decision-making.

Social Risks and Stigma. Students' comfort with accessing SRH services also factored into their willingness to seek contraception. In studies, confidentiality and privacy were cited as being of high importance when visiting a health clinic, and fear of exposure, embarrassment, awkwardness, or perceived social disapproval were barriers to accessing SRH services (Bersamin et al., 2017a; Cassidy et al., 2018; Claringbold et al., 2019; Hickey & Shedlin, 2017; Hickey & White, 2015; Szajbely & Neiterman, 2025; Vamos et al., 2020). Conversely, participants in one study stated that visiting an SRH clinic was a social activity done in solidarity with peers (Cassidy et al., 2018). In a study by Lally et al. (2015), 58.1% of sexually active students at a university in Ireland were hesitant to access on-campus health

services, although the reasons were unclear, and in Lechner et al. (2013), some participants stated that they did not rely on campus-based SRH services out of a desire to separate personal and academic life.

Another barrier to accessing SRH services was fear of spaces not being welcoming or approachable for gender and sexual minorities (GSMs). In a Canadian study, Cassidy et al. (2018) found that lesbian, gay, bisexual, transgender, and queer (LGBTQ) undergraduate students were less willing to seek SRH services due to experiences of HCPs assuming a heterosexual orientation or being uncertain with what services to provide once made aware of their sexuality. Similarly, Chen et al. (2023) found that nonbinary gender and transgender identity were risk factors for decreased contraceptive access, as HCPs often neglect contraceptive counselling for this population. In Wagner et al.'s (2023) study, concern about EC being denied to transgender men was also raised.

Altogether, this data suggests that there are social risks and stigmas associated with accessing SRH services, which may have an impact on contraceptive decision-making.

Limitations

A benefit of an integrative review is the ability to gather and synthesize diverse types of research (Whittemore & Knafl, 2005); however, the search conducted for this review resulted in only cross-sectional and qualitative research, not inclusive of the grey literature. These sources are typically considered as having low strength in the hierarchy of evidence as they lack generalizability beyond the study populations; however, observational studies of this nature are appropriate for the research question and contribute valuable insights.

The studies in this review were geographically diverse, and each country represented in the literature differs in their healthcare delivery models, contraception coverage policies,

and the sociodemographic characteristics of their populations. These differences, combined with the observational nature of the studies, mean the findings are not generalizable to other populations.

Of note, there was limited discussion around the experience of GSMs when seeking and accessing contraception within the retrieved articles. Out of 26 primary studies, nine studies accounted for sexual minorities (Asdell et al., 2022; Cabral et al., 2018; Cassidy et al., 2018; Chen et al., 2023; Lechner et al., 2013; Lemay et al., 2025; Payne et al., 2016; Sundstrom et al., 2015; Vamos et al., 2020), and six studies (Cabral et al., 2018; Chen et al., 2023; Lechner et al., 2013; Lemay et al., 2025; O'Connell et al., 2020; Wagner et al., 2023) accounted for gender minorities in their demographic data. In only four articles, the experiences of GSMs were directly addressed in the methods or findings (Cassidy et al., 2018; Chen et al., 2023; Lechner et al., 2013; Wagner et al., 2023). Consequently, little is known about how GSMs experience seeking and accessing contraception, and how to ensure equitable access to SRH services for this demographic.

Summary

The ability to acquire contraception easily and independently was identified as an enabler to access in the literature. The majority of the studies retrieved in this review were situated in the US, which employs a different health care delivery model than Canada. As the Internet was preferred over HCPs as a source of contraception information, and familiarity and exposure had an influence on contraceptive decision-making, exposure to American culture and media may affect perceptions of contraception access and availability. Despite differences in actual availability of EC between Canada and the US, perception of availability of contraception may have an impact on if, and how, Canadian students seek

contraception. As there was a significant lack of studies that sampled from Canadian universities, studying undergraduate students' experiences with seeking and accessing hormonal contraception in northern BC would contribute to narrowing this gap, and highlight considerations of SRH care delivery to students in rural communities, which is currently unknown.

When discussing how knowledge of contraception was shared, students mainly described conversations with other women, rather than men, suggesting that women's stories and intimate knowledge on this subject may carry weight compared with other sources. This suggests that the discourse surrounding hormonal contraception is deeply intertwined with women's stories, making an exploration of this discourse essential for understanding how contraceptive knowledge is constructed and how it influences reproductive decision-making. In particular, the perspectives of GSMs, outside of agglomerate data, were largely absent from the literature.

Motivating factors to use hormonal contraception were varied in the literature. Despite a pervasive fear of pregnancy among university students, the perceived risk of pregnancy was low. Meanwhile, the perceived risk of contraception, particularly LARCs, was high, but positive side effects were a primary reason for use of contraception in some cases. Feelings around accessing SRH services were also mixed, with differing levels of reported social risk. These conflicting findings suggest that contraceptive-decision making is a complex process that involves a multitude of internal and external influences.

Implications

There is a need for research on reproductive issues that not only examine existing structures but actively disrupts and transforms societal dynamics that uphold oppressive

systems. Feminist research offers an avenue for advancing these goals, particularly within institutions that are resistant to change, such as the post-secondary education sector (Harding, 1991). In the study of hormonal contraception, voice serves as a critical tool, capturing personal narratives and integrating them into broader discursive frameworks that foreground women's lived experiences. Individual realities are deeply enmeshed in larger social and political structures, simultaneously reflecting and shaping systemic forces (Thompson et al., 2018). Guided by the literature, the following research prioritizes amplification over researcher interpretation, providing a platform for perspectives that have been silenced or misunderstood, including those of GSMs, with the goal of challenging dominant discourses.

CHAPTER THREE

Theoretical Perspective, Methodology and Methods

The research question that guided the above literature review was: What are undergraduate students' experiences of seeking and accessing hormonal contraception? The studies found in response to this question largely represented the experiences of postsecondary students in the US and/or were situated on urban campuses. There exist gaps in the literature on Canadian students' experiences with contraception, specifically in rural settings. Northern BC is an ideal location to investigate this issue, as doing so provides insight into if, and how, the recent provincial implementation of universal contraception coverage has impacted young adults in post-secondary education.

This study aimed to answer two research questions:

3. *What are undergraduate students' experiences of seeking hormonal contraception in northern BC?*
4. *What are undergraduate students' experiences of accessing hormonal contraception in northern BC?*

The objectives of this study were to: (a) uncover power dynamics that influence undergraduate students' contraceptive decision-making and engagement with SRH services; (b) identify barriers and enablers for undergraduate students who are seeking and/or accessing hormonal contraception; and (c) amplify the voices of often marginalized and underrepresented groups. Grounded in a qualitative feminist approach informed by intersectional and poststructuralist theories, the study critically examines how power structures shape contraceptive decision-making (objective a). A small, yet diverse, sample of undergraduate students, engaged through purposive recruitment and in-depth, semi-

structured interviews, provides insight into the factors facilitating or obstructing access to hormonal contraception (objective b). Additionally, by applying the voice-centered methodology of Feminist Relational Discourse Analysis (FRDA), the study highlights the intersection of societal and personal discourses, ensuring that often-overlooked perspectives are brought to the forefront (objective c).

Theoretical Framework

The proposed study used a qualitative feminist methodology to explore undergraduate student's experiences of seeking and accessing contraception. Contraception access is inherently a feminist issue, as it allows women the ability to decide when, and if, they have children. Historically, women's health concerns and needs have often been ignored or minimized, and this pattern is reflected in androcentric health research that has not sufficiently or accurately represented the lives of women (Merone et al., 2022). Feminist researchers aim to conduct research in a way that is alert to these power imbalances and aligned with what disadvantaged groups want to know (Harding & Norberg, 2005). Qualitative methodologies lend themselves well to this goal, as such approaches value subjective knowledge and allow researchers to capture detailed, rich description of participant's experiences.

Although Canada has made efforts to make health research more inclusive of women, traditional research methods tend to assimilate all women into one category without giving adequate attention to the interactions between social determinants of health. Therefore, an intersectional feminist perspective, which strives to understand what is experienced at the intersection of two or more axes of oppression (i.e., race, ethnicity, gender, class, and sexuality), offers the opportunity to explore contraception access from multiple standpoints.

An intersectional feminist approach to contraception research offers a counterbalance to the patriarchal values that are prevalent in Western healthcare by foregrounding the perspectives of disadvantaged and marginalized groups (Hankivsky & Christoffersen, 2008). As Smith (1991) writes, "From feminism in particular has come the understanding that the apparently positionless accounts are indeed not so. There is an underlying organization of gender, race and class that structures yet is absent from the surfaces of objectified texts" (p. 157). Standpoint theorists, like Smith, propose an alternative approach to social research that aims to expose oppressive systems and liberate women by studying women's own accounts of their lives, experiences, and labours, and valuing these narratives as a source of authoritative evidence.

While standpoint theory emphasizes the value of women's lived experiences as a site of knowledge construction, critics of standpoint theory argue that this perspective can homogenize women by depicting them as one unified body with the same, or similar, experiences; in reality, power differentials exist among women. As Crenshaw (1989) argues, oppression is experienced differently for different women, depending on their race, sexual orientation, and other identities.

Poststructuralist feminism embraces the perspective that traditional methods of research obscure women's realities, without claiming that women have an epistemological privilege (Harding, 1991). Rather, poststructuralist feminists assert that all knowledge is partial, and there is no objective "truth"; instead, meaning and identity are rooted in language and discourse (Haraway, 1988). Research using a poststructuralist framework "offers critiques and methods for examining the functions and effects of any structure or grid of regularity that we put into place, including those poststructuralism itself might create" (St.

Pierre & Pillow, 1999, p. 6). In essence, poststructuralism refutes grand theories and universal claims and examines discursive sites of power to better understand and deconstruct hierarchies of gender and privilege (Butler, 1990). It is through a lens of poststructuralist feminism that the proposed study will be conducted.

Positionality

Historically, researcher objectivity has been a primary tenet of mainstream research methodologies, the goal being to produce "pure" data that is untarnished by the researchers' biases or values. As the feminist movement flourished in the latter half of the 20th century, a counterargument was made that "value-free research is an unachievable ideal" (Harding & Norberg, 2005, p. 2010). In recognition of this, feminist methodologies maintain that the researcher has a responsibility to consider how they are positioned in relation to the research process, and how this process affects the end product (Letherby, 2003). This awareness is fostered through the practice of reflexivity, a method of disciplined self-reflection that "begins from the perspective that researchers cannot ever be separate from the research process, and so reflecting on our personal identities, values, and politics is part of situating the knowledge we produce" (Lafrance & Wiggington, 2019, p. 541).

During this study, my role as a researcher inevitably affects all stages of the research process. My lived experiences, thoughts, values, and identity are inextricable from the study design, data collection, analysis, and knowledge translation processes. Failure to recognize this influence could result in prioritizing my interpretations of systemic and structural oppression over the participants' narratives (Saukko, 2008). As such, the practice of reflexivity played an important role in the research process.

One aspect of reflexivity is analyzing the ways in which my positionality coincides with, and differs from, that of the study participants. Although I am unaware of the specific ways in which my social position intersected with those of the participants, I maintained both an insider and outsider status with the study population. As a woman of childbearing age, who has graduated from an undergraduate program in northern BC, and has experiences of seeking contraception, I shared common ground with my participants, granting me "insider status" in some ways. However, there is inherently a power imbalance between me, as the researcher, and the participants. In addition, my social position as a graduate student, faculty member, and White middle-class woman, may have contributed to this power differential, and may or may not have placed me in the realm of "outsider."

The subjectivity of the researcher need not be a hindrance to quality research. Rather, according to feminist principles, by acknowledging and disclosing relevant personal information, research agendas, political commitments, and concerns around the research topic, the researcher and the participants can engage in a collaborative process of knowledge construction. The aim of feminist research is to foster a reciprocal exchange, rather than a one-way appropriation of data on behalf of the researcher (DeVault & Gross, 2014).

Methodology

In health research, qualitative research methodology is frequently used to understand and develop theories around health behaviours, describe lived experiences, and inform the development of health interventions based on identified needs (Polit & Beck, 2021). Qualitative research is well-suited to this study, as it seeks to explore individual experiences of seeking and accessing contraception. While phenomenological designs are commonly used to study how individuals make meaning of their lived experiences (Starks & Brown

Trinidad, 2007), phenomenology does not seek to address the broader societal structures and power dynamics underlying individual experiences, nor is it designed to challenge systems of oppression.

Discourse analysis is a qualitative method that uses a broader lens to examine the construction of social, cultural, and political practices through language experiences (Starks & Brown Trinidad, 2007). This provides a means to study how language is used in real-world contexts (Parker 1992, 2013), in this case, female postsecondary students seeking and accessing hormonal contraception. Applying discourse analysis facilitates an examination of how the meaning of language shifts depending on situation and social setting, while also revealing how language centers the phenomena of interest, reflects and sustains power relations, and reinforces norms, ideologies, and realities that shape women's social roles and identities within broader society (Haraway, 1988; Smith, 1991; St. Pierre & Pillow, 1999).

In drawing together the need for a feminist research and activism approach that constructs and examines identity, explores power, and illuminates overarching patterns of meaning, while positioning women's voices as central and actively constructed, Feminist Relational Discourse Analysis (FRDA) emerged as the guiding framework for this study. This is a voice-centered analytical approach that aims to capture both lived experiences and dominant discourses, with the motive of identifying and dismantling existing power relations (Thompson et al., 2018).

Feminist Relational Discourse Analysis

FRDA is a method of discourse analysis that was developed in response to an absence of an analytical framework that focused on the interplay between experience and discourse (Thompson et al., 2018). Previously established methods of discourse analysis sought to

account for macro-level structures of power and privilege (Parker, 2013). While these methods have value in highlighting oppressive institutions, Saukko (2008) argues that focusing on the structural can result in suppression of individual voices, and even appropriation of participant voices for the purposes of explanation or critique. FRDA strives to "shed light on structural systems of power and the voices of those who go unheard within these" (Thompson et al., 2018, p. 99).

While FRDA shares some overlap with broader discourse analysis, several key distinctions set it apart, including its explicit commitment to feminist goals and its unique two-phase analytical framework. These phases are outlined in the work of Thompson et al. (2018) and are visually depicted in Figure 3. Phase 1 involves a poststructuralist discourse analysis that identifies patterns of language use, culminating in the identification of discursive patterns and discursive realms. Phase 2 then engages a voice-centered analysis using the Listening Guide method (Gilligan & Eddy, 2017), tracing participants' voices through these discursive patterns to examine how individuals position themselves and how they negotiate personal meanings (i.e., contrapuntal voices). This dual-phase approach integrates macro-level discourse analysis with micro-level experiential insights, helping to avoid obscuring participants' first-hand experiences through interpretive abstraction, an aim underscored by the "I poem" generated from each participant's first-person statements in Phase 2.

Importantly, FRDA acknowledges the embodied, affective dimensions of discourse, recognizing how the oppressive structures upheld by discourse can "hit" and "bruise" individuals (Ahmed, 2017, p. 30). In this thesis, I adapted the terminology used in Phase 1, Step 7, originally referred to as "discursive realms," to "discursive interlude." This personal

adaptation was an intentional reframing to foreground and magnify the voice of a particular participant whose account risked being diluted in broader thematic interpretations.

At its core, FRDA prioritizes voice and the interplay between personal experience and broader discourse. As a voice-centered methodology, it seeks to disrupt and transform the social relations that marginalize individuals based on gendered identities, particularly within systems of patriarchal privilege, such as healthcare systems (Barker, 2015; Cole, 2009). FRDA is applied exclusively in research that advances feminist objectives by capturing the interaction between personal narratives and larger discursive frameworks (Thompson et al., 2018), facilitating a nuanced understanding of agency. This includes recognizing the structural constraints imposed by power while simultaneously creating space for the articulation of resistance through voice.

While traditional discourse analysis examines how discourses operate to position individuals within power relations (Parker, 2013), FRDA extends this by analyzing how individuals negotiate, internalize, or resist these discourses and what personal functions such negotiations serve. Central to FRDA is the conceptualization of discourse as a relational, socially situated practice that not only reflects but also constructs identities, power relations, and social meaning. Discourse, in this view, is shaped by historical, institutional, and sociocultural contexts, and is continuously reproduced through everyday interaction (Parker, 2013; Thompson et al., 2018).

By simultaneously capturing experience and discourse, FRDA offers a way to bridge the often-separated phenomenological and social constructionist paradigms, two approaches that are traditionally seen as epistemologically incompatible (Harper, 2011). FRDA instead posits that discourse and experience are interwoven, and that voice carries both. As Saukko

(2008) articulates, feminist methods of discourse analysis view the self not as solely constructed by discourse, but as emerging through the dynamic mediation between experience and discourse. Similarly, Gilligan et al. (2006) emphasize the relational nature of the self as it unfolds through narrative.

Ultimately, FRDA provides a critical lens through which to examine how dominant ideologies are perpetuated in everyday language, while also attending to how individuals actively navigate, challenge, or reconfigure these discursive frameworks.

FRDA is a fitting method for this study, as it operationalizes feminist principles using a structured approach while offering the flexibility to explore emerging narratives around experiences seeking and accessing hormonal contraception fully and authentically. By paying special attention to discourses around power and privilege, this study aimed to capture the ways in which structural realms (i.e., educational institutions and healthcare delivery models) interact with personal realms to shed light on discourses around reproductive agency among undergraduate students, one of three key themes identified in the integrative review in Chapter 2.

While FRDA is a complex methodology, the opportunity to have meaningful and open discussion with my committee members, which included a social scientist and strong feminist scholar who had to later step away, supported my decision to pursue this method. Recognizing the depth of analysis required, my committee also helped establish clear boundaries around sample size to ensure I could engage deeply with the methodology without becoming academically overextended. This process will be described in detail below.

Methods

This section will outline the sampling strategies, data collection procedures, and data analysis methods conducted in this study, along with ethical considerations and the steps taken to ensure validity. While FRDA does not require interviews as a method of data collection, they were chosen for this study because they elicit rich, first-person narratives that reveal how participants construct meaning within social and discursive contexts.

Ethical Considerations

Ethical approval was granted by the Research Ethics Board at UNBC (see Appendix C). The study adhered to principles of respect, confidentiality, and informed consent, as outlined by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2).

Consent. Participants were provided with a study information document and consent form outlining the full details of the study and the implications of participating in the study (see Appendix D). Informed consent was collected prior to the interview and participants were informed that their participation was voluntary and that they were free to withdraw their consent at any time if they wished to do so. Participation in this study was not anticipated to carry risks to the participants. However, participants were made aware that sensitive questions may be asked that could solicit an emotional response. A safety plan and a list of accessible BC resources were put in place, as described below, to address this type of response, should it occur.

Data Management. Privacy and confidentiality of participants was maintained throughout the study. Audio and video recordings of interviews were stored on a password-protected, secure UNBC OneDrive account, accessible only by the researcher, until they

were transcribed, after which they were destroyed. Identifiable information was deidentified, and the master list of names and their affiliated codes was stored separately in a designated locked drawer on the UNBC Prince George campus. The supervisory team reviewed the transcripts to elicit discussion; transcripts were shared via secure UNBC email. At time of consent, participants were required to consent that quotes can be used in final outputs such as reports, presentations, and academic papers. Further, as the thesis defense at UNBC is an open forum, a student audience may self-select to attend the final thesis defense. There will be no identifiable data shared. The information gathered during this study will be kept for five years, after which it will be securely destroyed.

Special Considerations. This study involved discussing potentially sensitive topics. As such, extra precautions to ensure participant safety were warranted. By acknowledging the harm caused by historically male-centered research, feminist research methodologies demand a high ethical standard to avoid perpetuating these harms, particularly in regard to the researcher-participant relationship. There exists an inherent power differential between the researcher and participant, and an awareness of this, paired with conscious efforts to reduce this disparity, are prioritized in feminist research (DeVault & Gross, 2014).

One strategy to reduce the risk of harm to participants is to embrace an "ethic of care"; in doing so, the researcher orients their approach to the researcher-participant relationship around the principles of support and respect for the population they are studying (Burgess-Proctor, 2015, p. 126). By supporting the emotional well-being of participants and fostering a transparent and honest exchange, the researcher can reduce the risk of harm to participants. An ethic of care was applied in this study by establishing a clear safety plan for

participants, and ensuring participants were always informed of their options, fostering a sense of agency.

While not the specific population under study, survivors of sexual assault may have been involved in the study, as women and marginalized groups are at higher risk of sexual violence. Discussion of topics such as contraception and sex may prompt secondary trauma or "revictimization" (Hlavka et al., 2007). If at any point the participant were to experience an emotional reaction to the topic being discussed, the researcher would not proceed without the participant's consent. Accessible and appropriate local resources were listed in the study information document, should the participant have wished to seek additional supports during or after the study. These supports included:

- Foundry, a multi-service health and wellness centre that offers virtual and in-person services for youth up to age 24 in BC.
- The Crisis Prevention, Intervention & Information Centre for Northern BC, a peer support service that has 24-hour phone lines staffed by crisis line workers.
- The Prince George Sexual Assault Centre, a free counselling and support service for people who have been affected by sexual abuse.
- Options for Sexual Health Care, a free service with clinics across BC that provide confidential sexual health care rooted in reproductive choice.

Sampling Strategy and Participants

Purposive sampling was conducted to obtain a sample of respondents from UNBC, inclusive of all campuses (Northwest [Terrace and Prince Rupert], South-Central [Quesnel], and Peace-River Liard [Fort St. John]). Purposive sampling is a method of nonprobability sampling that aims to produce a sample that is representative of the population by

intentionally selecting participants based on specific characteristics or elements (Lavrakas, 2008). This study aimed for a sample size of five participants. Given the high degree of methodological complexity and layered nature of FRDA, this decision supported a commitment to maintaining analytical depth while ensuring the study remained manageable and methodologically sound. Further, depth and richness of interaction matter more than quantity in relational discourse analysis. As Patton (1990) highlighted, "validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size" (p. 185).

Although data saturation, or the point at which no new themes or concepts emerge, is a commonly used principle for determining sample size in qualitative research, this study did not employ this approach. As Saunders et al. (2017) highlight, saturation is inconsistently conceptualized and operationalized across qualitative studies, often treated as a rigid threshold despite its fluid nature. Feminist methodologies emphasize flexibility, using saturation as a guideline rather than a definitive endpoint (Morrow, 2005). Given the exploratory, voice-centered nature of this study, new insights were expected to emerge continually, making traditional notions of saturation less suitable; rather, the focus was to capture the nuances and complexities of participants' experiences.

In keeping with feminist methodology, and recognizing that knowledge production is an ongoing, iterative process, careful attention was given to attaining a sample that contained participants of diverse cultural and ethnic backgrounds, gender identities, and sexual orientations. To achieve this within a small sample of five, an intentional sampling strategy that involved multiple stages of sampling was implemented, as follows:

1. Recruitment ads with the title of the study, purpose of the study, eligibility criteria, participation details, and contact emails for the student researcher and supervising faculty member, were distributed on UNBC bulletin boards. UNBC department administration were contacted to send recruitment ads out via their email list-servs. Student-led organizations and other campus resources, including the First Nations Centre, Pride Centre, and Northern Women's Centre, were approached to request assistance with distribution of recruitment ads.
2. Snowball sampling, a method in which a subject from an initial sample group is asked by researchers to recommend individuals to act as future participants, was used throughout the sampling process to locate individuals that purposive sampling may not reach (Frey, 2018).
3. To manage potential over-recruitment and ensure a diverse sample, a preliminary screening survey that included questions around gender and sexual identity, racial and ethnic identity, and residency, was emailed to interested participants to help hand-select individuals reflecting the diversity of the student body (see Appendix E). In total, over a period of seven weeks over the fall semester, 14 people expressed interest in the study, and five were selected based on responses to the screening survey.

Eligible participants included: part-time or full-time undergraduate students between the ages of 18 and 28 who attended UNBC at the time of sampling, are female or assigned female at birth, and had sought and/or accessed hormonal contraception from an HCP within the past year. All participants must be fluent in English. Participants who were excluded

from the study include those who did not meet the above criteria, or those who were unable or unwilling to participate.

Data Collection

This study used qualitative methodology that included semi-structured, in-depth interviews with female undergraduate students in northern BC who had sought hormonal contraception in the past year. Questions were generated based on the frameworks developed by Bertrand et al. (1995) and Bruce (1990). Bertrand et al. (1995) described key domains of access to family planning programs as cognitive, administrative, economic, geographic, and psychosocial. These domains acknowledge the complex barriers individuals face and reflect the principles of intersectionality theory, which calls attention to how social determinants and power structures interact to influence reproductive autonomy (Hankivsky et al., 2008). Bruce (1990) identified six elements of quality of care provided by family planning services: choice of methods, information given to clients, technical competence, interpersonal relations, mechanisms to encourage continuity, and appropriate constellation of services. These elements emphasize choice and informed consent, which align with feminist principles of empowerment and bodily autonomy (Ross et al., 2017).

These aspects of accessibility and quality of care were used to generate the following domains of inquiry: utilization of services that provide hormonal contraception, participants' experiences seeking hormonal contraception, priorities when seeking contraception, barriers and facilitators to seeking contraception, and perception of qualities of HCPs who prescribe contraception. These domains of inquiry reflect the findings of the integrative review, which highlight barriers to seeking contraception, such as misinformation and stigmas, the perception of HCPs as gatekeepers, and the desire for contraceptive methods that support

individual family planning and reproductive goals. The interviewer added or adapted questions based on participant cues or statements. See Appendix F for the semi-structured interview guide.

Interviews were conducted through a Zoom virtual meeting platform via UNBC's license. While in-person interviews would have been ideal for capturing body language and overall tone, a virtual platform offered greater accessibility and convenience for participants. As UNBC consists of four regional campuses across a geographical area of approximately 93,000 km^2, travel to complete one-to-one in-person interviews was outside the scope of this graduate thesis study. Interviews were scheduled for one hour. If the interview was not finished by the end of one hour, participants were given an opportunity for a second interview, should they have wished. All interviews were audio-recorded and transcribed using Zoom's audio transcription feature and reviewed for accuracy through a second listening. The interviewer took notes during the interview, and summarized reflections and salient points in a memo immediately after the interview.

Data Analysis

FRDA has a distinct methodological structure designed to capture individual voices, broad societal discourses and the experiences that negotiate them (Lafrance & McKenzie-Mohr, 2014). Thompson et al. (2018) outline two clear analytical phases (as depicted in Figure 3) to explore how experiences and discourses come to be situated together through voice: (1) poststructuralist discourse analysis and (2) analyzing emergent voices in relation to discourses. Phase 1 consists of a form of macro-level discourse analysis, informed by Foucauldian principles surrounding the relationship between power and knowledge (Arribas-Ayllon & Walkderdine, 2008). Phase 2 explores the ways in which individual voice is heard

in relation to the discursive patterns identified in Phase 1, with attention to the political contexts in which this occurs.

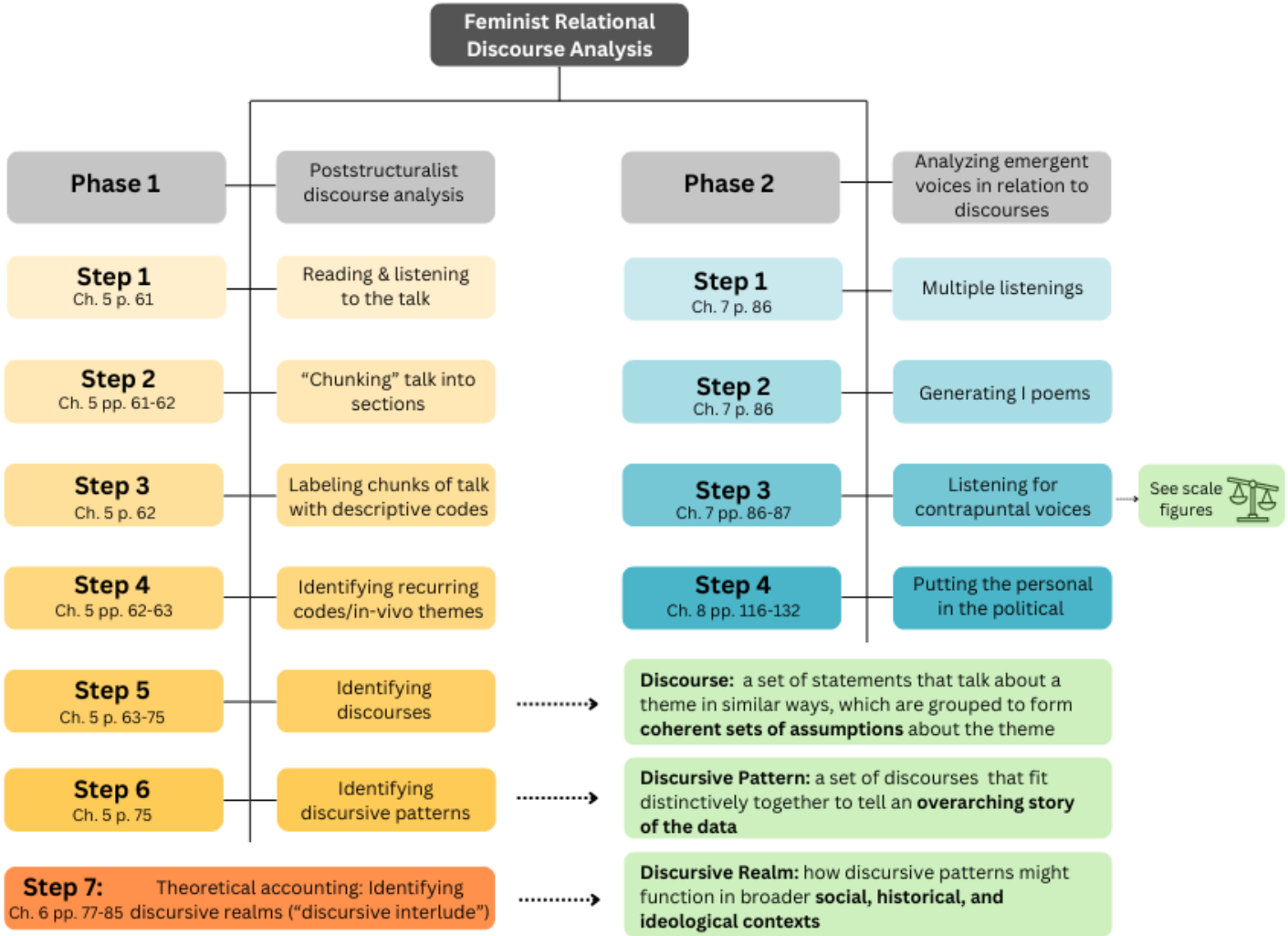
FRDA in this thesis focuses on key concepts across the different phases of analysis (see Figure 3) by centering intersectionality, challenging structural binaries, and emphasizing embodied experiences. These concepts include: (1) how gendered norms for women are shaped through medical and cultural discourses, and how sex and gender intersect within these discursive frameworks; (2) discursive formations as systems of meaning that govern what can be spoken, what is silenced, and who has the authority to speak in particular contexts; (3) how power produces expected behaviors through mechanisms such as self-regulation and internalization; (4) how power relations are embedded in everyday interactions connected to contraception and reproduction; (5) how power inevitably invites resistance, creating opportunities for contested discourses to be reinterpreted or redefined, which can disrupt dominant narratives like the male/female binary and open space for agency; and (6) subjectification, the process through which individuals take up and negotiate identities in relation to prevailing discourses and their consequences.

Phase 1: Poststructuralist Discourse Analysis. The first phase of data analysis consisted of analyzing the interview transcripts, using seven steps, to identify discursive patterns. Examples of how each step was applied are provided in Figure 4 in Chapter 5, with the exception of Step 7, which constitutes its own chapter, titled "Discursive Interlude." The steps are as follows:

Step 1: Reading and listening to the talk. Multiple listenings were conducted to identify different stories in the data, and the way these stories were told. The goal of this step is to build familiarity with the data, tune into the stories being told, and note emerging

Figure 3

Feminist Relational Discourse Analysis Method



Note: This graphic depicts the dual-phase method of Feminist Relational Discourse Analysis.

themes, voices, or plots. The researcher must pay attention to topics, how stories are told, and what happens in them. This is also the stage whereby the researcher reflects on their responses to situate themselves relationally and understand how these responses might shape their understanding, beginning the work of connecting the personal and structural.

Step 2: "Chunking" talk into sections. The transcripts were divided into sections, or "chunks," by identifying when there was a change in topic and bracketing each section. A bracket marks the end of one chunk and the start of another.

Step 3: Labelling chunks of talk with descriptive codes. Each chunk was assigned a descriptive code. Chunks labelled with similar codes were identified and grouped together.

Step 4: Identifying recurring codes, or in-vivo themes. Sections of text that were labeled with similar codes were grouped together in theme files, which were assigned a name after the topic being addressed.

Step 5: Identifying discourses. This step involved analyzing how each theme is constructed through language. A discourse is understood as a "system of statements which construct and object" (Parker, 1992, p. 5), meaning that statements which describe a theme in similar ways collectively represent a particular version of reality related to that theme, often reflecting taken-for-granted knowledge. Within each theme file, such statements were grouped together to create coherent clusters that "hang together" (Thompson et al., 2018, p. 105). These clusters were then analyzed as distinct sets of assumptions and meaning systems associated with the theme. Importantly, multiple, and even contradictory, discourses often emerged within a single theme, which is expected and valuable, as it opens space for deeper critical analysis.

Step 6: Identifying discursive patterns. All discourses across transcripts were analyzed to identify those that fit together distinctively to tell an overarching story of the data, which represent the discursive patterns**.**

Step 7: Theoretical accounting – identifying discursive realms. The final step in Phase 1 involves using theory and research to make sense of the identified discursive patterns. This section of the analysis is where power and subjectification are considered in conjunction with previous research to understand how these patterns function in broader social, historical, and ideological texts. At this stage, poststructuralist discourse analysis can shed light on how such discursive logics position people.

In this study, one participant, who identified as nonbinary and queer, was positioned distinctly from the other four participants. Their narrative diverged meaningfully due to their unique social location. To ensure this difference was not overshadowed or lost within the broader analysis, their account was given dedicated attention in a separate chapter (Chapter 6). During the analytic process, this part of the study was reframed as a "discursive interlude": a purposeful pause in the main findings to acknowledge and critically engage with discourses that did not align with the majority, yet offered important insight into the complexity of subject positions and discursive variation.

Phase 2: Analyzing Emergent Voices in Relation to Discourses. Phase 2 focuses on a detailed analysis of how the discursive patterns identified in Phase 1 were located in participants' voices. This phase uses an analytical approach set out by Gilligan and Eddy's (2017) Listening Guide method, and the discursive patterns act as a deductive framework to re-listen to the participant's narratives as a voice-centred relational method. This phase involved four steps, as follows.

Step 1: Multiple listenings. The first-person accounts were listened to again, with the intention of reflecting on the research process, while noting emerging elements that connect with the discursive patterns.

Step 2: Generating I poems. Each participant's transcript was carefully reviewed, and all first-person statements (those beginning with "I") were underlined. These statements were then arranged in the order they appeared, within each transcript, to create "I poems." These poems help reveal the internal logic of a person's thoughts and feelings. By focusing on how participants speak about themselves, the poems can uncover patterns or even unconscious processes, offering insight into ways of knowing or feeling that may not be fully recognized or expressed directly.

Step 3: Listening for contrapuntal voices. Each "I poem" was analyzed to identify contrasting or competing voices and narratives within each participant's story. Unlike the concept of subject positions in discourse analysis, this step focuses on highlighting the tensions and negotiations within the individual's own sense of self. Here, the self is understood as shaped not only by discourse, but also through the ongoing process of interpreting and making sense of personal experience. This approach allows for a layered understanding of participants' voices by capturing both what is spoken and what may be left unsaid, all while remaining attentive to the broader discursive context. By constructing "I poems" directly from participants' first-person statements in the order they were originally spoken, this method stays closely connected to the data. These contrapuntal voices are depicted using the image of a scale (located below each “I poem”) that compares and weighs the competing voices within each poem.

Step 4: Putting the personal in the political. The final step involved developing a theoretical analysis that connected the study's findings back to the research questions, with a focus on how personal experiences are shaped by, and push back against, broader discursive forces. By closely attending to the individual voices identified in Phase 2, this stage explores how larger societal discourses are taken up, resisted, or reinterpreted on a personal level. Individual voices are placed at the center of this analysis, creating space to better understand how lived experience and discourse intersect. This approach highlights not only how dominant discourses can constrain individuals, but also how participants' narratives may offer powerful counter-narratives of resistance. The outcomes of this analysis are presented in detail in Chapter 8 (Discussion).

Validity

This study implemented strategies to enhance the validity of the research by attending to credibility, authenticity, criticality, and integrity. Credibility and authenticity refer to the accurate portrayal of the participant's experiences and their meaning (Whittemore et al., 2001). Voice as a site of meaning is a core tenet of feminist research. Smith (1991) and Collins (1990) stress that authentic representation must include lived experiences of those marginalized by systems of power. This principle is integrated in FRDA through the creation of "I" poems that center the individual voices of participants through first-person statements, which promoted transparency and ensured no individual voice was omitted.

Criticality and integrity refer to the extent to which researcher bias is minimized and interpretations are firmly grounded in the data (Whittemore et al., 2001). In this study, integrity was upheld by closely adhering to the stages of the FRDA method, while criticality was fostered through ongoing reflexive practice. In line with Haraway's (1988) concept of

situated knowledge, attention was given to how the researcher's identity and positionality shaped observations and interpretations. A reflexive journal was maintained to document research decisions, preconceptions, emotional responses, and their potential influence on data collection and analysis. Additionally, regular meetings with the research supervisor provided opportunities for open dialogue, critical reflection, and discussion of how best to represent the analytical process within the thesis structure.

The rigor and trustworthiness of FRDA are demonstrated through its systematic process, its explicit theoretical grounding, its transparency in analysis, and its commitment to capturing the complexity and multiple layers of meaning in participants' accounts, particularly their voices in relation to discourse.

CHAPTER FOUR

Findings: An Overview

FRDA was used to answer two research questions: 1) What are undergraduate students' experiences of seeking hormonal contraception in northern BC? and 2) What are undergraduate students' experiences of accessing hormonal contraception in northern BC? The objectives of this study were to: (a) uncover power dynamics that influence undergraduate students' contraceptive-decision making and engagement with SRH services; (b) identify barriers and enablers for undergraduate students who are seeking and/or accessing hormonal contraception; and (c) amplify the voices of often marginalized and underrepresented groups.

Five semi-structured interviews were conducted between November and December 2024. Participants were aged 18 to 28 and were female or assigned female at birth (AFAB). Four participants identified as cisgender and heterosexual, and one participant identified as non-binary and queer. All participants attended UNBC at the time of their interviews but originated from rural and urban BC as well as internationally. Participants sought and accessed a variety of methods of hormonal contraception, including OCP, IUDs, vaginal rings (i.e. NuvaRing), and contraceptive implants (i.e. Nexplanon). One participant also discussed EC. Most participants had used multiple methods of contraception. Participants sought and accessed contraception from on-campus and off-campus services, both virtually and in-person. Participants with family physicians in other regions described SRH visits in their hometowns and their current community. Interviews lasted from 40 to 60 minutes and covered topics including: utilization of services that provide hormonal contraception, participants' experiences seeking hormonal contraception, priorities when seeking

contraception, barriers and facilitators to seeking contraception, and perception of qualities of HCPs who prescribe contraception.

The contributions of five participants allowed for an in-depth analysis of these topics; they will be referred to by the pseudonyms, Lena, Olivia, Maya, Sophia, and Jordan to protect their confidentiality. The next three chapters will discuss the outputs from the analytical phases of the FRDA framework developed by Thompson et al. (2018):

1. Phase 1: Poststructuralist discourse analysis (Steps 1 to 6)
2. Phase 1: Discursive Interlude (Step 7)
3. Phase 2: Analyzing emergent voices in relation to discourses (Steps 1 to 3)

While the stages of FRDA were described in detail in Chapter 3, they will be included here, on a broader level, to serve as guideposts throughout the findings. It must be noted that only two discursive patterns, along with their corresponding discourses, will be discussed in detail. While other discursive patterns and discourses were identified during data analysis, there was not scope in this thesis to present all the findings, due to the extensive nature of FRDA. The remaining themes, discourses, and discursive patterns can be found in Appendices G, H, and I.

These chapters use a reflective approach to present findings, which may diverge from the standard format of results chapters. Rooted in feminist epistemology and guided by FRDA, this research embraces the idea that knowledge is socially constructed and inherently shaped by discourse, power relations, and the positionality of both participants and the researcher (Thompson et al., 2018). At times, these chapters go beyond a descriptive reporting of participant responses to include some interpretative insights. This reflective and

relational approach to analysis is consistent with feminist qualitative methodologies, which prioritize transparency and reflexivity (Letherby, 2003).

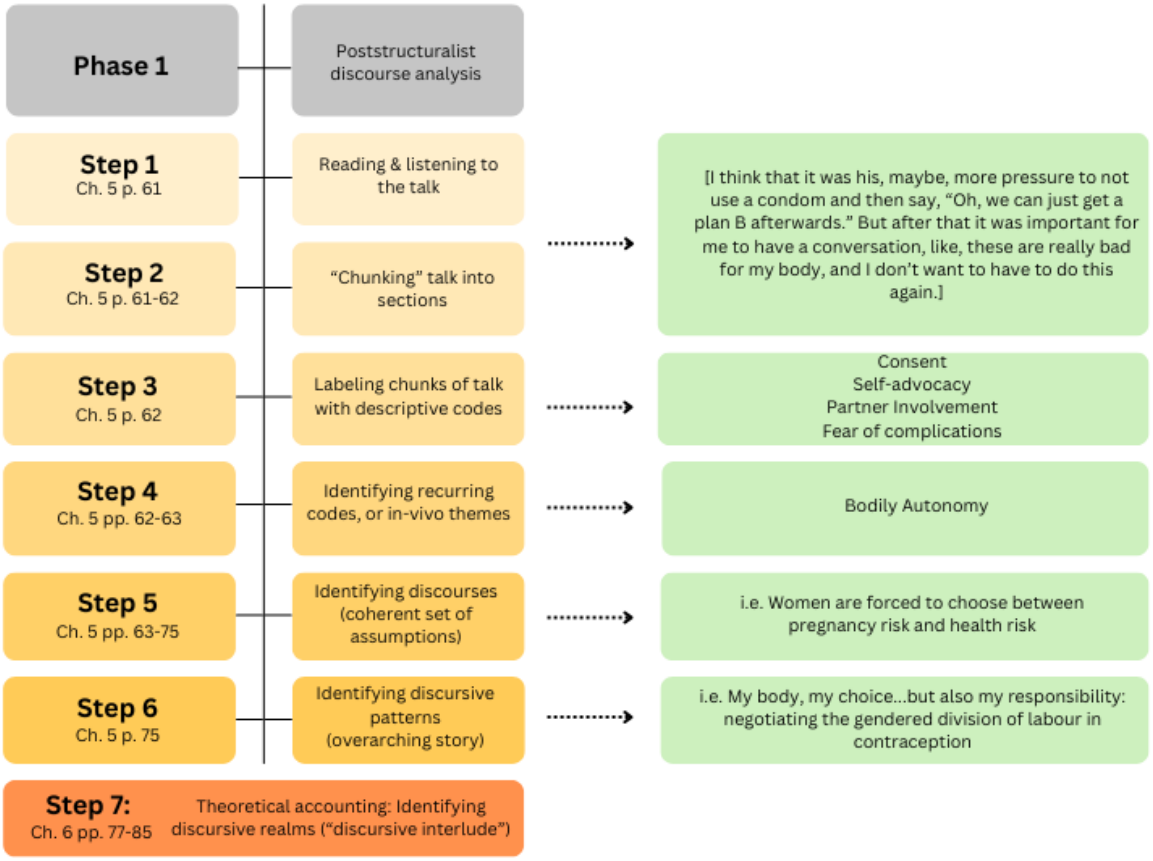
CHAPTER FIVE

Phase 1: Poststructuralist Discourse Analysis

In phase 1, the five transcripts were analyzed to identify discursive patterns using seven steps, as follows. Figure 4 displays each step with examples of how these were applied.

Figure 4

Phase 1: Poststructuralist Discourse Analysis



Note. The first phase of Feminist Relational Discourse Analysis consists of seven steps, as depicted above.

Step 1: Reading and Listening to the Talk

The initial step of data analysis involved reading and listening to the transcripts multiple times to get acquainted with the individual stories and begin to identify emerging "themes, voices, or plots" (Thompson et al., 2018, p. 103). Differences and similarities across the narratives were noted, as well as the overall tone and narrative voices within the transcripts.

During this stage, initial impressions that stood out were voices of strength and empowerment, as well as voices of self-doubt and defeat. Participants occasionally used humour, at times lighthearted, or with undertones of sarcasm. While participants shared moments of notable vulnerability and openness, there were also instances marked by pauses, hesitations, and what appeared to be reservations when discussing certain topics. These moments signaled the discursive boundaries of what is sayable, drawing attention to the dynamics of voice, silence, and authority. It was during this stage that questions began to emerge regarding which narratives could be expressed, which remained constrained or unspoken, and how power relations shaped who could speak, and in what contexts. Collectively, the narratives conveyed the layers of complexity underlying reproductive decision-making and, within each account, contained both contradictions and consistencies.

Step 2: "Chunking" Talk into Sections

In this step, the transcripts are divided into "chunks" of text to distinguish changes in topic. This was done by placing brackets around each section that concerned a certain topic. For example, the following extract from Maya's interview was divided into two "chunks":

> [Honestly, getting it, they did not educate me much about the contraception and the pills itself, because I was mainly using it to support Accutane. So I didn't get much

education before actually being put on it. But I kind of just knew that it was a form of contraception and it's really bad if you end up getting pregnant when you're on Accutane. So that's basically the gist of what I knew it was.] [But I feel like with the actual medication itself, I ended up getting a lot of side effects, like weight gain, a bunch of mood swings. I'd randomly be crying throughout the days and stuff like that. And so yeah, eventually, I just told them, I really can't, I just need to stop this. And then I also remember they didn't educate me. I forgot which one I first ended up taking, the birth control, but it really made me nauseous in the morning. So every single morning, I couldn't even eat at all. And then eventually I switched to Alysena, I think it was. That one. And then that one ended up working for me. And yeah, other than that, no major problems.]

Step 3: Labeling Chunks of Talk with Descriptive Codes

In step 3, each "chunk" of talk was labelled with a descriptive code. For example, in the above "chunk" of talk, the first "chunk" discussing the education Maya received when she first began using OCP was labelled with code "contraceptive counselling." The second "chunk" discussing her experience on OCP was labelled with "negative side effects." In total, 38 codes were identified across all five transcripts.

Step 4: Identifying Recurring Codes, or In-Vivo Themes

In this stage, segments of talk that were labelled with similar descriptive codes were sorted into theme files. The 38 descriptive codes identified in step 3 were collapsed into seven themes: ease of accessibility, social perception, gender of provider, patient-provider relationship, bodily autonomy, contraceptive effort, and gender-affirming care. The scope of this study does not allow for in-depth discussion of each theme; however, these themes

constructed the discourses in step 5, which will be further explored. Appendix G depicts a summary of each theme; examples of participant quotes that reflect each theme are provided in Appendix H.

Step 5: Identifying Discourses

In this phase, the segments of talk in each theme file were analyzed as a whole to locate discourses within each theme. Within each theme, there were multiple discourses, and at times, these discourses were simultaneously coherent and contradictory. These discourses reflect the nature of reality, in that reality is experienced in a multitude of ways that are at times overlapping or divergent. See Appendix H for examples of discourses that emerged from each theme.

Step 6: Identifying Discursive Patterns

In step 6, discourses were analyzed collectively to find discursive patterns, two of which will be explored in detail: *a uterus is a credential a man cannot acquire: gender concordance as a driver of trust* and *my body, my choice...but also my responsibility: negotiating the gendered division of labour in contraception.* Although many discourses were identified, the discourses that shaped these two discursive patterns will be discussed in this thesis.

These patterns stood out in both the content of participants' narratives but also in the emotional charge underpinning them. Participants voiced frustration, resentment, and, at times, outright rage at the perceived injustice of being the ones expected to manage contraception, while their male counterparts were not held to the same standard. In listening to the audio of the interviews during the first step of this phase, the emotion behind these statements was unmistakeable. Even when revisiting the transcripts without the audio, the

written words resonated, stripped of tone and expression. This emotional weight revealed how power structures invite resistance, creating opportunities for contested discourses, such as that of "pregnancy prevention is ultimately the female's responsibility", to surface and be challenged.

In contrast, the discursive pattern around gender concordance emerged more subtly. Participants often expressed hesitation or offered contradictory statements around HCP preference, demonstrating how power, while it invites resistance, also enforces expected behaviors through mechanisms such as self-regulation. Jordan's narrative, as a queer and non-binary participant, also offered a powerful counterpoint to the four stories shared by cisgender women in heterosexual relationships. To do justice to their experience, a deeper examination of gender and its role in shaping SRH care felt both necessary and appropriate, which will be detailed in Chapter 6.

A Uterus is a Credential a Man Cannot Acquire: Gender Concordance as a Driver of Trust

Six discourses around gender concordance, or the alignment of gender identity between patient and HCP, emerged across themes of patient-provider-relationship, bodily autonomy, and gender of provider. Examples of excerpts from the transcripts that support the findings are provided below.

Female Providers Are More Credible Than Male Providers When it Comes to Sexual and Reproductive Health. When discussing HCP gender as a factor in seeking SRH care, all participants concluded that a female HCP was preferable over a male HCP, largely due to experiential knowledge. Emphasis was placed on the belief that a male could not understand contraception needs to the same extent as a female. In this way, power relations revealed themselves as embedded in everyday interactions connected to contraception and

reproduction. Three participants described female reproductive anatomy as a credential in itself; males, in their lack of ability to bear children, were perceived to have a disadvantage in understanding the nuances of contraceptive decision-making. As Lena articulated,

> I do personally feel though, that when it comes to vaginal health and OBGYN, I will trust a female doctor over a male doctor the slightest bit, just because they understand what they are specializing in. They have the, I guess, the parts that makes me feel like, okay, when I speak about cramps or issues with my period she knows what is going on. She knows what I've experienced, whereas if I'm talking with a male doctor, he's educated, he's smart. He knows what he's talking about, but there's just that lack of experience as a woman that just makes me feel more comfortable with the female doctor.

While no participant denied the medical knowledge of male HCPs, theoretical knowledge was largely valued less than experiential knowledge. However, a contrasting discourse arose that sheds a different light on the subject.

A Provider's Knowledge is More Important Than Their Gender. Despite all participants claiming a preference for female HCPs, the ways in which HCP gender was discussed was, at times, paradoxical. For example, after Olivia stated, "I do feel that I would be more comfortable getting or trusting the information [from a female HCP]. Not that they have different training, but because that personal experience really plays a role in it.", she later went on to say:

> I think we talked a little bit about the gender of a provider, but I think that having a male provider who recognizes within themselves that they don't have that personal

> experience so takes the time to ask more questions, I think that's just as valuable. So, I wouldn't say that gender has a big role for me.

While, at face-value, these two statements may appear contradictory, her debate focuses on which qualities make an HCP trustworthy and credible, and to what extent. Olivia's statements align in that they both articulate the importance of self-awareness in an HCP. While lived experience as a female was highly valued by all participants, Olivia suggests that it is not the lack of lived experience that decreases a male's credibility, rather, the lack of acknowledgement of this limitation.

While both Lena and Olivia recognized the equivalent training of male and female HCPs, with experiential knowledge being a key difference, the overall adequacy of women's health education in medicine was also questioned.

Providers Are Not Sufficiently Informed on Women's Health. Throughout the interviews, there were undertones of resentment regarding the injustices women have experienced in terms of medical gaslighting or not being taken seriously. Olivia describes this phenomenon here:

> With the way that women are treated in the healthcare system, [female HCPs] have a better understanding of my fear of severe hormonal changes and they're going to take me more seriously and understand the effects that birth control can have on my body...just the gaslighting of some mental health stuff being related to hormonal changes, you know? Just having that being taken seriously.

While only one participant used the term "gaslighting," all participants discussed experiences of dismissal, minimization, or invalidation of concerns when seeking healthcare, specifically for SRH issues. Lena described the medical attitude towards women's pain as such: "'Oh,

you're more emotional so you have to be on your period. Oh, just take some ibuprofen and walk home.'" Similarly, Sophia summarized this outlook as: "'Oh, you know, women are built to have babies and what's an IUD compared to a baby?'" These imitations serve as explicit examples of how discourses and gender norms can influence and shape each other, i.e. women are perceived to have the innate ability to tolerate pain, which results in lesser pain management by HCPs, which reinforces the idea that women "should" bear the pain without complaint.

In addition to pain dismissal, three participants described receiving inaccurate or inadequate information around contraception before it was prescribed to them. Sophia offered subpar medical education around women's health issues as a potential contributing factor to HCP's being ill-equipped to discuss contraception, particularly male HCPS: "I don't know how much time providers spend, especially general practitioners, on women's health, how much of a focus there is in medical school. I've heard things about some topics being very brief." While participants alluded to androcentric beliefs as an explanation for medical gaslighting and other reproductive injustices, Sophia, among others, posed that miseducation around women's health could be perpetuating ignorance towards women's health. This discussion continued when comparing therapeutic approaches between male and female HCPs.

Female Providers are More Empathetic and Compassionate Than Male Providers. Female HCPs ability to relate to their contraception-seeking patients was discussed as a byproduct of shared anatomy and experience. Participants described the ways in which female HCPs expressed empathy and compassion in comparison to male HCPs. Participants described therapeutic qualities of female HCPs as being "lighthearted,"

"understanding," "supportive," "respectful," and "informative." Lena attributed these qualities to mutual understanding:

> So going to the pharmacy with female doctors, if you're picking up an IUD, or maybe mifepristone, I think it's what it's called, I can't remember, but there's just kind of that air of comfort, it's a comfortable environment. Because that woman understands, you understand, it's more relatable. I just feel better. And women also are more empathetic. So, I just feel more comfortable in that sense.

From the reverse perspective, Olivia described perceived lack of empathy and compassion in male HCPs as being attributable to narrow-minded and androcentric views:

> I kind of personally feel like it's because, I don't know. I feel like, maybe with male providers, they're not, I don't know. They don't understand that it's such a sensitive area. And I don't know, maybe they're just not as willing to hear about women's issues.

Feeling unheard or misunderstood by male HCPs was a commonly described experience, and female HCPs were perceived to be naturally more inclined to listen, understand, and empathize with female patients. This pattern reflected a broader discursive construction in which compassion, empathy, and relational care were framed as inherently feminine traits. Within this discourse, caregiving was not only feminized but also positioned as a natural extension of womanhood, reinforcing gendered expectations around who is best suited to provide emotionally supportive care.

A Female Presence in an Appointment is Valued Even if They Are Not the Provider. Of note, only one participant discussed the option of having a third-party female attend an SRH appointment. Sophia described feeling dismissed by her male HCP when she

expressed concerns around the pain of IUD insertion and requested to have the procedure done under sedation. Sophia was unaware prior to her appointment that her HCP was male, and this made her feel "uncomfortable" and "weird." She voiced that having another female attend the appointment with her would have made a difference, saying:

> I think the offer to have a female present. Even just an offer, I think would have been nice. I don't know if that's realistic to have somebody there all the time. But yeah, especially when it comes to pain and things like that, I feel like I would have felt a little more heard.

Even if the woman was a stranger, Sophia felt that having a female accompany her would have improved her experience. This example illustrates how the female presence serves as a symbol of comfort and safety, regardless of any pre-existing relationship.

Reproductive Decision-Making is a Universal Experience Among Women. A feeling of solidarity among women was an underlying thread through this discursive pattern. Participants' preference for a female HCP was related to perceived mutual experience and understanding, and the increased feelings of comfort and safety that stemmed from this belief. Participants reported feeling relieved when an HCP shared personal experience with using hormonal contraception. For example, Olivia's decision to use a NuvaRing was solidified when the campus clinic nurse revealed she used it as well, stating:

> I find that lots of them are like, you go in with a doctor, and they're like, "Give this a shot, we'll see how it goes." Whereas, this nurse could be like, "This was my experience," with me. It felt safer to have somebody who was like, "I personally use this."

Participants described feeling better understood by a female, regardless of whether they had a pre-existing patient-provider relationship or any previous knowledge of them. Lena theorized that this bond is a natural result of shared oppression, saying:

> I think that is the one thing we all have in common, and that can unite us as women is the fact that we all want equal rights. We all want the same thing at the end of the day... I think that's really what brings us all together, is the fact that we're trying to fight sexism and still live happy lives.

Female HCPs were assumed to have personal experience with reproductive decision-making, which increased feelings of trust. In this way, gender concordance between HCPs and female patients was a significant factor in establishing a therapeutic alliance.

My Body, My Choice...But Also My Responsibility: Negotiating the Gendered Division of Labour in Contraception

Six discourses around the gendered division of labour, or the allocation of contraceptive responsibility between sexual partners, emerged across the theme of bodily autonomy. Examples of excerpts from the transcripts that support the findings are provided below.

Romantic or Sexual Partners Have a Role in Contraceptive Decision-Making. Three out of five participants involved their sexual partners in contraceptive decision-making, all of whom were in long-term relationships. Participants discussed different ways in which they involved their partners and navigated inherent power dynamics, including solely discussing contraception without granting decision-making power, making a contraceptive decision together with their partner, ensuring their partner is educated on their contraceptive method, and asking their partners to remember and remind them about important

appointments (i.e. IUD removal, refills, etc.). Here, Maya discussed how her partner was involved in her contraceptive decision-making:

> Yeah, it was actually something that we both discussed before me actually getting any form of contraception. We kind of, after having the first appointment, we did end up talking to each other, and kind of going through all the side effects and everything like that. And then we kind of made that decision together.

Lena also commented on the role of partners in decision-making when she stated, "I think if [my friends] had a girlfriend or a partner, and they were to take some contraceptives, that would be a discussion between them, and maybe they'd have a bigger opinion." Although not explicit, this statement suggested that romantic partners have more of a role in contraceptive-decision making than casual sexual partners, which is also noted in the following discourse.

Contraceptive Decision-Making Should be Done Independent of One's Romantic or Sexual Partner. Both participants who chose not to involve a sexual or romantic partner in their decision-making were using contraception for pregnancy prevention as well as menstrual cycle management, which may have factored into their choice to exclude their partner from decision-making. The seriousness or longevity of their relationship may also have been a factor. Jordan explained:

> I was seeing someone at the time, but casually. We weren't in a relationship, but we were sleeping together. And I let her know, and she was aware of all the things going on, but I didn't let her make any decisions for me, help me make decisions, because I felt that it was my choice. You know?

While the other three participants had partner involvement in their contraceptive decision-making, two participants emphasized that the decision was ultimately their own. Lena clarified, “It wasn't my boyfriend telling me, ‘You have to go on the pill. You have to take this. You have to take this.’ It was me saying, ‘I'm choosing birth control. I'm choosing the IUD.’”

As is evident in these excerpts, there was fluidity across both discourses around partner involvement; participants described simultaneously how partners should and should not be involved in contraceptive decision-making, at times within the same interview, reflecting how power dynamics in relationships can shift based on the perception and/or internalization of gender roles in pregnancy prevention.

Hormonal Contraception Facilitates Safe Sex. While this statement may seem to be more fact than discourse, it was revealed through discussions around consent and bodily autonomy that contraception use is complicated in the ways in which it influences sexual dynamics. Most participants described seeking contraception for the same reasons as Lena, who stated, “I went to my family doctor, and I wanted to discuss birth control options with her cause I am in a relationship now, and I wanted to be intimate safely.” Taking hormonal contraception was viewed as a responsible measure to prevent unwanted pregnancy. However, informing partners of hormonal contraception use did not necessarily increase safe sex practices.

Hormonal Contraception Facilitates Condom Use Resistance. One participant described how partner awareness of contraception can create an opportunity for condom negotiation. While hormonal contraception does not protect against STIs, the reduction in

pregnancy risk may eliminate the need for condoms from the partner's perspective. As Olivia elaborates:

> ...a lot of heterosexual relationships there is quite a bit of pressure from men to not want to use condoms, so contraceptives are often a solution to that, but then that burden to fulfill someone else's needs falls on the woman, which I don't think is fair.

In this way, hormonal contraception may increase sexual risk by removing protection against STIs as a result of condom use resistance. Initiation of hormonal contraception due to partner refusal or pressure to not use condoms is a form of reproductive coercion; therefore, while hormonal contraception use can increase reproductive agency by lowering risk of unwanted pregnancy, it may also increase threats to bodily autonomy through physical harms associated with lack of condom use.

Pregnancy Prevention is Ultimately the Female's Responsibility. While most participants involved their partners in contraceptive decision-making, the decisions discussed in these conversations were not whether contraception would be used and by who, rather, which type of contraception would be used. The underlying assumption was that the onus to take contraception was on the female. Although participants accepted this responsibility, several questioned the societal norm of birth control being "for women." Lena embodied this dichotomy when she stated: "I've always thought, why is it the female that has to have the contraceptives? Why do we have to have the birth control to not get pregnant? It's easy to take the bullets out of the gun, for example." She later went on to describe the discussion around contraception with her partner as follows:

> He said, "You shouldn't get the IUD just because of me. Don't do that just because of me." And I said, "Yeah, well, I'm not just getting it because of you. I'm getting it

because I'm choosing to get it." And realistically, I don't think if there was a male birth control he would have taken the male birth control.

These two statements reflect two narratives around the division of responsibility in contraception: a) it would be logical and fair for men to take contraception, and b) men cannot be relied upon to take contraception. Male contraception use and contraceptive responsibility was broadly discussed as a hypothetical concept rather than a widely practiced reality.

Men Should Have More Responsibility for Pregnancy Prevention. Male condom use was discussed by four participants, only one of whom viewed condoms as a viable method of contraception when used on their own. Participants believed that hormonal contraception was the most reliable method of pregnancy prevention, and while they valued the ability to maintain control over their contraceptive method, there were undertones of resentment when discussing women's perceived responsibility to use contraception. Olivia maintained that "men can really get away with not knowing anything about contraceptives" when discussing the mental burden of contraceptive use and decision-making, and Maya alluded to this contraceptive burden when she stated "[It's important] definitely that [my boyfriend] understands everything that I'm doing for him, first of all."

Gendered messaging around sex through the education system was raised as a potential contributing factor to the social expectation for women to shoulder the contraceptive burden. Two participants reported receiving abstinence-based messaging, which contributed to feelings of shame and guilt around sex and seeking contraception. Other participants described the different SRH education that was offered to boys and girls in school, with content tailored by gender. Olivia claimed that "miseducation makes it harder

on women" when discussing male condom resistance and the expectation for women to use hormonal contraception. Four participants reported that more comprehensive SRH education in schools would help address misconceptions around contraception use and pregnancy prevention. In turn, increased SRH literacy was theorized to shift some of the contraceptive burden off the shoulders of women to be shared more equally with their male counterparts. Participants expressed early education as a powerful influence in how they negotiated their identity as individuals who could get pregnant, and consequently, how this would shape their reproductive decision-making.

Step 6: Identifying Discursive Patterns

Step 6 involved looking for patterns across discourses that form an "overarching story" (Thompson et al., 2018, p. 105) of the individual narratives. While discourses describe the ways in which subjects are talked about and understood, discursive patterns refer to the broader and recurring configurations of meaning that emerge when multiple discourses converge, overlap, or contradict each other within and across stories (Thompson et al., 2018). Eight discursive patterns emerged from the discourses. See Appendix I for all discursive patterns and their corresponding discourses. Two discursive patterns were selected to discuss in detail: *a uterus is a credential a man cannot acquire: gender concordance as a driver of trust* and *my body, my choice...but also my responsibility: negotiating the gendered division of labour in contraception.* Upon reflection and listening to the narratives, it became clear that these discursive patterns had emerged from the participants' voices as subjects of importance, rather than those that the researcher found most compelling. The discourses described above wove together to form overarching narratives, which will be described and

contextually situated in the next step: theoretical accounting – identifying discursive realms, which will constitute its own chapter.

CHAPTER SIX

Discursive Interlude

Step 7 of Phase 1 involves consulting theory and research to understand how these discursive patterns play out in society (Thompson et al., 2018). By analyzing the social, historical, and ideological contexts first, the researcher is able to locate individual voices within each discursive realm.

During the second phase of analysis, the researcher identifies contrapuntal voices within individual accounts. The term "contrapuntal" originates from musical theory, referring to the idea of counterpoint, or the art of combining several voices to balance interplay (Mazzola et al., 2011). When applied to narrative voice, as opposed to musical composition, counterpoint can be observed in how individual stories interweave to form a complex melody, at times both consonant and dissonant. This will be explored further in the second phase of analysis; however, the idea of counterpoint begins to emerge in the exploration of discursive realms.

Identifying discursive realms requires the researcher to reflect on how the broad discursive patterns are situated in current sociological contexts before turning to individual voice. In musical terms, a transitional piece is referred to as an interlude, which is a fitting description for this analytical step. This discursive interlude will examine how two of the discursive patterns identified in the last phase (*a uterus is a credential a man cannot acquire: gender concordance as a driver of trust*, and *my body, my choice...but also my responsibility: negotiating the gendered division of labour in contraception)* fit within broader societal discourses around gender and gender identity. To do this, feminist theory will be revisited through an overview of intersectionality, reproductive justice, and contraceptive labour.

Crenshaw (1989) coined the term "intersectional feminism" as a method of understanding what is experienced at the intersection of two or more axes of oppression (i.e., race, ethnicity, gender, class, and sexuality). The concept of intersectionality emerged from the Black feminist movement to describe how neither race nor gender on their own could capture the oppressive experiences of Black women. The work done by Black feminists, such as Crenshaw and Ross, laid the groundwork for feminist theory, and has since been applied to various realms of power and oppression, including the experience of reproduction. The reproductive justice framework, developed by Loretta Ross, is founded in the understanding that different axes of oppression are “not additive but integrative” (Ross & Solinger, 2017, p. 74). Individual sexual autonomy and gender freedom are, therefore, impacted by markers of difference that situate people at various levels of advantage or disadvantage.

Where participants were located on different axes of oppression had an impact on the amount and type of labour required of them to access contraception. Bertotti (2013) coined the term “fertility work” as “the time, attention, stress, and physical burden associated with avoiding pregnancy” (p. 13). This type of domestic labour has disproportionately fallen upon women and women’s bodies. Kimport (2018b refers to this as the “feminization of contraception,” (p. 44) while Littlejohn (2021) terms it “gendered compulsory birth control” (p. 3). The argument that it is natural for women to assume responsibility for pregnancy prevention due to their ability to bear children rests on the premise that there are inevitable and unavoidable inequalities between genders as a result of biological difference, also known as biological determinism (Littlejohn, 2021). Drawing on intersectionality, the reproductive justice framework challenges this theory of biological determinism by asserting that contraception is a shared, and equal, responsibility. Among participants, contraceptive labour

was negotiated in various ways, and the philosophy of biological determinism was further challenged through analysis of the discursive patterns around gender and gender identity, which emerged as a key marker of difference between participants.

Of five participants, four identified as cisgender and one identified as nonbinary and queer. While the narratives of the four cisgender participants wove together harmoniously, the voice of Jordan stood out as a separate melody, offering a distinct counterpoint that warrants further exploration. Gender identity as a marker of difference was evident in two discursive patterns: *a uterus is a credential a man cannot acquire: gender concordance as a driver of trust*, and *my body, my choice...but also my responsibility: negotiating the gendered division of labour in contraception*. To illustrate how intersectionality, reproductive justice, and contraceptive labour are located within these discursive patterns, gender and gender identity as axes of oppression will be discussed in greater detail.

A Uterus is a Credential a Man Cannot Acquire: Gender Concordance as a Driver of Trust

All participants expressed a preference for a female HCP when seeking SRH services. While participants acknowledged that male HCPs receive the same training as female HCPs and were competent to provide care, there was an element of experiential knowledge presumed to be had by female HCPs that was valued by participants. Having an HCP with the same anatomy increased feelings of safety and support. When discussing the characteristics of male versus female HCPs, there was an underlying sense of solidarity with female HCPs and the belief that another woman would have their best interests at heart. In this way, trust was something that had to be earned by a male HCP, but could only be broken by a female HCP, as it was already earned by nature of gender concordance.

Jordan expanded on the therapeutic impacts of patient-provider gender concordance when discussing HCP preferences. As a non-binary person, Jordan expressed a preference for female HCPs for SRH needs and male HCPs for mental health needs, stating:

> It was an interesting experience, because in my past I've always had female therapists, and it was the first time that I ever got a male therapist, and it was interesting seeing that different kind of perspective. I think so. I think it was helpful to kind of talk about man things to a man, kind of... I feel like if you're going to a gynecologist, I prefer that it's a female. If you're seeking help about a specific female body part, I feel like I'm more comfortable with a female that has that body part.

This distinction brings attention to the nuances of patient-provider relationships and the role gender plays in this. The notion that female HCPs are better equipped to provide quality SRH care is not entirely unfounded. As Sophia alluded to when she queried how much time was allotted to women's health issues in medical school curricula, training in women's health in Canadian medical education is lacking and not well-integrated (Anderson & Gagliardi, 2021). A recent systematic review and meta-analysis conducted by Heybati et al. (2025) found that patients treated by female physicians experienced significantly lower mortality rates and fewer hospital readmissions compared to those of male physicians. In Canadian datasets of the same study, gender discordance between female patients and physicians translated to significantly higher mortality rates compared to gender concordance; this was not the case among male patients, in which gender discordance resulted in lower odds of mortality.

While the data supports a preference for female HCPs among female patients, participants hesitated when discussing preferences for HCPs of a certain gender, with

comments such as “I don’t want to seem sexist, but…” and, “I feel like, maybe with male providers, they're not, I don't know...”. At times participants would revisit the topic of provider gender after stating a personal preference for a female HCP to state that gender did not matter. While participants still chose to voice their personal preferences, these moments of pause or contradiction may be a byproduct of the social landscape, in which making generalized statements about male versus female HCPs might be viewed as “anti-woke” or sexist (Cammaerts, 2022). The fear of being perceived as sexist by the interviewer may have been a factor in participant hesitancy, or these pauses could reflect internal conflict between their worldview (i.e., “all people are equal”), instinctual preferences (i.e., “I feel safer with a woman”) and societal beliefs (i.e., “physicians are objective and impartial”). Being an undergraduate student and part of the culture of academia may also play a role in how participants navigate their feelings and beliefs around gender dynamics, as this is often a time when preconceived notions and worldviews are challenged (Edwards & Ritchie, 2022).

My Body, My Choice...But Also My Responsibility: Negotiating the Gendered Division of Labour in Contraception

Three out of five participants mentioned the unequal burden of pregnancy prevention in heterosexual relationships. As Olivia describes:

> …I know that there's so much miseducation around contraceptives, particularly like, my partner's a man, and that men can really get away with not knowing anything about contraceptives. So the fact that I carry the burden of managing that, I also feel that it's really important for him to carry some burden in the same way.

Participants expressed not wanting to use hormonal contraception due a number of factors, including known and unknown side effects, pain of insertion, and inconvenience, but

decided to do so anyway because they felt it was the safest way to avoid pregnancy. All participants described the time, effort, and stress involved in seeking and accessing hormonal contraception, including: completing self-directed research, arranging appointments, experiencing long wait times, contraceptive decision-making, trying multiple methods of contraception, having stressful or emotional conversations with HCPs, and undergoing uncomfortable procedures, all of which are reflected in Bertotti's (2013) description of fertility-related domestic labour.

Most participants stated that they had discussed contraception with their partner, who had a role in decision-making. Several participants described how they negotiated contraceptive labour with their partner despite maintaining control and ownership over their choice of method. For example, Maya made an agreement with her partner that they would remind each other of when her IUD was due to be removed, whereas Olivia insisted that her partner be able to understand how her contraception works and how it should be used, sharing in the mental load.

While extensive discussions around the gendered division of labour among heterosexual couples are present in the literature, there is a lack of representation of non-heteronormative couples. Jordan discussed how they did not consider using hormonal contraception, as they were in a relationship with a trans woman and did not believe themselves able to conceive. When they attended an appointment to discuss gender-affirming hormone therapy, the HCP identified that they were at risk of pregnancy and advised that they take hormonal contraception, which they agreed to.

Jordan's experience of being unaware of their pregnancy risk reflects the historical lack of SRH education for the transgender and gender-diverse community. While Jordan had

a positive experience with an HCP who was comfortable with providing gender-affirming contraceptive counselling, there is widespread inconsistency in contraceptive counselling. Krempasky et al. (2020) highlights the inadequate training HCPs receive in providing SRH services to transmasculine people and the lack of clinical guidance to support HCPs in offering comprehensive care. HCPs often report lack of confidence in their ability to provide SRH care to transgender and gender-diverse individuals (Fix et al., 2020), which is not lost on the patients on the receiving end. Nonbinary and transgender young adults have reported feeling that HCPs were unfamiliar with their needs, made assumptions about bodies, partners, and identities, and lacked adequate knowledge to provide effective contraceptive care (Gomez et al., 2020). The resulting knowledge gap around contraception needs for transgender and gender-diverse individuals presents a challenge for people whose reproductive goals include pregnancy prevention.

Given the lack of awareness and inconsistent messaging around fertility and pregnancy risk for transgender and gender-diverse individuals, contraceptive decision-making processes are potentially misinformed. In the case of Jordan, if their HCP had not assessed for and discussed pregnancy risk in their visit, Jordan would not have had the opportunity to make an informed decision around contraception use. This example highlights the inequities in healthcare for transgender and gender-diverse individuals which in turn, creates greater contraceptive labour in terms of the self-directed research required, effort to find a gender-affirming and well-informed HCP, and emotional toll. There are unique considerations in contraceptive decision-making for transmasculine individuals, including concerns about interactions with gender-affirming hormone therapy, need for a pelvic exam,

and tasks associated with being a cisgender woman, such as taking a daily pill (Boudreau & Mukerjee, 2019).

These factors suggest that the decision around who will assume contraceptive responsibility would be negotiated differently among non-heteronormative couples, with potentially shifting power dynamics. When considering reproductive justice, this interplay presents an area of interest as it is situated on an axis of oppression in relation to gender identity and gender roles. While family planning and fertility preservation for non-heteronormative couples has been researched extensively in recent years (Ainsworth et al., 2020), pregnancy prevention and contraceptive decision-making have not received the same attention and warrants further exploration.

Summary

In the discursive pattern, *a uterus is a credential a man cannot acquire: gender concordance as a driver of trust*, participants recognized gender as a factor in patient-provider relationships and described a higher level of trust in female HCPs that was founded in a feeling of solidarity and sameness. However, feelings towards HCP gender were complex, in that HCP knowledge was also valued, which was considered a gender-neutral quality. These competing factors highlight how users of contraception are not passive participants, but are actively negotiating different, and at times, competing, discourses. In *my body, my choice...but also my responsibility: negotiating the gendered division of labour in contraception,* gendered expectations of women to shoulder the burden of contraception were discussed by participants, who made sense of their role in pregnancy prevention through the negotiation of contraceptive labour with their partners. The counterpoint to these narratives was that of Jordan, whose social location as a queer and non-binary person highlighted the

ways in which gender and gender identity as axes of oppression can be experienced in different ways.

Through the lens of intersectionality and reproductive justice, systems of oppression overlap and interact with each other; while people across the spectrum of gender identity experience reproductive oppression in different ways, there is overlap in that those who are able to conceive are also disproportionately burdened with the task of preventing conception. Ross and Solinger (2017) assert that transgender issues (referring to a range of identities on the gender continuum) overlap with reproductive justice issues, as both recognize that concepts related to reproduction, including womanhood and birthing, "do not fit neatly into the male-female binary" (p. 196). In this way, while Jordan's story may not fit neatly into the discursive patterns identified across the narratives, it adds an important contrapuntal voice that cannot be separated from the greater melody. The following chapter will revisit the discursive patterns identified in Phase 1 in order to locate them within the individual accounts of each participant.

CHAPTER SEVEN

Phase 2: Analyzing Emergent Voices in Relation to Discourses

In the second phase, individual narratives are revisited to explore each first-person account in the context of the discursive patterns identified in the first phase. The end product of this phase is an account of both personal and political, experience and discourse, with individual voice at the center.

Step 1: Multiple Listenings

Step 1 involves listening and reading to the transcripts again, this time through the lens of the themes, plots and voices identified in the first phase. This step allows for reflection on the part of the researcher. At this stage, an effort was made to locate researcher voice within the analytical process, and re-center participant voice.

Step 2: Generating I Poems

In step 2, each transcript is re-read and statements made in the first person, or "I statements," along with accompanying verbs, are highlighted. For each discursive pattern, the "I statements" within each individual account are placed in sequential order. This set of statements creates an "I poem" that encapsulates the ways in which each discursive pattern is reflected in the reality of each participant. The poems can be read at the end of this chapter.

Step 3: Listening for Contrapuntal Voices

The previous phase of analysis focused on identifying broad discourses and discursive patterns across participant narratives. Phase 2 attempts to "capture the personal in relation to the political" (Thompson et al., 2018, p. 108), which is achieved by reading the "I poems" individually to locate contrasting, or contrapuntal, voices within each first-person narrative. During this process, individual voice becomes the central site of meaning, set

against a backdrop of discourses, discursive patterns, and discursive realms that reflect the historical, social, and ideological contexts that shaped them.

Contrapuntal voices were identified within each account. In each of the following "I poems," a pair of contrapuntal voices was identified, as depicted by the image of a scale (see Figures 5-13). These voices ranged from subtle and muted undertones to loud or obvious statements, reflected in the balance of the scale.

I Poems

Discursive Pattern: A Uterus is a Credential a Man Cannot Acquire: Gender Concordance as a Driver of Trust

at the end of the day (Lena)

both [doctors] being women, both being in the medical field

I just knew I could trust them

I knew, okay, they understand what I want

I trusted them

I trusted their opinions

I felt like, because it's a smaller pharmacy, and it was mostly women working there,

in the nicest way possible, they don't care

I've grown up in environment to understand that

the gender of the doctor doesn't really matter

it's more about their knowledge

if my family doctor were to refer me to a male specialist I would have gone

when it comes to vaginal health and OBGYN,

I will trust a female doctor over a male doctor the slightest bit

they understand what they are specializing in

they have the parts that makes me feel like when I speak about cramps,

or issues with my period,

she knows what is going on

she knows what I've experienced

If I'm talking with a male doctor, he's educated, he's smart

he knows what he's talking about,

but there's just that lack of experience as a woman

I feel like, we're all just kind of this big girl group,

and you don't have to like each other,

but when it comes to protecting ourselves,

taking care of ourselves,

helping each other,

making sure we don't feel judged for these types of things,

I think it really comes together

so going to the pharmacy with female doctors, if you're picking up an IUD,

there's just kind of that air of comfort,

because that woman understands, you understand, it's more relatable

I just feel better

women also are more empathetic,

I just feel more comfortable in that sense

I think that is the one thing we all have in common, and that can unite us as women

is the fact that we all want equal rights

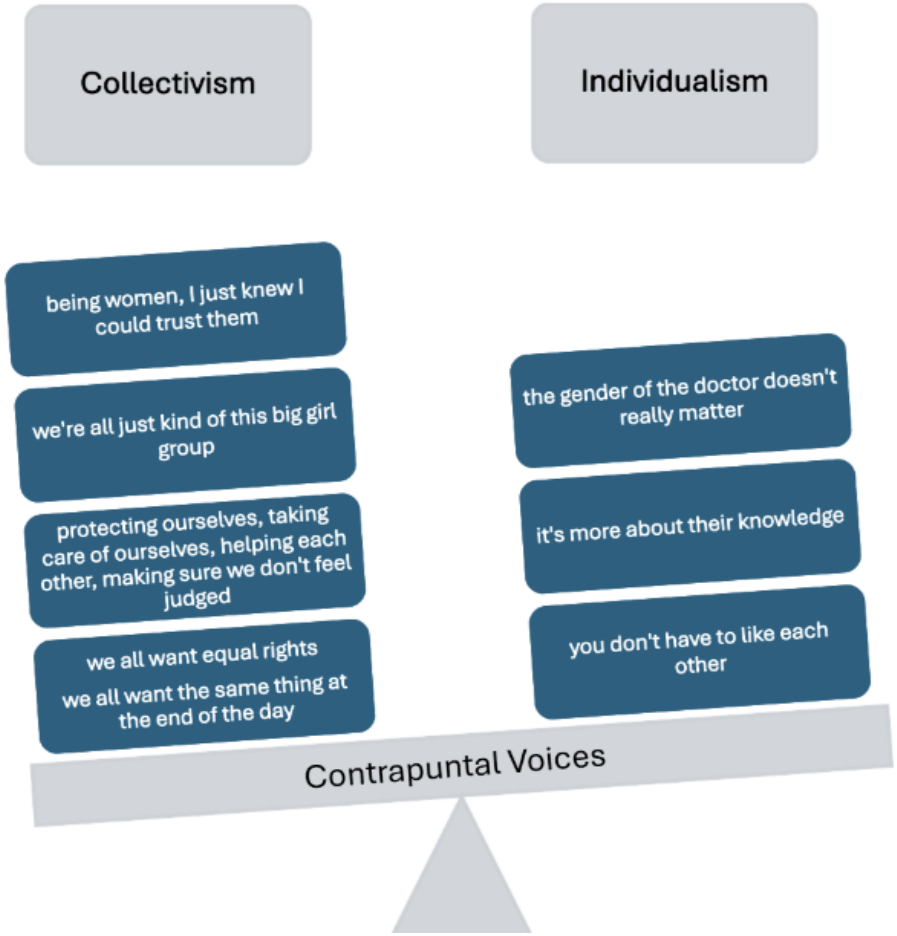
we all want the same thing at the end of the day

I think that's really what brings us all together,

is the fact that we're trying to fight sexism and still live happy lives

Figure 5

Lena: Collectivism versus Individualism



Note. Lena's poem reflects a tension between collectivism, through shared experiences and solidarity among women, and individualism, through personal preferences and agency in reproductive decision-making.

personal experience (Olivia)

I had a really good experience because the nurse who gave me [my NuvaRing]

she had used that one before, so she had personal experience

she was super well informed on that, and she also really understood my past experiences

I just got her to explain a bit more about how that works, what hormones it is

she shared kind of her experience with it

and it seemed super user friendly, which I really liked

I've been on so many different medications in my life

I find that lots of them are like, you go in with a doctor, and they're like,

"*give this a shot, we'll see how it goes*"

Whereas, this nurse could be like,

"*this was my experience*"

It felt safer to have somebody who was like,

"*I personally use this*"

and even though our bodies are different, it felt safer

so for her to explain exactly how she did it was helpful

I don't think I've ever had a male provider give me birth control before

not that they have different training

personal experience really plays a role in it

with the way that women are treated in the healthcare system,

they have a better understanding of my fear of severe hormonal changes

and they're going to take me more seriously

and understand the effects that birth control can have on my body

I got birth control very young

I just had really heavy periods and I couldn't control it

I feel like having a female provider made me feel more comfortable in that,

because they understood the way that I could be looked upon badly,

being a young person with birth control

I think that having a male provider who recognizes within themselves

that they don't have that personal experience

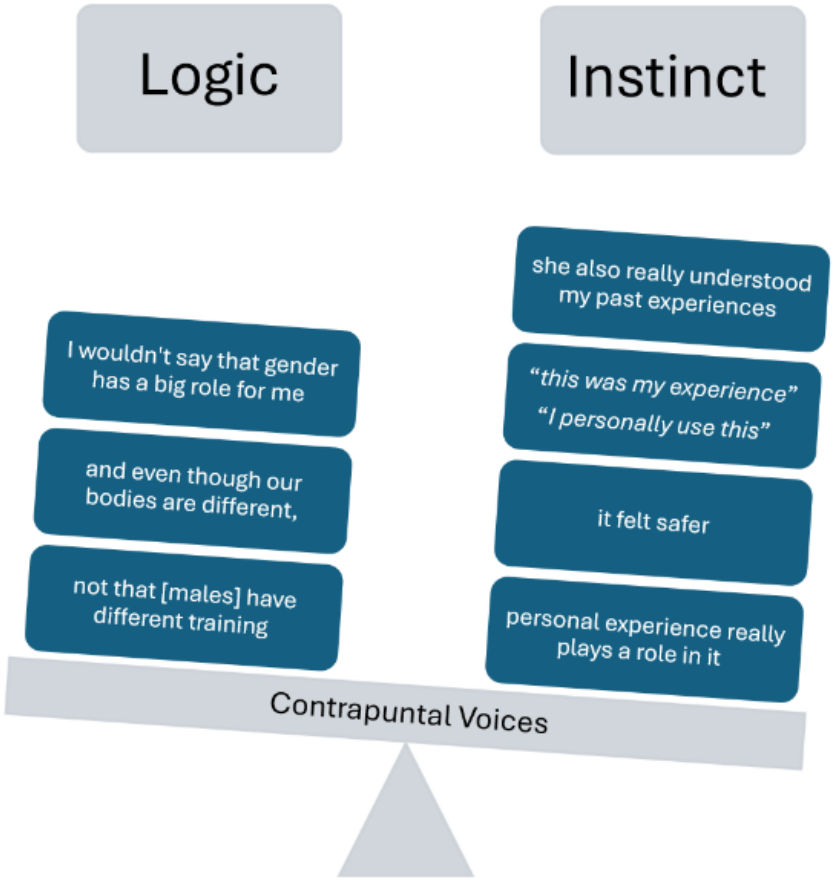
so takes the time to ask more questions,

I think that's just as valuable

so I wouldn't say that gender has a big role for me

Figure 6

Olivia: Logic versus Instinct



Note. In Oliva's poem, logic is represented as clinical knowledge and the recognition that male providers can offer competent care. In contrast, instinct emerges through her affective response when female providers share personal, embodied experiences that resonate with her own, especially in gendered contexts.

anatomy (Maya)

in my personal experience I've always been seeking it from women

it just ended up playing out that way

I haven't really seeked any form of contraception from men,

so I don't exactly know how it would feel with men until I'm actually put in that situation

I feel like maybe I would probably be more comfortable with a female

I don't know, just for some reason,

having the same anatomy and everything like that

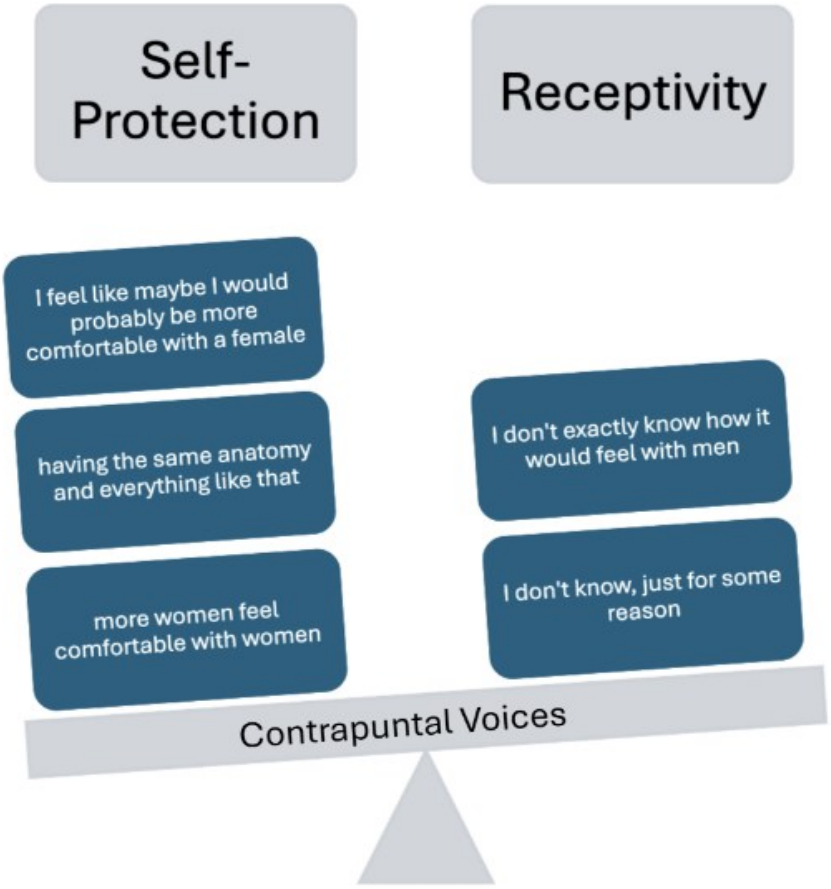
and I feel like more women feel comfortable with women

talking about contraception and actually doing these services for them,

so they would have more experience in that field

Figure 7

Maya: Self-Protection versus Receptivity



Note. In Maya's poem, self-protection is evident in her cautious preference for female providers, rooted in a desire for safety and the comfort of shared embodied experience, while receptivity surfaces in her acknowledgment of her limited experience with male providers.

the pain aspect (Sophia)

I think I just also felt a little bit uncomfortable because it was a male doctor,

and it was just me and him there

I felt a little bit weird

[having a female present] would have been nice for the first visit,

especially because I'm meeting this doctor for the first time

I think [gender] matters to me when talking about things like that

not usually, if it's just a regular appointment

but I think when talking about like contraception and things like that,

it would be nice [to have a female present]

I think because they can understand a little bit more on a personal level,

whereas maybe the doctor is coming from more a clinical thing

when I was first talking about my worries about the pain of having it inserted,

he was like,

"*no, it's painful, but it's not that painful, I have people…*"

I did kind of stand up for myself and I said,

"*no, I'm really not comfortable having it done in the office*"

I feel like maybe a woman could maybe understand that part a little bit better

I think the offer to have a female present

even just an offer,

I think would have been nice

I don't know if that's realistic to have somebody there all the time,

but especially when it comes to pain and things like that,

I feel like I would have felt a little more heard

I would probably be more likely to choose a female,

especially for contraception and reproductive health

their gender, would maybe influence it a bit

I feel like, maybe with male providers,

they don't understand that it's such a sensitive area

I don't know

maybe they're just not as willing to hear about women's issues

it's crazy to me that [IUD insertion] is being done in office,

for a lot of people with no pain management,

and you're dilating their cervix and putting something in there

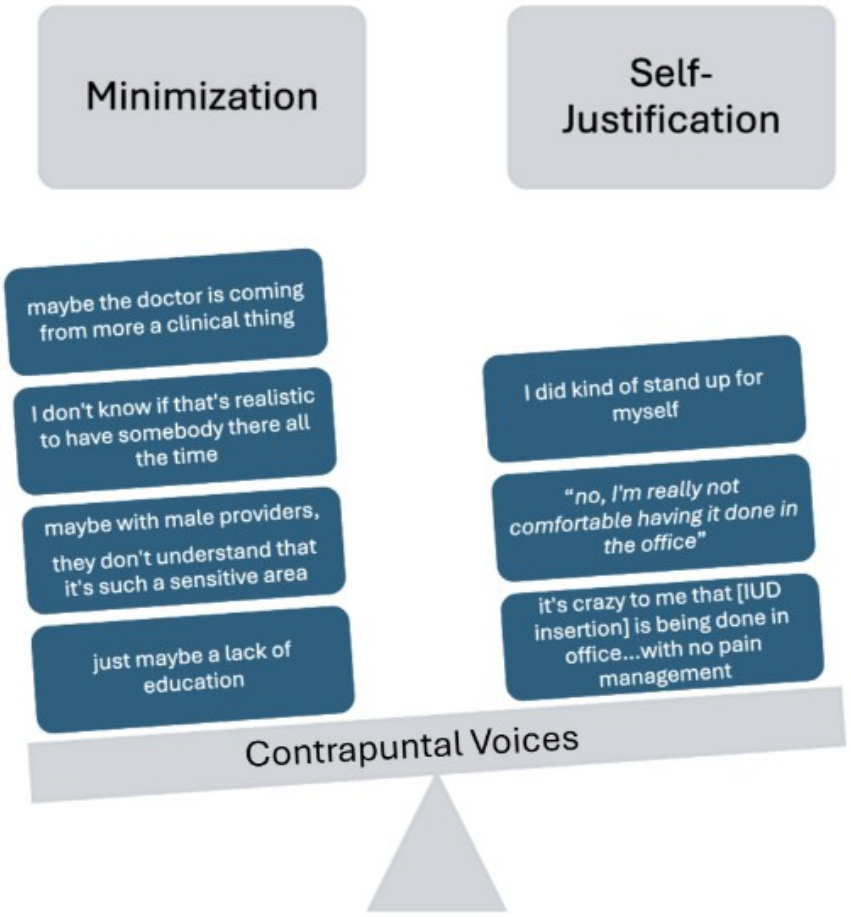
I don't know

it's just maybe a lack of education around that

the pain aspect

Figure 8

Sophia: Minimization versus Self-Justification



Note. In Sophia's poem, minimization appears in the downplaying of her own feelings with qualifiers like "I think," "maybe," and "I don't know". Concurrently, she engages in self-justification by acknowledging the gender pain gap and asserting her bodily autonomy in healthcare decision-making.

man things v. female things (Jordan)

in my past I've always had female therapists,

and it was the first time that I ever got a male therapist,

and it was interesting seeing that different kind of perspective

I think it was helpful to kind of talk about man things to a man

I think that [gender] does [matter]

I think it depends on what you're doing

I hate to appear sexist,

but I feel like if you're going to a gynecologist,

I prefer that it's a female

if you're seeking help about a specific female body part,

I feel like I'm more comfortable with a female that has that body part

it's situation dependent

I don't want to sound sexist,

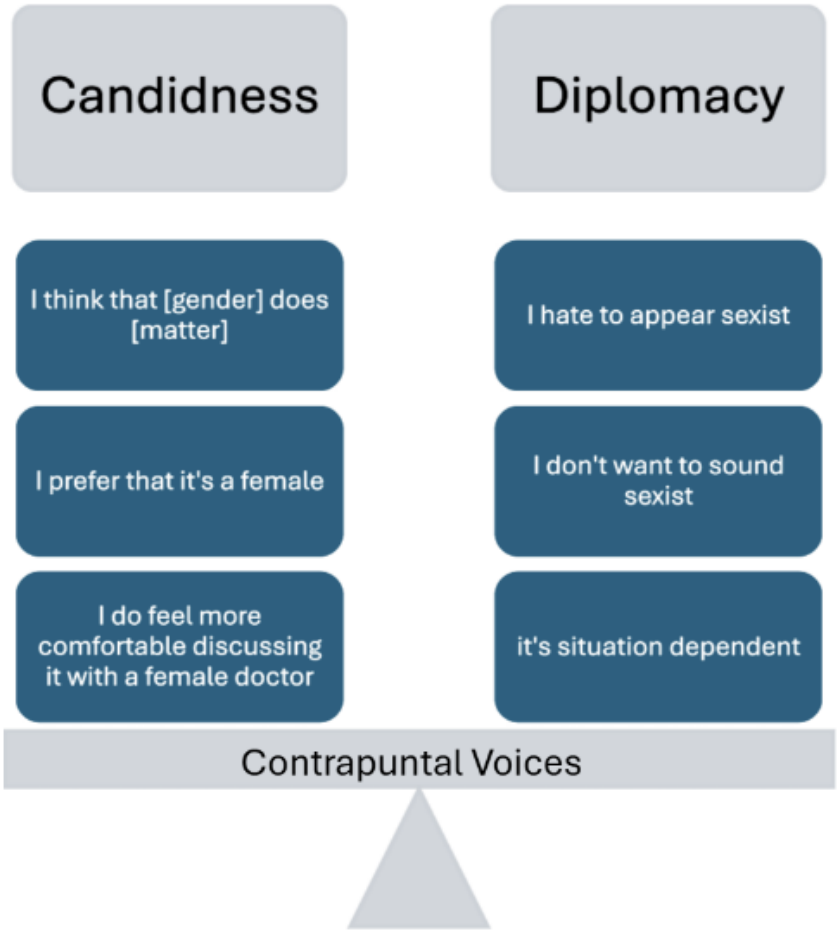
but I feel like if the doctor was a man,

I wouldn't necessarily be comfortable talking about that kind of thing

I do feel more comfortable discussing it with a female doctor

Figure 9

Jordan: Candidness versus Diplomacy



Note. In Jordan's poem, their candidness is evident in straightforward admissions about feeling more comfortable with female providers for gender-specific care. At the same time, diplomacy appears in the comments that preface these admissions, which reflect an awareness of social expectations around inclusivity and a desire to avoid making offensive statements or generalizations.

Discursive Pattern: My Body, My Choice... But Also My Responsibility: Negotiating the Gendered Division of Labour in Contraception

it's easy to take bullets out of the gun (Lena)

I was just completely terrified that I felt like I had to go on some sort of birth control

I told myself I was going to avoid it for the longest time

in a world where I don't have much control,

my body is something that I like to control

I feel like any hormonal disruptors will just stress me out

and make me feel out of control

I felt scared and I was also a little bit angry

I've always thought,

why is it the female that has to have the contraceptives?

why do we have to have the birth control to not get pregnant?

it's easy to take the bullets out of the gun

I guess me choosing not to take birth control was kind of in protest to that,

but I was also scared of any side effects I might experience

I think the fact that we can still choose in British Columbia

what contraceptive you want and having access to it,

I think is so helpful for bodily autonomy,

because I'm still choosing which one

if I don't like this one, I can get it removed and try something else

still, it's not ideal autonomy, but it does help me because I chose the IUD

I received helpful information from my doctors, my peers, social media

but it was me that was choosing the IUD

I'm listening to your recommendations, and I'm choosing this IUD

it wasn't my boyfriend telling me, "*You have to go on the pill. You have to take this*"

it was me saying, "*I'm choosing birth control I'm choosing the IUD*"

I don't hate men at all

I just feel like they do not understand completely when we speak about the inequality and inequity among women

when we get pregnant, we are the ones carrying and growing that child

I just feel like women have to endure so many physical issues, as well as societal issues,

I feel like us being the ones that have to take the birth control

when it has so many risks and side effects,

is extremely, extremely unfair

and if the roles were reversed,

if men were on birth control,

if men were the ones to grow children,

I feel like everything would be completely different

everything would be focused on them,

making sure that they're happy and healthy and comfortable

whereas with us, it's kind of just,

"*oh, you're more emotional so you have to be on your period*"

"*oh, just take some ibuprofen and walk home*"

my boyfriend was actually really supportive

he said, "*You shouldn't get the IUD just because of me. Don't do that just because of me*"

and I said, "*Yeah, well, I'm not just getting it because of you*

I'm getting it because I'm choosing to get it"

I don't think if there was a male birth control he would have taken the male birth control

so I'm biting the bullet

I'm making the decision to take the contraceptive

I do feel that the sex education system has failed a lot of people

I know there's a variety of birth controls out there which is nice for women to pick,

but I was kind of frustrated that all of them had some sort of negative side effect

that no matter what thing I would have chosen there was always that risk,

the underlying risk that when you get on it you might experience something bad

when you get off of it you might experience something bad

there were still options

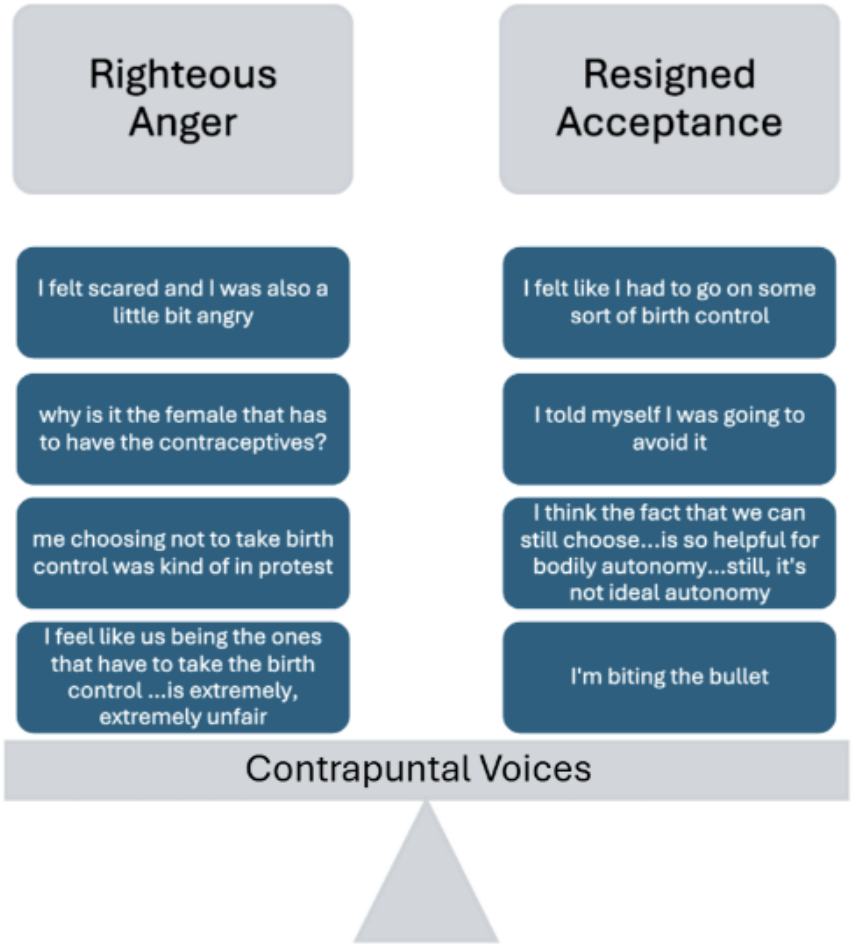
I was still able to choose, which is great,

but there was always just that part of me that was like,

this is unfair

Figure 10

Lena: Righteous Anger versus Resigned Acceptance



Note. Lena's poem reveals righteous anger through her frustration with the gendered burden of contraception and the physical and societal inequities women endure. Simultaneously, there is a voice of resigned acceptance as she acknowledges her need for contraception while asserting her bodily autonomy through her right to choose.

a burden that I am choosing (Olivia)

I think I was on the pill, which I wasn't perfect at

it was one time that I had had sex without a condom and I just panicked

I went and got a plan B at the pharmacy

it wasn't a positive experience mentally

I know that those medications can be really hard on your body

I didn't want to have to do that kind of harm

I had to pay for it as well

I know that there's so much miseducation around contraceptives

my partner's a man,

men can really get away with not knowing anything about contraceptives

I carry the burden of managing that,

I also feel that it's really important for him to carry some burden, so

I always make sure that he knows what I'm on,

how it works, and how it's affecting me and the efficiency of it

I mean, even the other day, [my NuvaRing] came out during sex for the first time ever

and he was like, "*Oh, no*!" and I was like,

"*you're not remembering how this works. That's not the deal*"

I like to have his involvement in that

I'm trying to remember that incident with the plan B

I was younger,

I would say that that decision maybe more came from him

which I'm not proud of,

I think that it was his, maybe, more pressure to not use a condom and then say,

"*oh, we can just get a plan B afterwards*"

but after that it was important for me to have a conversation,

I don't want to have to do this again

a lot of heterosexual relationships there is quite a bit of pressure from men

to not want to use condoms,

contraceptives are often a solution to that,

but then that burden to fulfill someone else's needs falls on the woman,

which I don't think is fair

I'm very aware that contraceptives are a solution that I kind of need right now

I'm also very aware that I am putting different substances in my body,

I think that if there was another way that could be as effective, I would do that

that is a burden that I am choosing

but yeah, it's affecting my body

I've gone through a lot of different negative situations

I think there should be more widespread knowledge for all genders on birth control

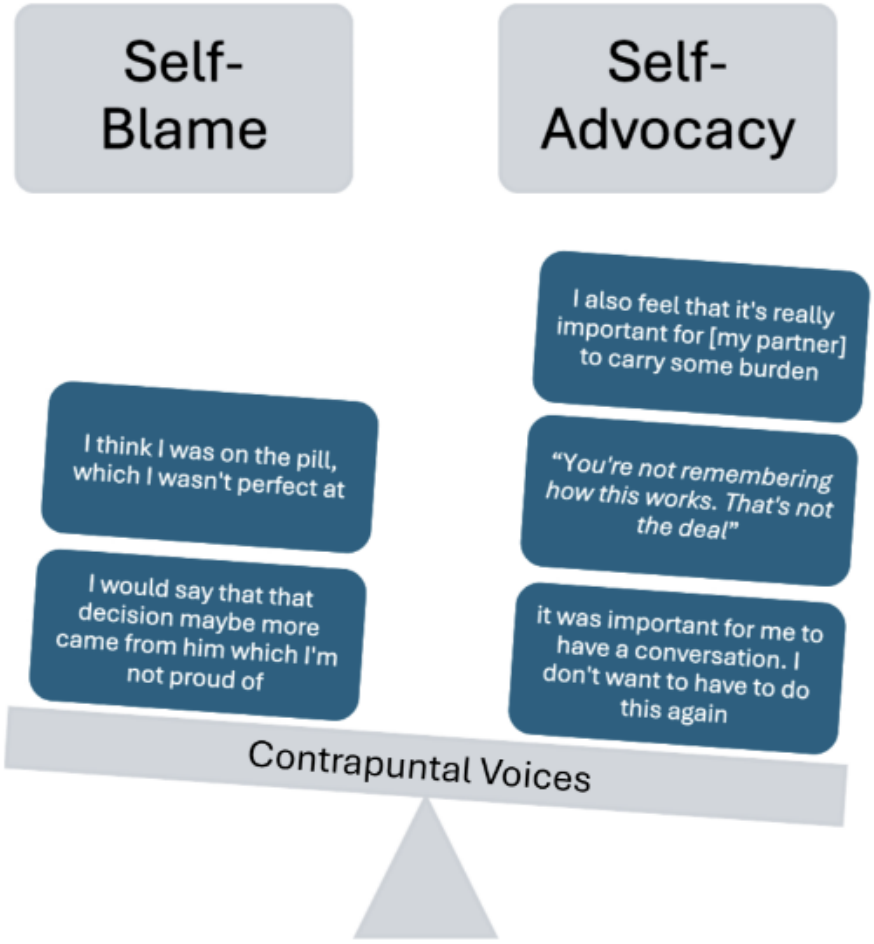
if heterosexual men understood pill hormonal contraceptives better that they wouldn't be

pressuring their partners as much to not use condoms

I feel that miseducation makes it harder on women

Figure 11

Olivia: Self-Blame versus Self-Advocacy



Note. Olivia's poem contains voices of self-blame through the internalization of responsibility for contraception use. She also engages in self-advocacy through her efforts to demand shared responsibility in an act of resistance to unfair gendered expectations around contraceptive use.

because I've had to (Maya)

I've been on the birth control pill

it was basically because I've had to,

I've been taking Accutane

and then my doctor said, just to cover his license

that he put me on birth control for that

I was on it for, I think, about a year

I kind of stopped because I told him at that point I wasn't sexually active

I don't really want to be on birth control because it has so many side effects

I didn't get much education before actually being put on it

I kind of just knew that it was a form of contraception and

it's really bad if you end up getting pregnant when you're on Accutane

I ended up getting a lot of side effects,

like weight gain,

a bunch of mood swings

I'd randomly be crying throughout the days

eventually, I just told them,

"*I really can't, I just need to stop this*"

it was actually something that we both discussed

after having the first appointment, we did end up talking to each other,

and then we kind of made that decision together

I feel like, definitely that he understands everything that

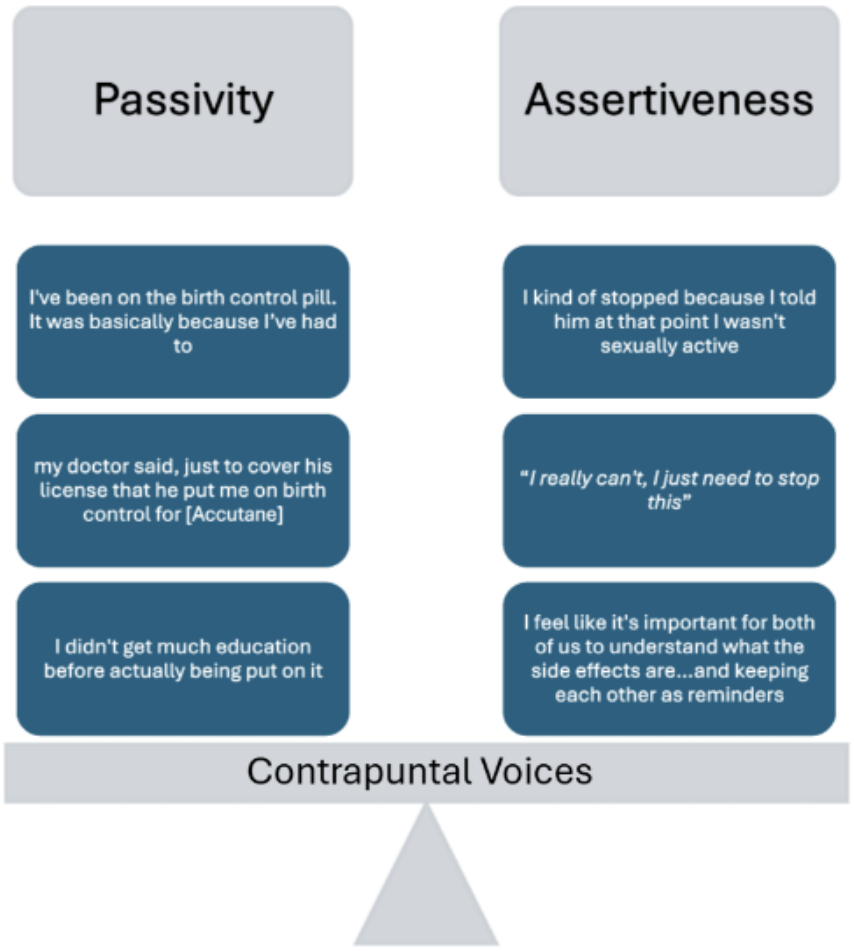
I'm doing for him,

I feel like it's the contraception for females have more research and statistics behind them compared to male contraception

I feel like it's important for both of us to understand what the side effects are and kind of keeping each other as reminders because it’s only valid for a certain amount of time, so that we can kind of remind each other to make sure that I go in and check up again for my appointments

Figure 12

Maya: Passivity versus Assertiveness



Note. Maya's poem articulates an initial voice of passivity characterized by acquiescence to medical authority in accepting contraception, which evolves into a voice of assertiveness as she resists continuation of a contraceptive method that adversely affects her and negotiates contraceptive responsibility within her relationship.

built to have babies (Sophia)

I think accessing the pill was a lot easier,

especially because it was just offered to me

I was 15, and my doctor was like,

"*oh, I see you're 15 and you're having this problem with acne and you're also getting to the age where you might become sexually active*

so would you be interested in starting birth control?"

he didn't give me any options really, for different brands or anything

it was just like,

"*this is the one I recommend*"

I think a lot of women have a high pain tolerance

and especially when it comes to reproductive things, it's like,

"*oh, you know, women are built to have babies and what's an IUD compared to a baby?*"

I feel like the way that men express pain also might play into that

this is just my personal opinion,

men are very expressive when it comes to pain,

whereas a lot of women,

I feel like, are not as expressive

they can control their emotions a little bit more

I feel like that probably has to do with,

I don't know, maybe gender roles

women are expected to be able to take care of the family and do a hundred things,

whereas men, I don't know,

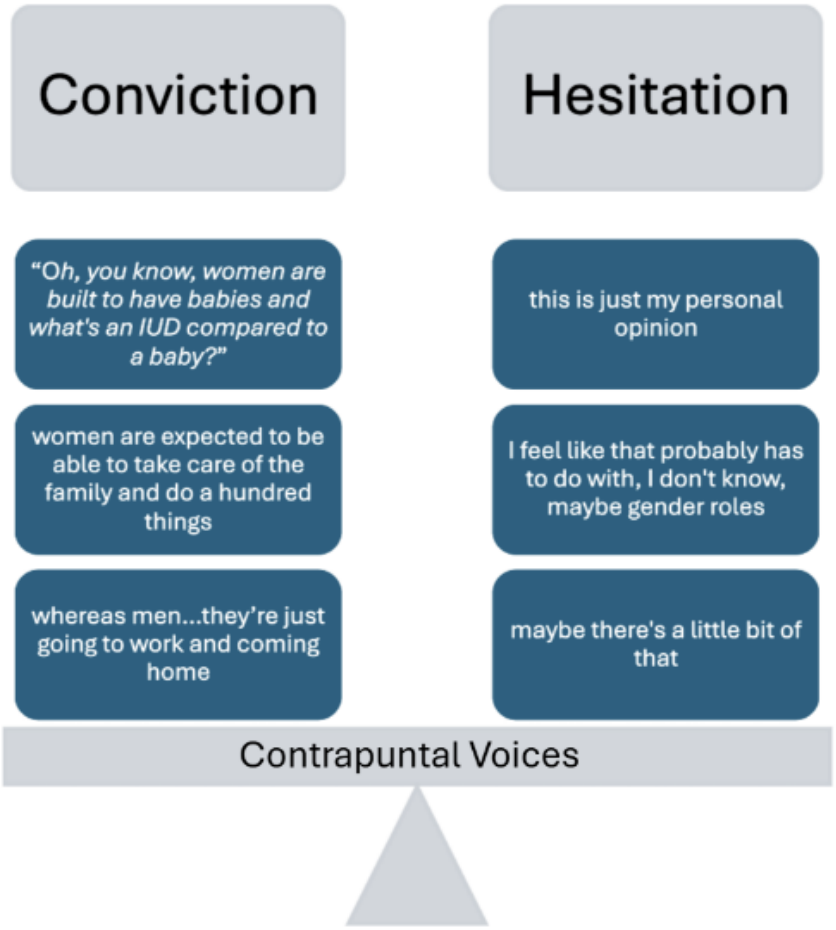
aren't

they're just going to work and coming home

I feel like maybe there's a little bit of that

Figure 13

Sophia: Conviction versus Hesitation



Note. Sophia's poem oscillates between a voice of conviction in her critique of gendered expectations imposed upon women, and a voice of hesitation manifested in the tentative manner in which she offers these perspectives.

penis can get you pregnant (Jordan)

I was in a relationship with a trans woman

I thought that conceiving wasn't something that was possible,

but she told me that it is so they were kind of like,

"*we need to get you on birth control right away*"

so I actually wasn't accessing contraceptives,

but it ended up being that that's what I was provided with

I guess people who have a penis can get you pregnant

I just thought that hormones would suppress that

it was kind of eye-opening to me

it was kind of a little shock, like,

"*holy crap I can still get pregnant by these people"*

it was quite an emotional appointment

I was seeing someone at the time, but casually

we weren't in a relationship,

but we were sleeping together

I let her know, and she was aware of all the things going on,

but I didn't let her make any decisions for me,

help me make decisions,

because I felt that it was my choice

I think sometimes health education could be a little bit better in schools

I find something that I struggled with as a queer person is the health

I felt like the sex ed that I was given was very heteronormative

so it's like:

man

woman

this is how you be safe

I had to learn my own sexual safety things kind of by myself, and in queer interactions

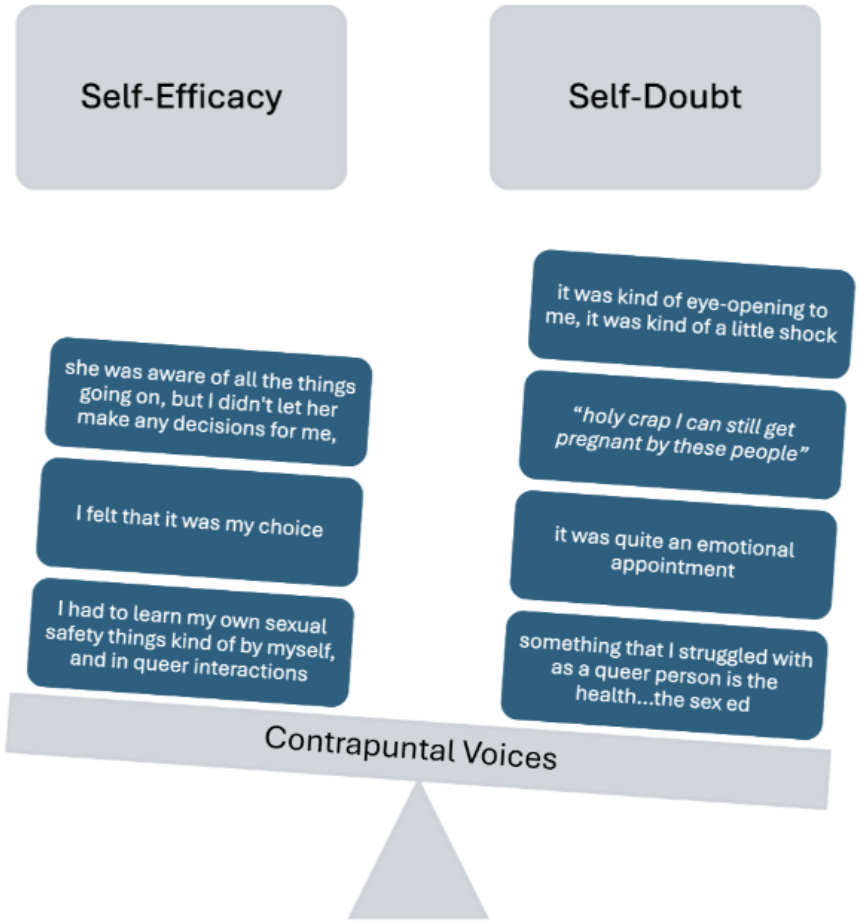
I think that maybe it might be important that people know that

even if you are sleeping with a trans woman,

you should probably use birth control if you have a uterus

Figure 14

Jordan: Self-Efficacy versus Self-Doubt



Note. Jordan's poem articulates a voice of self-efficacy through the assertion of autonomous decision-making in contraceptive use. Simultaneously, self-doubt emerges in the challenges of independently navigating sexual safety within a heteronormative educational framework, resulting in gaps and inaccuracies in sexual knowledge.

Summary

In this phase, the first-person accounts of each participant were revisited through the lens of broader discursive patterns. Each narrative revealed tensions through contrapuntal

voices, such as collectivism versus individualism, logic versus instinct, and self-blame versus self-advocacy, that illuminate how personal experiences are shaped by, and resist, dominant gendered discourses. By juxtaposing lived experience with socio-political structures, this phase revealed the complex emotional and moral negotiations embedded in contraceptive decision-making.

These negotiations often reflected a discursive double bind: a paradox in which participants were required to make contraceptive decisions amid social expectations that imposed judgment regardless of the choice made. For example, the gendered expectations surrounding contraceptive use were perceived as deeply unfair; fulfilling these expectations could be viewed as submissive or overly accommodating to a male partner, while refusing that responsibility could be framed as irresponsible or careless. This "catch-22" exposes how participants were frequently caught between contradictory expectations: to be sexually consenting but also self-regulating, to make a mutual decision with their partner while also asserting independence. These competing imperatives, between "doing it for my partner" and "doing it for me", highlight the gendered tensions that shape reproductive agency and bodily autonomy.

The fourth, and final, step of Phase 2 involves putting the personal in the political. The following discussion will achieve this by situating the above findings within feminist theory and reproductive justice frameworks, with a focus on how personal experiences are shaped by, and push back against, broader discursive forces. It will critically examine how gendered power dynamics, provider roles, and institutional systems shape contraceptive access and autonomy for undergraduate students, particularly in rural contexts.

CHAPTER EIGHT

Discussion

Participant narratives revealed that layers of social interaction exist when seeking and accessing contraception, from the personal to the systemic. Undergraduate students described engaging in internal dialogue around hormonal contraception use, information-seeking from social networks (both within immediate social circles and the Internet/social media), interacting with HCPs to receive contraceptive counselling or prescription, and navigating institutional structures, in both the postsecondary and public healthcare realms. The gendering of contraception as a "woman's" issue revealed itself in different ways across these interactions, through discourses and discursive patterns based on what was said, as well as through what was left unsaid, through contrapuntal voices and "unconscious processes" (Gilligan & Eddy, 2017, p. 79) that may otherwise remain silenced.

This chapter will discuss female undergraduate students' experiences of seeking and accessing hormonal contraception in northern BC and how these experiences: (a) uncover power dynamics that influence undergraduate students' contraceptive-decision making and engagement with SRH services; and (b) identify barriers and enablers for undergraduate students who are seeking and/or accessing hormonal contraception. The overarching purpose of this discussion is to amplify the voices of often marginalized and underrepresented groups and identify ways in which principles of reproductive justice can be operationalized on postsecondary campuses.

Experiences of *Seeking* Hormonal Contraception

Interactions at the level of self and the social network were involved in undergraduate students' experiences of seeking hormonal contraception.

The Self: Contraceptive Responsibility and Gendered Expectations

Participants often internalized the role of pregnancy prevention as solely theirs, although they acknowledged the inequity in this. There was evidence of internal dialogues that weighed the risks and benefits of hormonal contraception use. At times, this involved justifying the use of contraception to themselves, despite being resistant to ingesting hormones or going through an invasive and painful procedure. This tension between the desire for bodily autonomy and the fear of pregnancy was evident in the contrapuntal voices across the discursive pattern of *my body, my choice...but also my responsibility: negotiating the gendered division of labour in contraception*, including righteous anger versus resigned acceptance and self-blame versus self-advocacy.

Participants' belief that non-hormonal methods of contraception (i.e. condoms) were inferior to hormonal methods, in conjunction with a sense of distrust in sexual partners to consistently and appropriately use these methods, created an expectation that it was their responsibility to use hormonal contraception. Despite the acknowledged unfairness of this expectation, there was a general consensus that taking hormonal contraception was the "right" and responsible choice, as well as an unavoidable aspect of the female experience. This internal conflict was represented in Lena's "I poem", which contained contrapuntal voices of righteous anger versus resigned acceptance.

The seeming misalignment between participants' preference to not take contraception and their choice to take contraception is not unique to this study. In a recent Canadian study of sexually active 18- to 35-year-old females, Lévesque et al. (2024) found that while 82% of respondents disagreed that women must be responsible for contraception, nearly three out of

four estimated the percentage of contraceptive responsibility they bore in their relationship at 50% or more, and nearly half estimated it at over 75%.

Underlying the gendered division of labour in contraception are power dynamics at the personal and societal levels, which can be traced back to the origin of hormonal contraception. Hormonal contraception was developed in 1960 (Black, 2019) and was initially celebrated as a tool of empowerment, allowing women to take control over the timing of a pregnancy. Hormonal contraception also offers the opportunity to cease other "male" methods of contraception, such as condoms or withdrawal, allowing them to maximize their sexual pleasure without fear of pregnancy (Littlejohn, 2021). Additionally, as hormonal contraception is the most effective method of pregnancy prevention, the onus to use contraception becomes the female's responsibility by default (Fennell, 2011). Due to the toted benefits of hormonal contraception, societal discourses shifted from contraception being the "man's responsibility" to that of the "woman's responsibility". These discourses continue to perpetuate power dynamics that are rooted in the prioritization of male pleasure and the feminization of contraception. These societal constructs materialized in the firsthand experiences of the participants in this study.

Olivia's experience of being pressured to take EC to avoid condom use is an overt example of the societal prioritization of male pleasure over shared responsibility and consent. This moment reflects a discursive site of power, where gender norms legitimize condom use resistance and shift the burden of contraception onto the female partner. Condom use resistance is often considered a normative behaviour among males (Davis et al., 2014) and a scoping review found that the prevalence of experiencing coercive condom use resistance is as high as 59.6% (Chen et al., 2024). In this context, hormonal contraception functions not to

exert reproductive agency, but as a defensive strategy employed in response to coercion or the exertion of power.

The feminization of contraception was less explicit in the participant narratives, but was nonetheless apparent in the way participants discussed their contraceptive decision-making. When participants discussed their decision to seek hormonal contraception, they detailed the planning involved in this task, which was largely undertaken alone. Only one participant discussed any active partner involvement in contraception-seeking, through appointment reminders. Male disengagement from family planning activities aligns with Lévesque et al.'s (2024) study that found 79% of women attended contraceptive appointments alone, and only 52% shared the costs of contraception with their partners. Planning, in general, is often considered a feminine trait (Fennell, 2011), and this gendered stereotype transfers to that of family planning.

While these examples include partner interactions, it can be argued that societal discourses, more so than direct personal influence, shaped the internal dialogues of the participants and influenced their contraceptive decision-making. For example, when Olivia described her experience of taking EC after her partner resisted condom use, she reflected on her feelings at the time when taking EC was her only viable option to prevent pregnancy. However, with hindsight, she recognized the coercive nature of the situation, acknowledging that the pressure to forgo condom use was not entirely of her own making. Despite this awareness, Olivia projected blame onto herself in two distinct ways: first, for allowing the situation to arise by not insisting on condom use initially, and second, for acquiescing to the pressure to take EC. This internalized blame is deeply intertwined with the pervasive social stigma surrounding women's sexual behavior, where moral judgments disproportionately

target women perceived as sexually "irresponsible" or "promiscuous." Olivia's reflections expose a tension between recognizing external pressures and internalizing accountability. Ultimately, the interplay of self-blame and social discourses shaped her decision-making and underscored the complex moral and emotional terrain navigated by women in contraceptive contexts.

This complexity is further reflected in the largely unquestioned absence of partner involvement during contraception-seeking tasks. With the exception of one participant, contraceptive responsibilities were generally accepted as part of a perceived natural order rather than an actively negotiated choice, highlighting how the subconscious self often drives decision-making in this domestic realm.

The Social Network: Negotiating Information Landscapes

After making the decision to use hormonal contraception, participants proceeded to seek information regarding their contraceptive options. In alignment with the literature that highlighted the influence of familiarity and exposure (Garrett et al., 2016; Hickey & Shedlin, 2017; Payne et al., 2016; Szajbely & Neiterman, 2025; Vamos et al., 2020), participants relied heavily on peers, the internet, and social media for information. Although there exist large knowledge gaps around contraception (Cabral et al., 2018), female university students consistently demonstrate significantly greater SRH health literacy compared to their male counterparts across the literature (Alhussaini et al., 2025). This trend was reflected in participants' expressed views that men were not only uninformed about contraception, but also not socially expected or held accountable for possessing this knowledge. This perceived lack of responsibility further reinforced gendered divisions in contraceptive knowledge and labour.

Bertotti (2013) found that highly-educated women are often better positioned to leverage their health-related knowledge to negotiate or shift contraceptive responsibility onto their male partners, regardless of their partners' level of knowledge. However, this dynamic was not commonly observed among participants in this study. One possible reason is the inclusion criteria, which required participants to have sought or accessed hormonal contraception, thereby excluding individuals who relied on “male” methods of contraception, such as condoms or withdrawal. Despite this, a notable tension emerged in the “I poem”s through the contrapuntal voices of self-efficacy and self-doubt. While there were palpable undertones of empowerment and autonomy throughout the narratives, participants also expressed being overwhelmed or uncertain throughout information-seeking and decision-making processes. Female undergraduate students’ status as being better informed than their male partners, yet not informed “enough”, may have had an impact on participants’ ability, or perceived ability, to change the division of labour in contraception.

A potential underlying factor to gendered power structures within contraceptive decision-making surfaced in the way participants discussed their formal education. Participants from different communities, and even countries, described SRH curricula in schools as lacking in depth, leaving them feeling unprepared, or even blindsided, when confronted with real-world experiences around seeking and accessing contraception. Additionally, participants strongly disagreed with the traditional separation of genders during the delivery of SRH education, claiming that it creates gendered gaps in knowledge that, in turn, widen the gendered gaps in contraceptive responsibility. There is a notable lack of research on the outcomes of gender-segregated SRH education compared to gender-inclusive SRH education, but it has been theorized that gender-segregation reinforces

heteronormativity by forcing students into binary categories, and can potentially leave students with limited understanding of other bodies and perspectives, which may increase information-seeking from unreliable sources (Wilson, 2024).

Ultimately, the gendered social landscape in which participants sought and received contraception information, from early education to postsecondary, impacted the ways in which participants accessed contraception as undergraduate students.

Experiences of *Accessing* Hormonal Contraception

Interactions at the level of the HCP visit, and at the broader institutional level were involved in undergraduate students' experiences accessing contraception.

The HCP: Paternalism or Partnership

Participants described accessing contraception from a variety of settings, including campus clinics, family physicians, and gynecologists. Satisfaction with care was highly variable; some participants recounted rushed visits, dismissiveness, and breaches of confidentiality while others described experiences of therapeutic interactions, thorough contraceptive counselling, and gender-affirming care. Across the spectrum, these interactions evoked strong reactions from participants, both positive and negative, demonstrating the significance of the patient-provider relationship and the contraception visit.

HCPs are in a position of power to steer patients towards certain methods of contraception, and this decision is often based on the medical logic of efficacy. Tiered effectiveness approaches to contraceptive counseling have been widely implemented since the development of LARCs (Brandi & Fuentes, 2020; Gomez et al., 2014). Canadian clinical practice guidelines recommend that prescribers provide contraceptive counselling on a range of methods, emphasizing that LARCs have the highest efficacy and should be considered for

all women of childbearing age (Black et al., 2015). In a study by Kimport (2018b) that analyzed 101 transcripts of contraceptive counseling visits, HCPs rarely discussed "male" forms of contraception, and when they were discussed, negative features, such as lower efficacy were emphasized, while positive features, such as lack of side effects, were omitted. This study reflected these findings, with only one participant being offered condoms as a method of contraception.

The distinction between efficacy and effectiveness is important to note; efficacy refers to how well a method prevents pregnancy when used correctly and consistently, while effectiveness refers to how well it works under real-world conditions (Black et al., 2015). Advertised contraception effectiveness is often based on perfect use, not typical use, and Littlejohn (2021) argues that steering women toward methods based solely on efficacy "treats effectiveness as a scientific fact, rather than a moldable social outcome influenced in part by gender expectations" (p. 126). Several participants noted that taking OCPs at the same time every day was unrealistic, leading them to choose a LARC by default, despite concerns about side effects or bodily autonomy.

While the "set it and forget it" nature of LARCs, coupled with their high efficacy, may be interpreted as enhancing reproductive agency by offering freedom from daily management of hormonal birth control, this framing does not resonate with all users (Gomex et al., 2014). Some participants described LARCs as tools that granted autonomy by reducing anxiety around unintended pregnancy and/or suppressing menstruation. For others, the reliance on an HCP for both initiation and discontinuation were experienced as constraints on agency. These diverging interpretations demonstrate that autonomy is not a one-size-fits-all concept; it is relational, contextual, and shaped by individual needs and preferences.

The ways in which participants spoke about their appointments revealed that, at times, they were positioned by HCPs as passive recipients of care. In many cases, contraceptive decisions were framed by the provider through a narrow focus on clinical effectiveness, with limited space for the participant to express personal preferences, needs, or values. Several participants described being presented with a method without being fully informed of alternatives or asked about their contraceptive goals. These accounts reflect a broader dynamic in which clinical authority was privileged over the patient's reproductive autonomy and decision-making agency.

Participants who experienced contraceptive counselling that centred on shared decision-making described these encounters as empowering. When HCPs provided clear information, invited consent, and offered space to explore options without judgment, participants reported feeling heard, respected, and in control of their reproductive decisions. These moments of agency stood in sharp contrast to encounters where decisions were made on their behalf or where their concerns were dismissed. These accounts demonstrate that the counselling visit is an opportunity to build autonomy rather than reinforce paternalism. In this light, the contraception visit becomes a site not only of clinical care, but also of gendered power negotiation.

The expectation that women are ultimately responsible for pregnancy prevention also contributed to participants' contraceptive choices, particularly with regard to methods that require male cooperation. Condoms, for example, which are 98% effective with perfect use (WHO, 2025), offer similar protection to OCPs (WHO & Johns Hopkins Bloomberg School of Public Health Center for Communication Programs Knowledge for Health Project, 2022) but were often considered unreliable due to the need for male participation. This reflects

broader social dynamics in which women must navigate not only medical considerations, but also relational expectations and power imbalances when making contraceptive decisions.

Importantly, the gendered nature of contraceptive responsibility also presents unique challenges for gender and sexual minorities (GSMs). For transmasculine, nonbinary, or gender-nonconforming individuals, contraception can be a source of tension, compounding the practical and emotional labour involved. As discussed in Chapter 7's discursive interlude, seeking out services (often designed with cisgender women in mind) can feel invalidating or exclusionary (Fix et al., 2020). Navigating a healthcare system founded on cisnormative assumptions can provoke inner conflict and distress, further complicating contraceptive decision-making and exacerbating feelings of invisibility (Agénor et al., 2020). In such cases, the act of seeking contraception may not affirm bodily autonomy but instead challenge one's sense of self. Normative ideas around sex combined with a narrow clinical focus on pharmacological efficacy, may lead HCPs to unknowingly perpetuate the feminization of responsibility for contraception (Kimport, 2018a). The contraception counselling visit presents an opportunity for HCPs to dismantle longstanding paternalistic attitudes towards family planning which position the HCP as the gatekeeper to contraception. While female gender was a strong driver of patient-provider trust in this study, other notable contributors to a therapeutic alliance were active listening, clear communication, humor, knowledge, and supportive counselling. By developing an awareness of the inherent power relations in the patient-provider relationship, re-centring the woman as the primary decision-maker, and providing contraceptive counselling that is inclusive of "male" and "female" methods, HCPs can promote contraceptive agency and contribute to the de-feminization of responsibility for

contraception. However, while individual efforts are meaningful, institutional support is required to promote environments that support true contraceptive agency.

The Institution: The Illusion of Universal Access

While BC's universal contraception policy eliminates cost barriers to contraception, the lived experiences of participants in this study reveal that social and structural factors have the potential to constrain meaningful access, decision-making freedom, and comfort in care-seeking. Participants' experiences seeking and accessing contraception were shaped by gender norms, patient-provider relationships, and fragmented informational landscapes. The discourses in this study underscore that contraception access is a highly nuanced issue, and that universal coverage does not equate to universal accessibility or autonomy. In order to identify strategies to address barriers to seeking and accessing contraception, institutional roles, in both postsecondary and healthcare realms, must be considered.

Contraceptive Literacy 101: Not a Pre-requisite. Participants' early experiences with SRH education, prior to entering postsecondary education, served as the foundation from which they built their understanding of reproduction and their roles and responsibilities around it. Although this discussion does not have the scope to address curriculum reform at the primary and secondary school level, it is important to acknowledge how pre-existing knowledge gaps inform the ways students approach and engage with SRH services once on campus.

Participants shared that they received limited or inadequate SRH education in secondary school, often marked by gendered assumptions and a lack of practical, inclusive information. Traditional gender scripts play a powerful role in shaping these early experiences: girls and young women are commonly socialized to suppress their sexuality and

assume the role of sexual gatekeepers, while boys are encouraged to embrace their sexual desires (Masters et al., 2012). This dichotomy was reflected in participants' observations that by having female anatomy, they were expected to take precautionary measures to prevent pregnancy and manage sexual risk, whereas possessing male anatomy permitted a socially sanctioned ignorance of SRH. Such double standards reinforce the perception that, should unintended consequences of sexual activity arise, it is women who must bear the social stigma and responsibility for resolution. The internalization of these discourses manifested as feelings of guilt, anxiety, and pressure among participants, underscoring the enduring impact of gendered norms on sexual agency and reproductive accountability.

This context is relevant to postsecondary institutions and healthcare infrastructure, as students enter these settings already shaped by a system that consists of inadequate formal SRH education and an overreliance on informal sources such as peers and the internet. This invisible SRH curriculum influences how students navigate health care services, their expectations from HCPs, and their understanding of reproductive responsibility. Campus-based initiatives should aim to challenge gendered narratives around contraception and address persistent knowledge gaps among young adults through inclusive, evidence-based education and engagement strategies. Meanwhile, primary care efforts should attend to the improvement of contraceptive counselling strategies and LARC insertion practices through HCP training and support. All institutions must recognize rural considerations when implementing interventions.

Reproductive Justice on Campus. Participants identified campus-based services as enablers of access, citing convenience, short wait times, and knowledgeable providers as benefits. As students expressed trust in the campus clinic, there is an opportunity to leverage

this positive reputation to implement SRH initiatives, with the goals of increasing access to contraception, as well as narrowing the gender divide in terms of contraceptive responsibility.

As Alhussaini et al. (2025) suggest, campuses can serve as hubs for culturally tailored, evidence-based SRH interventions. These might include online education tools, peer-led workshops, and integration of SRH content into orientation sessions and student society events. The "Just in Case" initiative described by Olson et al. (2024) offers a novel, student-led approach to addressing SRH needs on campus. This model involved collaborating with faculty to develop a health promotion program that discreetly and anonymously provided students with supply kits containing contraceptives, sexual health wellness products, basic hygiene supplies, and education materials. Aside from increasing users' perception of contraception availability and SRH education, students involved in the development of the program gained valuable skills and course credit through participating in grant-writing. By positioning students as leaders, integrating program development into coursework, and offering opportunities for mentorship, health initiatives can operate successfully in settings with limited resources. Collaborations with student societies, local SRH services (i.e. Options for Sexual Health [OPT]), or campus-based non-profit organizations, (i.e. the Northern Women's Centre), could further support sustainable programming. Student-led and institution-supported interventions can normalize SRH conversations, challenge reproductive gender norms, and foster environments where students have autonomy over their reproductive decision-making.

Rurality: Contraception at the Margins. Rurality played a supporting role in how participants sought and accessed contraception; while geography was not emphasized as a

key factor in experiences of seeking and accessing contraception, rural limitations were an undercurrent to discussions around choice and agency. There was an overall perception of HCP scarcity, and the rural sentiment of being "lucky to have a doctor at all" was pervasive, suggesting an acceptance of limited choice and potentially lower expectations of care. While provider recruitment and retention strategies remain important for addressing rural health care gaps, this discussion will focus on how existing HCPs can be better equipped to deliver comprehensive contraceptive care, even in contexts where choice is limited.

Contraceptive counseling, as described by Holt et al. (2020), is shaped by normative and paternalistic frameworks. Despite positive intentions, HCPs may inadvertently position their own contraceptive preferences as the ideal, emphasize pregnancy prevention above other considerations, or treat contraception as compulsory for women deemed "at risk" (Mann, 2022). A more nuanced, person-centered approach, such as the one advocated by Gomez et al. (2014), acknowledges that reproductive autonomy is not about maximizing contraception use but about respecting and facilitating informed, values-aligned decisions.

To align contraceptive counselling practices with reproductive justice principles, clinical education must evolve. Recently, several reproductive life-planning frameworks have been developed to help HCPs navigate the contraceptive counselling visit by providing supportive scripts. One approach that was successfully piloted in Oregon, Washington, is the "One Key Question" (OKQ) initiative (2020). OKQ prompts HCPs to ask patients whether they would like to become pregnant within the next year, and offer personalized counseling and care based on their response.

Aiken et al. (2016) cautions that that reproductive life-planning has the potential to alienate those who are either ambivalent towards pregnancy, or whose reproductive goals

differ from normative timelines. This concern is especially relevant to undergraduate students, as they navigate the intersecting pressures of young adulthood. Callegari et al. (2017) presents an alternative to OKQ, called PATH, which assesses Pregnancy Attitudes, Timing, and How importance is pregnancy prevention to the patient. This model is designed to account for the spectrum of reproductive goals and intentions that patients may have and the understanding that these may shift over time.

When done well, reproductive life-planning offers the opportunity to support all women's fertility desires, through preventive health education and opportunities to improve overall health (Morse & Moos, 2018). However, OKQ, PATH, and similar tools are not intended to be implemented at a clinic-only level and require structural support to be effective, including integration into funding models and institutional protocols, which may be an obstacle to implementation (Allen et al., 2017). Broader strategies that are applicable to various clinical encounters, yet address the same concepts of equity, inclusion, and autonomy, may be more feasible in rural or low-resource areas. Brandi and Fuentes (2020) suggest that implicit bias training, alongside broader anti-oppression education may be an effective strategy to mitigate conflict between a patient's right to choose and provider bias. Through increased self-awareness, HCPs are better equipped to engage in shared decision-making in a more authentic way than "one-fits-all" counseling scripts.

Procedural Pain and the Gendered Body. Attending to bodily autonomy should extend beyond the contraceptive counselling visit to SRH procedures. One notable theme in participants' narratives was the anticipation and experience of pain related to LARC insertion. Some participants prepared to self-advocate in advance, expecting that their concerns might be minimized or dismissed. This anxiety reflects a broader social norm: that

those in female bodies are expected to tolerate pain silently and without question. Purcell and Greenfield (2025) describe this as the "gender pain gap," highlighting how women's pain has been systematically ignored or undertreated in medical contexts. This is particularly true in contraceptive care, where providers often underestimate patient pain (Maguire et al., 2014) and where training on analgesic use, such as paracervical blocks, is often lacking in primary care (Daidone et al., 2024).

The failure to address procedural pain not only compromises the care experience but can deter individuals from future engagement with SRH services. As Bayer et al. (2025) note, there is no established standard of care for IUD pain management, a glaring gap that perpetuates androcentric practices in medicine. Establishing guidelines that prioritize autonomy, choice, and trauma-informed care would affirm patients' right to pain control and dignity during procedures.

Summary: Centering Autonomy, Not Just Access

While the policy shift to universal contraception coverage in BC represents progress, it does not guarantee universal access or autonomy. Participants' experiences reveal the persistent influence of misinformation, limited provider choice, and systemic paternalistic attitudes towards contraception. True reproductive justice is not achieved by making contraception cost-free; it requires that services be accessible, comprehensive, and affirming of individual identities and needs. See Table 4 for recommendations for how the healthcare sector and education sector can further these goals.

Reproductive decisions are never made in a vacuum. They are shaped by relationships, social norms, and broader systems of power that often undermine bodily autonomy. Postsecondary institutions, as both health service providers and influential social

institutions, have an opportunity, and responsibility, to challenge the gendered division of contraceptive labor and reimagine what student-centered care can look like. Universal access is not an endpoint; it is a continual process of identifying and dismantling barriers, amplifying voices, and affirming the right of all individuals to make informed, supported, and pain-free reproductive choices.

Table 4

Recommendations

Health Care Sector	Education Sector

• Train HCPs in contraceptive counselling
  ○ Promote bias-aware shared decision-making and gender-inclusive counselling
  ○ Implement patient-centered tools or frameworks for reproductive life-planning conversations
• Standardize and prioritize pain control during contraceptive procedures
	• Offer inclusive, evidence-based education and integrate SRH into student life
	• Support peer-led programs like contraceptive supply kits and SRH workshops

• Go beyond cost coverage to tackle social, relational, and systemic barriers to true contraceptive access	

CHAPTER NINE

Limitations

This study has several limitations that must be considered when interpreting the findings and applying recommendations for practice. As part of the sampling strategy, participants self-selected, which could result in differences between those who chose to

participate and those who did not in terms of demographic characteristics, motivations, or experiences, which could potentially skew the results.

The aim of this study was not to produce statistically generalizable results, but to further understanding of how undergraduate students navigate seeking and accessing hormonal contraception within a particular context and through a feminist lens. While broad findings were reported alongside a deeper discussion of two discursive patterns, it was not possible to fully capture the scope of participants' experiences and the complexity of all emerging discourses and discursive patterns within the confines of this project. Some nuances and contradictions may have been left unexplored or only partially articulated.

Additionally, the study was conducted at a single institution, which is situated within the unique demographic and healthcare landscape of northern BC. Doing so contributed to filling in the literature gap on rural undergraduate students' experiences seeking and accessing contraception, but the results may not be transferable to students' attending universities in different geographic regions or larger urban centers.

FRDA in Hindsight

FRDA is a relatively new and evolving methodology. While the lived experiences of seeking and accessing contraception could have been explored using phenomenological approaches, FRDA was chosen for its emphasis on contextual complexity and the power of individual voice. Unlike methods that prioritize thematic categorization, FRDA allowed for an analysis that extended beyond identifying what participants said to critically examining how they said it, and what that reveals about the social and discursive forces shaping their realities. Specifically, FRDA enabled a deeper exploration of how dominant discourses, such

as those surrounding gender, responsibility, and reproductive control, inform and constrain contraceptive decision-making for female undergraduate students.

While the concept of FRDA was appealing, the application of this methodology presented challenges as a novice researcher. There is limited precedent for its application in similar studies and its multi-step analytical process demanded deep immersion in the data, along with the analytical skills to recognize and interpret subtle contrapuntal voices. Extensive study of feminist theory was undertaken, along with discussion and deliberation with other scholars, including Dr. Lucy Thompson herself. At times, the analytical process felt messy, as contradictions surfaced, discourses overlapped, and narratives resisted neat categorization. However, facing these complexities and their accompanying internal struggles culminated in an acceptance of uncertainty and a willingness to explore meaning beyond conventional structures. By embracing the messiness, FRDA became not only an analytic tool but a catalyst for intellectual and creative growth.

CHAPTER TEN

Conclusion

This study explored female undergraduate students' experiences of seeking and accessing hormonal contraception at a rural northern university. Using an FRDA framework,

the personal narratives of five participants were analyzed for discourses, discursive patterns, and discursive realms. Two prominent discursive patterns emerged: *a uterus is a credential a man cannot acquire: gender concordance as a driver of trust* and *my body, my choice...but also my responsibility: negotiating the gendered division of labour in contraception.* Through exploration of these discursive patterns, it became evident that while logistical improvements such as universal contraception coverage have removed financial barriers, significant relational, educational, and systemic barriers to contraceptive access persist. The participants' narratives illuminated the complexity of reproductive decision-making, revealing how bodily autonomy, patient-provider relationships, knowledge gaps, and social perceptions are deeply intertwined with the broader sociocultural context in which hormonal contraception is sought and accessed.

The findings affirm that reproductive healthcare access cannot be understood solely through structural availability, but must be analyzed through the lens of lived experience and power relations. Participants expressed a strong desire for reproductive agency but often encountered clinical interactions that were one-sided or shaped by underlying gendered expectations. Inadequate contraceptive counseling, experiences of stigma, gendered power dynamics with HCPs, and burdens placed on the contraceptive user all surfaced as critical factors influencing access. These discourses align with existing literature, yet also highlight the unique ways in which rurality shapes students' realities.

By centering participant voices and attending to the interplay of personal experience and societal discourse, this research contributes important insights for HCPs, university administrators, and policymakers, particularly in rural areas. Future research should prioritize the development, implementation, and evaluation of campus-based SRH interventions that

are both accessible and sustainable in low-resource environments. Future research should continue to prioritize the experiences of GSM students, whose unique needs were only lightly touched upon in this study.

Ultimately, reproductive autonomy entails more than the removal of financial barriers; it necessitates the ability to make fully informed, supported, and autonomous decisions regarding one's reproductive health. To meaningfully advance reproductive justice, postsecondary institutions and healthcare systems must engage in ongoing efforts to dismantle structural barriers, critically evaluate service delivery models, and foreground the lived experiences of those they aim to serve. The findings of this study demonstrate that reproductive justice is not merely a theoretical construct, but an essential and immediate priority. The findings of this study serve as a call to action: ensuring that all students, regardless of background, geography, or identity, can seek, access, and utilize contraception in ways that fully support their rights, dignity, and autonomy.

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Appendix A

Data Reduction

Cross-Sectional Surveys

Author(s)	Year	Purpose	Sample	Quality Rating	Results	Limitations
Waltermaurer, E., Doleyres, H. M., Bednarczyk, R. A., & McNutt, L. A.	2013	Examine current EC use among college students, including the prevalence of EC consideration and use, factors associated with EC consideration and use, and the relationship between ever using EC and the use of other means of contraception.	N=482, female undergraduate students (82% aged 18 to 21) with a history of vaginal sexual intercourse who are enrolled at a large public university in the United States	Analytical Cross-Sectional Studies: 8 criteria Yes (7) No (0) Unclear (0) NA (1)	-58% reported ever considering using EC -46.5% reported ever using EC -Those who reported ever binge drinking were more likely to consider EC than those who did not ($p = 0.05$) -EC consideration increased by 30% among those worried about pregnancy, but had no impact on EC use -Use of condoms and hormonal contraception showed no individual effect on EC consideration; those who reported frequent condom use were less likely to ever use EC (($p = 0.01$) -As total number of sexual partners increased, so did reported EC use ($p = 0.01$)	-Unable to determine causation -Did not measure use of LARC methods -Self-report
Fitzpatrick, V., Mouttapa, M., Park	2014	Examine whether perceptions and knowledge	N=214, students enrolled in a	Analytical Cross-Sectional	-Among females, factors associated with higher rates of intention to use EC were:	-Unable to determine if independent

Tanjasiri, S., & Napoli, J.		regarding EC use were associated with women's intentions to use EC, and men's intentions to support their partner's EC use	personal health class at a community college in southern California (45% female, mean age 21.3)	Studies: 8 criteria Yes (7) No (0) Unclear (0) NA (1)	knowing that EC can be purchased without a prescription (p< 0.01), the belief that EC is worth using even if the cost is high (p< .001), and past EC use (p< 0.05) -Among females, factors associated with lower rates of intention to use EC were: the belief that EC is morally wrong (p< .0001) and having had previous abortion (p < 0.05) -Among males, the perception that EC is worth using despite high cost was positively associated with EC use intentions (p< 0.01) and the belief that EC is morally wrong (p< .001) and that EC encourages promiscuity (p< .01) were negatively associated with EC use intentions	variables preceded EC use intentions -Potential for self-reporting bias, recall bias, and social desirability bias -Small sample size resulted in large confidence intervals for odds ratios -Findings may not be generalizable beyond study population
Lally, K., Nathan-V, Y., Dunne, S., McGrath, D., Cullen, W., Meagher, D., Coffey, J. C., & Dunne, C.	2015	Investigate awareness and knowledge of sexual health and STIs, and risky sexual behaviour among university students	N=419, students at the University of Limerick, Ireland (56.1% female, 77.5% undergraduate	Prevalence Study: 9 criteria Yes (7) No (1) Unclear (1)	-90.7% of respondents were sexually active -51% believed OCP was adequate protection against STIs and pregnancy -72.7% believed ECP must be taken within 24 hours	-Low response rate (4.1%)

			students, 73.9% aged 18 to 24)		-22.6% attended a family planning/sexual health clinic or GP for advice regarding sex -58.1% of sexually active students were reluctant to attend the college health clinic -Most frequently access sexual health resources were the Internet (72%), peers (33%), health professional (31%), magazines (29%), secondary school sex education (24%), student union (13%), family (6%) and none (9%) -Condoms (89.6%) and OCP (51.1%) were most common methods of contraception among sexually active students	
Garrett, K. P., Widman, L., Francis, D. B., & Noar, S. M.	2016	Examine information sources about EC and their association with perceptions of access	N=352, undergraduate students at a large, public university in the southeastern US (67% female, mean age 19.78)	Analytical Cross-Sectional Studies: 8 criteria Yes (5) No (0) Unclear (2) NA (1)	-20.5% reported ever having used EC -Perceived access reported at a mean of 3.32 on the 5-point scale; females (mean = 3.49) and individuals who had previously used EC (mean = 4.17) showed higher perceptions of access -Students who had heard of EC reported having heard of	-Potential for self-report bias and self-selection bias -Sample reflected more women and more racial diversity than the campus from which study was drawn; may not accurately reflect study population

					it from an average of four sources -Receiving information about EC from media, interpersonal sources, or health education sources was associated with higher perceptions of EC access for women, but not men	-Did not assess accuracy of EC knowledge and how this was associated with information sources or access
Bersamin, M., Fisher, D. A., Marcell, A. V., Finan, L. J.	2017	Examine associations between different domains of barriers and the receipt of RH services among young adults attending college, and whether these associations vary by gender	N=212, aged 18-19, northern California public university, (40% men)	Analytical Cross-Sectional Studies: 8 criteria Yes (8) No (0) Unclear (0) NA (1)	-50.9% of students reported R-RHC in the past year , 16.2% reported visiting more than one setting -Most frequented locations were primary care and school-based clinics -More female, sexually experienced and Latino college students reported R-RHC in the past year than males, students who had not had sexual intercourse, and Whites -For males, only K-RHC was positively associated with R-RHC For females, having sexual intercourse and greater K-RHC were positively associated with R-RHC, and perceived social disapproval was negatively associated with R-RHC	-Not possible to determine temporal order -Did not gather data on living situation (i.e. parental involvement) -Only reported on services accessed in past year (may omit accessing long-acting methods of contraception)

Bersamin, M., Fisher, D. A., Marcell, A. V., & Finan, L. J.	2017	1. Examine gender differences in college students' K-SRHC service access points and 2. Assess the relationship between demographic and psychosocial factors and college students' K-SRHC service access points.	N=183, aged 18-19, northern California public university, heterosexual (39.9% men)	Analytical Cross-Sectional Studies: 8 criteria Yes (8) No (0) Unclear (0) NA (1)	-Students reported knowledge of >5 locations to obtain SRH services on average -K-SRHC was positively correlated with maternal education and family planning self-efficacy -Significantly higher proportion of women than men reported knowing where to access all SRH services except condoms -Most reported service students knew where to access was condoms and pregnancy tests	-Low response rate -Limited, non-probability sample (one university, subset used so as not to interfere with concurrent study) -Only heterosexual students represented
Hopkins, K., Hubert, C., Coleman-Minahan, K., Stevenson, A. J., White, K., Grossman, D., & Potter, J. E.	2018	Identify preferences for and use of short-acting hormonal or LARC among community college students in Texas	N=966, female community college students from three community colleges in Texas, aged 18 to 24 who had ever had sexual intercourse and were not currently	Analytical Cross-Sectional Studies: 8 criteria Yes (6) No (0) Unclear (1) NA (1)	-Contraceptive method use was as follows: condoms or withdrawal (54.4%), short-acting hormonal methods (20.7%), LARC (9.1%), and no method (15.9%) -69% wanted to be using a more-effective method -Reasons for not using a more effective method included not having insurance, insurance not covering their preferred method, not knowing where to get the method, or too	-Response rate of 37% -Large confidence intervals in logistic regression model predicting preference for and use of a more effective method (not precise)

			pregnant or trying to get pregnant		much hassle/not having made an appointment -Women without insurance were just as likely as women with insurance to prefer a short-acting hormonal or LARC method, but less likely to be using these -Many women who reported having a regular HCP were not using their preferred method -Single women with no children were less likely to be using more effective methods than women with children	
O'Connell, M. B.m Samman, L., Bailey, T., King, L., & Wellman, G. S.	2020	Determine female college students' opinions about and willingness to use pharmacists for obtaining hormonal contraception in a community pharmacy across a wide range of student characteristic, attitudes, and health service opinions	N=859, female or intersex college students of any age from any college in any curriculum in Michigan, United States (average age 23.0 years)	Analytical Cross-Sectional Studies: 8 criteria Yes (7) No (0) Unclear (0) NA (1)	-73% reported they were likely to obtain birth control from a community pharmacist -Commonly reported advantages were: more convenient, save time, easier to get birth control, less likely to run out of birth control, better hours, and lower cost -Common concerns were not getting regular Pap smears and screening and being prescribed the wrong birth control	-Represent one Midwest state and one college – not generalizable -Respondent bias may exist -Difficulty with recruitment; did not meet target number of responses -Race and ethnicity diversity limited (83% of participants were White)

					-Previous experience with pharmacists including receiving a vaccination, having confidence in prescription dispensing and counselling, and believing pharmacists have more knowledge than their HCP were associated with greater likelihood of getting birth control from a pharmacist -Most thought that receiving birth control from a pharmacist would increase their birth control adherence and would decrease unintended pregnancies -Trustworthiness and approachability were positively associated with likelihood to use a pharmacist for birth control; visit expense was negatively associated with likelihood to use a pharmacist for birth control	-Long survey may result in survey burden
Yarger, J., Schroeder, R., Blum, M., Cabral, M. A., Brindis, C. D., Perelli, B., & Harper, C. C.	2021	Examine insurance coverage, access to free or ow-cost birth control, and concerns about contraceptive	N=389 (aged 18-25, identified as female, had ever had vaginal sex, and were not	Analytical Cross-Sectional Studies: 8 criteria Yes (8) No (0)	-81% knew where to get free or low-cost birth control -69% of participant who did not know where to get free or low-cost birth control were concerned about the cost compared with the 44% who	-Sub-sample from an intervention study; not generalizable -Unable to identify causal relationship between concerns about the cot of

		costs among women in community college.	pregnant or trying to conceive, enrolled at one of five community colleges in California and Oregon)	Unclear (0) NA (0)	had this knowledge (p < .001) -49% were concerned about the cost of birth control -Uninsured and publicly insured women were more likely to be concerned about the cost of birth control than privately insured women (p = .002)	contraception and contraception use
Asdell, S. M., Bennett, R. D., Cordon, S. A., Zhao, Q., & Peipert J. F.	2022	Investigate the relationship between LARC knowledge and intent to use LARC among female university students; assess awareness of the three types of LARC methods	N=292, female undergraduate students (79.5%), graduate students (18.8%) and resident physicians (1.7%) above age 18 (mean age of 20.2 years) at a large midwestern university in the US who were eligible for campus health services	Analytical Cross-Sectional Studies: 8 criteria Yes (7) No (0) Unclear (0) NA (1)	-Average score on 10-item LARC knowledge assessments was 4.8/10 (SD 2.5) -OCPs used by 62.0% of contraceptive users; LARC methods used by 13.4% -Statistically significant difference in willingness to use a LARC in the future between students scoring below the mean vs. above the mean on the LARC knowledge assessment (RR 1.81, 95% CI 1.24-2.65; *p* <.01) -Among students who were not using LARC, would not consider LARC, or were uncertain about LARC, a need for more information was most commonly cited, followed by concern about	-Unable to infer causation between LARC knowledge and intention to use LARC -Only one university surveyed

					pain, safety and potential side effects	
Chen, E., Hollowell, A., Truong, T., Bentley-Edwards, K., Myers, E., Erkanli, A., Holt, L., & Swartz, J. J.	2023	Assess contraceptive access and use among undergraduate and graduate students in North Carolina during the COVID-19 pandemic	N=934, students, aged 18 to 30, enrolled in a two- or four-year undergraduate or graduate program in North Caroline (71% cisgender women)	Analytical Cross-Sectional Studies: 8 criteria Yes (7) No (0) Unclear (0) NA (1)	-96% reported that they maintained access to their preferred contraceptive method -Attending a four-year college was associated with increased access to the preferred method compared to attending a two-year college (aRR 0.34, 95% CI 0.16-0.71) -Gender minorities reported increased risk of difficulty accessing preferred method (aRR 2.43, 95% CI 1.01-5.87) -10% reported increased likelihood of using EC during the pandemic; risk factors were Black race (aRR 3.53, 95% CI 1.24-10.03) and reporting religion to be very important (aRR 2.97, 95% CI 1.12-7.86) -64% reported increased likelihood to use telehealth to with their doctor to access contraception; 54% reported avoiding the doctor's office since pandemic	-Possibility of self-selection bias; may limit generalizability -Participant population skewed toward White females with high rates of being insured (reflects demographics of institution); may limit generalizability

Wagner, B., Brogan, N., & Cleland, K.	2023	Examine three areas of knowledge about EC in college students: EC methods, potential outcomes of EC use, and EC access; describe the prevalence of misinformation and identify sources of uncertainty surrounding EC that may influence its use by college students	Survey: N=150 Interviews: N=24 -All participants were college students aged 18 to 29 residing in the US with experience as a student activist; 90% female	Prevalence Study: 9 criteria Yes (7) No (2) Unclear (0) Qualitative Research: 10 criteria Yes (7) No (3) Unclear (0)	-Lack of awareness of EC methods beyond levonorgestrel -Perceptions of greater barriers to access EC than exist; confusion around whether or not age restrictions exist, identification was needed, and if pharmacists could limit EC access	-Participants recruited from listserv of students who had expressed interest in EC campus activism; knowledge of EC in this population may be higher than the general college student population
Lemay, V., Whalen, A., Cohen, L., & Bratberg, J.	2025	Assess college student and community pharmacy patients' perspectives on pharmacist-prescribed hormonal contraceptives, likelihood of accessing	N=358, college students (60%) and patients (40%) accessing care at community-based pharmacies in Rhode Island, aged 18 and older	Prevalence Study: 9 criteria Yes (7) No (1) Unclear (1)	-55% of students reported experiencing at least one barrier to accessing contraception -Most commonly reported barriers were time, delay in appointment, cost, and not having a gynecologist -93% of students supported pharmacist-prescribed contraception	-Survey method may have allowed for multiple submissions -Possibility for selection bias; lacks generalizability

		contraceptives from a pharmacist, and perspectives regarding EC and over-the-counter (OTC) oral contraception				

Qualitative (Individual Interviews)

Author(s)	Year	Purpose	Sample	Quality Rating	Results	Limitations
Lechner, K. E., Garcia, C. M., Frerich, E. A., Lust, K., & Eisenberg, M. E.	2013	Examine students' perceptions of responsibility and the role of the college in relation to sexual health resources	N=78, students aged 18 to 24 currently enrolled in post-secondary education on five two- and four-year campuses in one state in the US (49% women)	Qualitative Research: 10 criteria Yes (10) No (0) Unclear (0)	-Described themselves as adults with the responsibility to access health resources when needed, independent of their families or institutions -Desire support from their institutions; students from four-year schools expected resources be available on campus whereas students at two-year schools wanted information on available community resources -A welcoming and supportive environment for LGBT students was cited as the responsibility of the institution	-Did not measure resources available in the surrounding community -Findings not generalizable beyond study population -Recruitment may have been influenced by research team (white females in the health sector)

Sundstrom, B., Baker-Whitcomb, A., & DeMaria, A. L.	2015	Investigate how female college students living in the US perceive LARC options	N=53, women aged 18 to 24 enrolled in a mid-sized, urban, public liberal arts and scienced university in the Southeast US	Qualitative Research: 10 criteria Yes (9) No (1) Unclear (0)	-Most participants-initiated contraception for positive side effects, not pregnancy prevention -Reported physicians infrequently discussed LARC options and recommended the OCP; had to advocate to both receive and remove LARC -Cost was a determining factor in method choice; OCPS perceived as a less expensive option than LARC -Described LARC as invasive and unnatural; perception of LARC insertion as a surgical procedure was a deterrent -Underestimated risks of the OCP and over-estimated risks of LARC (complications, infertility, ectopic pregnancy, death) -Viewed LARC as more effective than the OCP -Reported challenges maintaining and filling prescription as well as medication adherence -Long-lasting nature of LARC was not appealing due to uncertainty about when	-Participants who were familiar with LARCs were purposively recruited; may not represent college population in which LARC use is rare -Students primarily White, from an urban college in the Southeast US; Unable to generalize to geographically or demographically dissimilar populations

					participants may want children	
Payne, J. B., Sundstrom, B., & DeMaria, A. L.	2016	Further understand the beliefs of women concerning IUDs and contraceptive choice.	N=53, women aged 18 to 24 enrolled in a midsize liberal arts college in the southeastern United States	Qualitative Research: 10 criteria Yes (7) No (2) Unclear (1)	-Expressed fear that IUDs cause physical damage and negatively impact future fertility -Expressed greater familiarity and comfort with oral contraceptives -Insufficient observability was a barrier to using IUDs; social network the primary resource for contraceptive information -Reported limited or no information provided about IUDs from HCPs; oral contraceptives sometimes automatically prescribed -Most desired an effective method as they did not intend to become pregnant, but valued future fertility -Desired a menstrual cycle and viewed amenorrhea as "unnatural" and unfavourable -Viewed motherhood and career development as incompatible	-Not generalizable -Most participants White and heterosexual -Women enrolled in a liberal arts college may have different beliefs than other young women
Hickey, M.T. & Shedlin, M. G.	2017	Gain insight into risk perceptions for STIs and unintended	N=21, aged 18-24, private urban	Qualitative Research: 10 criteria Yes (7)	-Majority of participants did not consider themselves at risk for STI or unintended pregnancy	-Sample well-educated and well-informed

		pregnancy in women who have purchased ECP OTC	university in USA	No (2) Unclear (1)	-Decision to use ECP influenced by view of pregnancy as life-altering event, family, and social network -Info about ECP acquired through high school education, Internet, friends, family, media; health care providers were least cited source -Majority used ECP as "back-up" method; some used as primary method of contraception -All believed in ECP's effectiveness; varying degrees of knowledge related to medication (side effects, safety etc.) -Primary facilitator to use of ECP was ease of availability -Majority reported partner involvement in decision-making and purchase of ECP -Potential barriers cited included cost and embarrassment/awkwardness	-Most reported being in a relationship with a consistent partner
Cabral, M. A., Schroeder, R., Mitchell Armstrong, E., El Ayadi,	2018	Explore community college students' contraceptive experiences and	N=57, students enrolled in a community college in	Qualitative Research: 10 criteria Yes (8) No (2)	-Many women thought of their SRH behaviours as being tied to educational outcomes/career goals. Some men thought unintended	-California has extensive contraceptive coverage and mandatory

A. M., Gurel, A. L., Chang, J., & Harper, C. C.		pregnancy intentions and risks, and ow these factors relate to students' educational goals.	California, aged 18-25, 56% female, 81% heterosexual, 67-85% identified as a person of colour	Unclear (0)	pregnancy would motivate them further. -All participants wanted to prevent pregnancy, yet commonly engaged in unprotected intercourse -Negative attitudes and beliefs towards contraception were common, including beliefs that contraception was unsafe or unnatural or could negatively impact long-term fertility -Most students believed the likelihood of an unintended pregnancy was low or overestimated the effectiveness of their contraceptive methods	contraception education in secondary school, so students may have more resources/knowledge than other states
Claringbold, L., Temple-Smith, M.	2019	Explore factors influencing Australian young women's contraceptive choices	N=20, women, aged 18-24, from University of Melbourne, Australia	Qualitative Research: 10 criteria Yes (8) No (1) Unclear (1)	-Over half stated that they started contraception for reasons other than preventing pregnancy alone -Half made decision about type of contraception they wanted before seeing a physician -Social context: family and friends influenced choices, internet (mostly forums/blogs) used regularly to gain knowledge of contraception, many felt	-Potential recruitment bias -Single university -Student researcher who conducted interviews a young woman of similar age

					discussion with physician persuaded them toward or away from a method -Fear: adverse side effects, invasiveness of LARC, and stigma surrounding contraception use; LARC seen as unnatural by some -Control: LARC viewed negatively due to inability to insert or remove it themselves, wanted to control menstruation, distrusted male partners to use contraception appropriately -Positive side effects: acne and menstrual cycle management motivated some to use oral contraception	
Szajbely, K., & Neiterman, E.	2025	Explore how female post-secondary students in Ontario describe their experiences of obtaining EC and what methods and strategies they used to obtain EC	N=11, female post-secondary students, aged 18 to 23, in Ontario who have taken EC	Qualitative Research: 10 criteria Yes (7) No (2) Unclear (1)	-Felt uninformed about EC prior to use -Sought information about EC from peers and the internet -Perceived shame and judgment from others regarding EC use, which was a barrier to access -Choice to use EC was empowering	-Participants from rural universities not included -Participant demographics not reported -Lacks generalizability

Qualitative (Focus Groups)

Author(s)	Year	Purpose	Sample	Quality Rating	Results	Limitations
Hickey, M. T., & White, J.	2015	Gain insight and depth into the perceptions and experiences of college women regarding OTC EC	N=24, women aged 19 to 24, undergraduate students at a private university in a suburban area of one of the eastern tri-states in the United States	Qualitative Research: 10 criteria Yes (10) No (0) Unclear 0)	-Aware of EC and its availability, but gaps in knowledge around timing, effectiveness and side effects; many felt they needed more information prior to purchase and use -Motivators to use EC were desire to prevent unintended pregnancy, influenced by family values and educational/career goals -Barriers to access included lack of transportation to a pharmacy (especially if living on campus), cost, and fear of exposure and embarrassment -Many unaware of campus health services; viewed campus health centre as convenient but worried about confidentiality and expertise of HCPs -Relied on friends and Internet for information about EC, knowing it was unreliable; many reported not having received	-Snowball sampling; some participants knew each other -Majority of participants were nursing students and researcher is a professor within the School of Nursing at the same institution -Primarily White females -Private university

					comprehensive contraceptive counselling from their HCP	
Cassidy, C., Bishop, A., Steenbeek, A., Langille, D., Martin-Misener, R., & Curran, A.	2018	Use the COM-B model and Theoretical Domains Framework (TDF) to identify barriers and enablers for students' use of SRH services on campus	N=unknown -Two universities in Nova Scotia, Canada (one large urban university and one small rural university) -Six focus groups (one all female, one all male, one with members of LGBTQ community from each campus, aged 18-25), seven key informant interviews	Qualitative Research: 10 criteria Yes (8) No (2) Unclear (0)	-Lack of awareness of SRH services, especially in first year; key informants used to learn about available services -LGBTQ participants expressed lack of clarity regarding when and why they should access SRH services -Preferred to see the same clinician at each visit -HCPs often assumed students were in heterosexual relationship which negatively influenced willingness to return -Accessing SRH services described as a social activity with friends, but felt discomfort seeing other classmates at the clinic; confidentiality and privacy were important to satisfaction and willingness to return -Campus culture promotes risk-taking behaviours; may contribute to avoidance of SRH services -Expressed that having a clinic that was visible on	-Focus groups may introduce social desirability bias \

					campus and was seen as safe and welcoming highly valued -Described difficulties accessing services that are only open during class times; appreciated evening and weekend hours -Described university as a period of sexual exploration and experimentation and the importance of normalizing sexual health matters	
Mann, E. S., White, A. L., Beavin, C., & Dys, G.	2020	Examine expressed feelings about LARC and gain insight into the factors that influenced college women's decisions to use LARC	N=45, cisgender women aged 18 to 25, enrolled in a large public university in the southeastern US; four focus groups based on contraceptive method used	Qualitative Research: 10 criteria Yes (9) No (1) Unsure (0)	-Nearly all participants at ever used the OCP -Among current OCP users, familiarity and perception of safety made the method acceptable -About half of participants were unfamiliar with LARC -Lack of familiarity with LARC along with stories of adverse experiences contributed to fear of LARC -Effectiveness and ease of use were primary reasons for switching from the OCP to LARC -LARC users tended to strongly favour one method over the other (implant versus IUD)	-Potential for self-selection bias and social desirability bias -Not generalizable beyond study population

					-LARC users reported enjoying the freedom of the method and limited side effects -Perception was that young women do not discuss their contraceptive use, with the exception of LARC users; implant served as a conversation starter	
Vamos, C. A., Thompson, E. L., Logan, R. G., Griner, S. B., Perrin, K. M., Merrell, L. K., & Daley, E. M.	2020	Assess college students' self-perceived SRH literacy, specifically focused on contraception use and STI prevention	N=43, students 18 years or older enrolled at a large, southeastern university in the US (mean age 22.6, 70% female)	Qualitative Research: 10 criteria Yes (8) No (1) Unclear (1)	-Most cited source of contraception information was the Internet due to convenience and privacy; used to decide whether a healthcare appointment needed -Friends and family frequently used for knowledge based on personal experience -HCPs were infrequently used for information as participants felt appointment time was limited; only when considering STI prevention (not pregnancy prevention) did participants describe healthcare-seeking -Use of diagrams, decision-aids and infographics were cited as being helpful for understanding contraception	-Small, convenience sample; not generalizable to other students -Sample includes adults who are older than traditional undergraduate college students -Potential recruitment bias (may exclude those uncomfortable discussing SRH) -Potential recall bias due to fluid timeline of events under discussion

					options; strongly desired for information to be given in plain language -Factors in SRH decision-making included religion/culture, lifestyle, and advice of friends/family -Competing demands and little consistency in college students' schedules make OCP adherence challenging -Involvement of sexual partners in SRH decision-making depended on length or seriousness of the relationship	

Gray Literature

Author(s)	Year	Purpose	Sample	Quality Rating	Results	Limitations
Nearen, N.	2018	Understand some of the perceived and actual barriers for usage of LARCs, as well as any gaps in education around LARCs	N=113 (female undergraduate nursing students aged 18-53 at Salem State University; majority of respondents aged 18 to 22)	Qualitative Research: 10 criteria Yes (2) No (8) Unclear (0)	-The OCP was cited as the most commonly used method (55%); 14% reported IUD use - Commonly cited reasons for selecting a LARC method were: birth control, menstrual cycle regulation, and management of menstrual symptoms -Commonly cited benefits of LARC use included: length of protection, lack of upkeep,	-Limited use of the "other" or "fill in the blank" option, more prevalence data than insight into individual experiences, narratives or opinions -Population was nursing students, which may have a higher level of

					and lightened menstrual cycle -93% of participants cited fear of side effects as a reason not to use LARCs -87% of participants selected weight gain as a side effect of LARC; this was the most frequently cited side effect -HCPs were most frequently cited source of LARC information (71%), followed by friends (47%), then media (42%)	knowledge of LARCs than the general college student population -Not generalizable beyond study population
Institute for Women's Policy Research	2020	Present evidence on the association between childbearing and educational outcomes, illustrate the importance of addressing students' reproductive health needs, and provide policy recommendations to improve college students' access to reproductive health services	N/A	N/A	-Access to SRH services is limited for college students due to cost, lack of knowledge, and access to HCPs -Lack of contraceptive knowledge likely contributes to high rates of unintended pregnancy in this age group; misinformation about contraception is prevalent -Campus health centres vary in what services they offer -Students have limited knowledge of available campus services, and may be deterred from using due to stigma and confidentiality concerns	-Based on research and policies in the US; may not be generalizable beyond this geographic region

Appendix B

Data Displays

Articles	Contraception					
	Knowledge/Health Literacy	Decision-Making Influences			Utilization	
		Internal	*External*	*Other*	*Enablers*	*Barriers*
Waltermaurer, E., Doleyres, H. M., Bednarczyk, R. A., & McNutt, L. A. (2013)		-Worry about pregnancy increased consideration of EC use, but not actual use		-Students < age 20, nonwhite, or with a history of binge-drinking were more likely to consider EC use than their counterparts -Students who had intercourse before age 17 had higher prevalence of EC use -As total number of sexual partners increased, so did report EC use		

			-Those who reported frequent condom use were less likely to use EC		
Fitzpatrick, V., Mouttapa, M., Park Tanjasiri, S., & Napoli, J. (2014)		-Among females: -Belief that EC is worth using even if the cost is high and past EC use were positively associated with intention to use EC -Belief that EC is morally wrong and having had a previous abortion were negatively associated with intention to use EC	Among males: -Belief that EC is worth using despite cost was positively associated with intention to use EC -Belief that EC is morally wrong and encourages promiscuity were negatively associated with intention to use EC	-Knowledge that EC can be purchased without a prescription	
Sundstrom, B., Baker-Whitcomb, A., & DeMaria, A. L. (2014)	-Underestimated risks of the OCP and over-estimated risks of LARC (complications, infertility, ectopic pregnancy, death)	-Uncertainty about timing of starting a family (long-lasting nature of LARC was not appealing)	-Reported physicians infrequently discussed LARC options and recommended the OCP; had to advocate to	-Most initiated contraception for positive side effects, not pregnancy prevention	- LARC viewed as invasive and unnatural; perception of LARC insertion as a surgical procedure was a deterrent -Challenges with maintaining and filling prescription and medication adherence -Cost was a determining factor in method choice

	-Viewed LARC as more effective than the OCP -OCPS perceived as a less expensive option than LARC		both receive and remove LARC	
Hickey, M. T., & White, J. (2015)	-Aware of EC and its availability, but gaps in knowledge around timing, effectiveness and side effects	-Desire to prevent unintended pregnancy, family values and educational/career goals	-Relied on friends and Internet for information about EC, knowing it was unreliable -Many reported not having received comprehensive contraceptive counselling from their HCP	-Lack of knowledge; felt they needed more information prior to purchase and use -Lack of transportation to a pharmacy (especially if living on campus), cost, and fear of exposure and embarrassment
Lally, K., Nathan-V, Y., Dunne, S., McGrath, D., Cullen, W., Meagher, D., Coffey, J. C., & Dunne, C. (2015)	-51% believed OCP was adequate protection against pregnancy -Knowledge gaps around EC; 72.7% believed must be taken within 24 hours -Sources of SRH information were:			

	the Internet, peers, health professionals, magazines, secondary school sex education, student union, and family				
Garrett, K. P., Widman, L., Francis, D. B., & Noar, S. M. (2016)			-Information about EC from media, interpersonal sources, or health education sources were associated with higher perceptions of access for women	-Being female associated with higher perception of access -Past EC use associated with higher perception of access	
Payne, J. B., Sundstrom, B., & DeMaria, A. L. (2016)	-Expressed greater familiarity and comfort with oral contraceptives -Feared that IUDs cause physical damage and negatively impact future fertility	-Most desired an effective method as they did not intend to become pregnant, but valued future fertility -Desired a menstrual cycle and viewed amenorrhea as	-Social network the primary resource for contraceptive information -Reported limited or no information provided about IUDs from HCPs; oral contraceptives		-Insufficient observability was a barrier to using IUDs

		"unnatural" and unfavourable -Viewed motherhood and career development as incompatible	sometimes automatically prescribed		
Hickey, M.T. & Shedlin, M. G. (2017)	-Majority did not consider themselves at risk for unintended pregnancy -All believed in ECP's effectiveness; varying degrees of knowledge related to medication (side effects, safety etc.)	-View of pregnancy as life-altering event that would prevent them from attaining goals	-Info about ECP acquired through high school education, Internet, friends, family, media; health care providers were least cited source -Majority reported partner involvement in decision-making and purchase of ECP	-Primary facilitator to use of ECP was ease of availability	-Potential barriers cited included cost and embarrassment/awkwardness
Cabral, M. A., Schroeder, R., Mitchell Armstrong, E., El Ayadi, A. M., Gurel,	-Most students believed the likelihood of an unintended pregnancy was low or overestimated	-Educational outcomes/career goals -Desire to prevent pregnancy			

A. L., Chang, J., & Harper, C. C. (2018)	the effectiveness of their contraceptive methods -Not familiar with the full range of contraceptive methods	-Belief that contraception was unsafe or unnatural or could negatively impact long-term fertility			
Hopkins, K., Hubert, C., Coleman-Minahan, K., Stevenson, A. J., White, K., Grossman, D., & Potter, J. E. (2018)			-Many women who reported having a regular HCP were not using their preferred method	-Single women with no children were less likely to be using more effective methods than women with children	-69% wanted to be using a more-effective method -Reasons for not using a more effective method: not having insurance, insurance not covering their preferred method, not knowing where to get the method, or too much hassle/not having made an appointment
Claringbold, L., Sanci, L., & Temple-Smith, M. (2019)	-	-Fear: adverse side effects, invasiveness of LARC, and stigma surrounding contraception use; LARC seen as unnatural by some -Control: LARC viewed negatively due to inability to insert or remove it themselves, wanted to control	-Family and friends influenced choices, internet (mostly forums/blogs) used regularly to gain knowledge of contraception -Many felt discussion with physician persuaded them	-Positive side effects: acne and menstrual cycle management motivated some to use oral contraception	

		menstruation, distrusted male partners to use	toward or away from a method		
Mann, E. S., White, A. L., Beavin, C., & Dys, G. (2020)	-About half of participants were unfamiliar with LARC		-Effectiveness and ease of use were primary reasons for switching from the OCP to LARC -Perception was that young women do not discuss their contraceptive use, with the exception of LARC users; implant served as a conversation starter	-LARC users reported enjoying the freedom of the method and limited side effects -Among current OCP users, familiarity and perception of safety made the method acceptable	-Lack of familiarity with LARC along with stories of adverse experiences contributed to fear of LARC
O'Connell, M. B.m Samman, L., Bailey, T., King, L., & Wellman, G. S. (2020)				-Most thought that receiving birth control from a pharmacist would increase their birth control adherence and would decrease	

				unintended pregnancies	
Vamos, C. A., Thompson, E. L., Logan, R. G., Griner, S. B., Perrin, K. M., Merrell, L. K., & Daley, E. M. (2020)	-Use of diagrams, decision-aids and infographics were cited as being helpful for understanding contraception options	-Religion/culture, and lifestyle	-Most cited source of contraception information was the Internet; used to decide whether a healthcare appointment needed -Friends and family frequently used for knowledge and advice based on personal experience -HCPs were infrequently used for information -Involvement of sexual partners in SRH decision-making depended on length or		-Competing demands and little consistency in college students' schedules make OCP adherence challenging

		seriousness of the relationship	
Yarger, J., Schroeder, R., Blum, M., Cabral, M. A., Brindis, C. D., Perelli, B., & Harper, C. C. (2021)			-49% were concerned about the cost of birth control -Uninsured and publicly insured women were more likely to be concerned about the cost of birth control than privately insured women
Asdell, S. M., Bennett, R. D., Cordon, S. A., Zhao, Q., & Peipert J. F. (2022)	-Average score on 10-item LARC knowledge assessments was 4.8/10 (SD 2.5)	-Statistically significant difference in willingness to use a LARC in the future between students scoring below the mean vs. above the mean on the LARC knowledge assessment	-Among students who were not using LARC, would not consider LARC, or were uncertain about LARC, a need for more information was most commonly cited, followed by concern about pain, safety and potential side effects
Chen, E., Hollowell, A., Truong, T., Bentley-Edwards, K., Myers, E.,			-Gender minorities reported increased risk of difficulty accessing preferred method

Erkanli, A., Holt, L., & Swartz, J. J. (2023)					
Wagner, B., Brogan, N., & Cleland, K. (2023).	-Lack of awareness of EC methods beyond levonorgestrel				

Articles	**Sexual and Reproductive Health Services**				
	Access & Availability	**Awareness**	**Perceptions of Roles & Responsibilities**	**Utilization**	
				Enablers	***Barriers***
Lechner, K. E., Garcia, C. M., Frerich, E. A., Lust, K., & Eisenberg, M. E. (2013)			-Students responsibility to access health resources when needed, independent of their families or institutions -Desired support from their institutions; students from four-year schools expected resources be available on campus whereas students at two-year schools wanted information on available community resources -A welcoming and supportive environment for LGBT students was cited as the		

		responsibility of the institution		
Hickey, M. T., & White, J. (2015)		-Many unaware of campus health services	-Viewed campus health centre as convenient	-Worry about confidentiality and expertise of HCPs
Lally, K., Nathan-V, Y., Dunne, S., McGrath, D., Cullen, W., Meagher, D., Coffey, J. C., & Dunne, C. (2015)				-58.1% of sexually active students were reluctant to attend the campus health clinic
Bersamin, M., Fisher, D. A., Marcell, A. V., Finan, L. J. (2017a)	-50.9% reported accessing RHC in the past year; 16.2% at more than one location -Most frequented locations were primary care and school-based clinics -Students who were female, sexually experienced and Latino accessed SRH services more than	-	-For females: having sexual intercourse and greater knowledge of SRH services	-For females: perceived social disapproval

	males, students who had not had intercourse and were White		
Bersamin, M., Fisher, D. A., Marcell, A. V., & Finan, L. J. (2017b)	-Knowledge of average of >5 locations to obtain SRH services -Knowledge of SRH was positively associated with maternal education and family planning self-efficacy -More women than men knew where to access all SRH services except condoms -Condoms and pregnancy tests were most reported SRH service		
Cassidy, C., Bishop, A., Steenbeek, A., Langille, D., Martin-Misener, R., & Curran, A. (2018)	-Lack of awareness of SRH services, especially in first year; key informants used to learn about available services	-Ability to see the same clinician at each visit -Confidentiality and privacy were important to satisfaction and willingness to return -Having a clinic that was visible on campus	-LGBTQ participants expressed lack of clarity regarding when and why they should access SRH services -HCPs often assumed students were in heterosexual relationship which

		and was seen as safe and welcoming -Services that are open during evening and weekend hours	negatively influenced willingness to return - Discomfort with seeing other classmates at the clinic -Campus culture promotes risk-taking behaviours -Services that are only open during class times
O'Connell, M. B., Samman, L., Bailey, T., King, L., & Wellman, G. S. (2020)	-73% reported they were likely to obtain birth control from a community pharmacist if available	-Reported advantages of pharmacist prescribing were: more convenient, save time, easier to get birth control, less likely to run out of birth control, better hours, and lower cost -Having previously received a vaccine from a pharmacist, having confidence in prescription dispensing and counselling and believing pharmacists have more knowledge than their HCP were associated with greater likelihood of getting	-Common concerns about pharmacist prescribing were: not getting regular Pap smears/screening and being prescribed the wrong birth control -Visit expense was negatively associated with likelihood to use a pharmacist for birth control

			birth control from a pharmacist -Trustworthiness and approachability were positively associated with likelihood to use a pharmacist for birth control	
Vamos, C. A., Thompson, E. L., Logan, R. G., Griner, S. B., Perrin, K. M., Merrell, L. K., & Daley, E. M. (2020)	-Only when considering STI prevention (not pregnancy prevention) did participants describe healthcare-seeking		-Strongly desired for information to be given in plain language -Convenience and privacy	-Limited appointment time
Yarger, J., Schroeder, R., Blum, M., Cabral, M. A., Brindis, C. D., Perelli, B., & Harper, C. C. (2021).		-81% knew where to get free or low-cost birth control -69% of participant who did not know where to get free or low-cost birth control were concerned about the cost compared with the 44% who had this knowledge		

Chen, E., Hollowell, A., Truong, T., Bentley-Edwards, K., Myers, E., Erkanli, A., Holt, L., & Swartz, J. J. (2023)	-96% reported that they maintained access to their preferred contraceptive method during the COVID-19 pandemic -Attending a four-year college was associated with increased access to the preferred method compared to attending a two-year college		-64% reported increased likelihood to use telehealth to with their doctor to access contraception	-54% reported avoiding the doctor's office since pandemic
Wagner, B., Brogan, N., & Cleland, K. (2023)		-Lack of awareness of regulations around EC access, confusion about whether or not age restrictions exist, identification was needed, and if pharmacists could limit EC access		

Appendix C

Research Ethics Board Approval

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

September 26, 2024

Ms. Breanna Siemens & Dr. Caroline Sanders c/o University of Northern British Columbia
Faculty of Human and Health Sciences\Nursing

Dear Ms. Siemens & Dr. Sanders,

File No: 6009643
Project Title: Reproductive Justice on Campus: Undergraduate Students in Northern British Columbia's Experiences Seeking and Accessing Hormonal Contraception
Approval Date: September 26, 2024
Expiry Date: September 25, 2025

Thank you for submitting the above-noted proposal to the Research Ethics Board ("REB"). Your project has been approved.

We are pleased to issue approval for a period of twelve months from the date of this letter. To continue your proposed research beyond September 25, 2025, you must submit an Annual Renewal and Study Progress form at least one month prior to that date. If your research has been completed before the form is due, please submit a Study Closure form in order to close the REB file.

Throughout the duration of this REB approval, all requests for amendments and renewals, or reporting of unanticipated problems, must be submitted to the REB via the Research Portal.

Please refer to the Chair Bulletins found on the REB webpage for updates on in-person interactions with participants during the COVID-19 pandemic.

If you have any questions or encounter any problems when working in the Research Portal, please contact the REB by email to reb@unbc.ca.

Good luck with your research.

Sincerely,

Dr. Neil Hanlon, Chair,
Research Ethics Board

Appendix D

Information Letter/Consent Form

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

Information Letter / Consent Form

August 9, 2024

Reproductive Justice on Campus: Female Students in Northern British Columbia's Experiences Seeking and Accessing Hormonal Contraception

Who is conducting the study?

Student Researcher
Breanna Siemens
School of Nursing
University of Northern British Columbia
Prince George, BC V2N 4Z9
Breanna.Siemens@unbc.ca

Supervising Faculty Investigator
Dr. Caroline Sanders
School of Nursing
University of Northern British Columbia
Prince George, BC V2N 4Z9
Caroline.Sanders@unbc.ca
(250) 640-1012

This study is being conducted as part of a thesis, which is a public document. There will be no identifiable data shared. By participating in this study, you consent that quotes can be used in final outputs such as reports, presentations, and academic papers. Further, as the thesis defence at UNBC is an open forum, a student audience may self-select to attend the final thesis defence.

Project Sponsor

This study is funded by the Research Strategic Initiatives Grant.

Why are you being asked to take part in this study?

You are being invited to take part in this research study because you are a part-time or full-time undergraduate student between the ages of 18 and 28 who currently attends UNBC, are female or assigned female at birth (AFAB), and you have sought hormonal contraception from a health care provider (HCP) within the past year. Hormonal contraception means methods of birth

control that contain estrogen or progestin and require a prescription. Some examples are: oral contraception (or “the pill”), hormonal intrauterine devices (i.e., the Mirena), the patch, the Depo-Provera injection, contraceptive implants (i.e. Nexplanon), or a vaginal ring (i.e. the NuvaRing).

We want to learn more about how to tailor sexual and reproductive health (SRH) services to students’ needs with the goal of improving the overall health and well-being of Canadian students, particularly those in northern BC. Students in rural areas, like northern BC, may face barriers to accessing contraception and SRH services, such as transportation, limited service availability, and concerns about privacy or confidentiality. Power dynamics may also influence students' contraceptive-decision-making. Sexual and reproductive health (SRH) data is not routinely being collected in Canada, and there is very little research on Canadian students' experiences with contraception. This study will help us learn more about factors that influence students’ ability to access hormonal contraception and the quality of the services that provide hormonal contraception from the student perspective.

Participation in this study is voluntary and you can choose to skip any questions that you don’t want to answer, or take a break if you need to. You have a right to withdraw from the study at any time, without giving a reason. If you withdraw from the study before or during the interview, any information you have provided up to that point will be withdrawn and securely destroyed. If you wish to withdraw after the interview, this will be accommodated if the interview data has not already been analyzed and reported.

What happens if you say “Yes, I want to be in the study”?

If you have not already done so, you will complete a 5 questions preliminary screening survey, which will be used to guide the selection of eligible participants. This study intends to include 5 participants. If you are selected to participate in this study, the researcher will contact you to arrange a virtual interview via UNBC Zoom. If you are not selected for the study, you will receive an email informing you of this. You may choose to use audio and video, or use only audio. The interview will be recorded for the purpose of transcription. The interview will consist of questions about your experiences seeking and accessing hormonal contraception, including topics such as: your perspectives on healthcare services that offer contraception counselling and prescriptions for contraception, barriers and facilitators to accessing hormonal contraception, and your primary concerns when seeking services that provide hormonal contraception. The interview will be scheduled for 60 minutes, but may last 10-60 minutes depending on how much you wish to share. If, at the end of the 60 minutes, you have more you would like to share, you may choose to schedule a second interview.

Once completed, we will analyze the data from the interviews. The study findings will be reported in a thesis, which will be publicly available, and be presented at the thesis defence. The outputs from the study will distributed to interested parties, including HCPs who can prescribe contraception, postsecondary campus health services, undergraduate student societies, and policy and decision-makers in the Northern Health Authority. No identifiable data will be shared.

What are the risks and benefits of participating in this study?

We do not think there is anything in this study that could harm you. Some of the questions we ask may seem sensitive or personal. Please let one of the study staff know if you have any concerns. You do not have to answer any question if you do not want to. If, at any point in the study, you feel uncomfortable or upset and wish to end your participation, please notify the

researcher immediately and your wishes will be respected. We offer a list of support information at the end of this form.

We do not think taking part in this study will help you. However, in the future, others may benefit from what we learn in this study, as the insights you provide may be used to improve students' experiences seeking and accessing contraception.

How will your identity be protected?

Your privacy and confidentiality will be maintained throughout the study. Audio and video recordings of the interviews will be stored on a password-protected and secure UNBC OneDrive account, accessible only by the researcher, until they are transcribed, after which they will be destroyed. We will remove any identifiable information from the transcripts, and we will identify you only by a code number, which will be held in a locked cabinet in a locked office at UNBC, separate from any other study documents or data. If necessary, anonymized de-identifiable transcripts will be shared via secure UNBC email with the supervisory team overseeing the project. Quotes from your interview may be used in final outputs such as reports, presentations, and academic papers. Quotes are an important part of presenting the study findings, as they allow the reader to gain an authentic understanding of the results and demonstrates transparency. There will be no identifiable data shared, and a pseudonym will be used. The information gathered during this study will be kept for five years, after which it will be securely destroyed.

Will you be paid for participating in this study?

We can offer you a $25.00 e-gift card for Tim Hortons as an appreciation of your time. The e-gift card will be sent to the email address provided within 72 hours of your interview. Please check your junk mail folders.

How will the study results be used?

The findings will be reported in a published thesis, and submitted for publication in journals. The findings may be shared at conferences, and with interested parties in campus health and SRH service delivery, including HCPs who can prescribe contraception, postsecondary campus health services, undergraduate student societies, and policy and decision-makers in the Northern Health Authority, with the intention of improving SRH service delivery for students. If you would like to be informed of the thesis defense, should you wish to attend, please provide your email address below and we will send you the details when it is scheduled.

Questions, Concerns or Complaints

If you have any questions about what we are asking of you, please contact the Supervising Faculty Investigator, Dr. Caroline Sanders, at 250-960 6523 or by email at caroline.sanders@unbc.ca. Questions can also be directed to the Student Researcher, Breanna Siemens at breanna.siemens@unbc.ca

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the UNBC Office of Research at 250-960-6735 or by e-mail at reb@unbc.ca

Participant Consent and Withdrawal

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact.

Your signature below indicates that you have received a copy of this consent form via email or post for your own records.

Your signature indicates that you consent to participate in this study.

Consent

I have read or been described the information presented in the information letter about the project:

YES NO

I have had the opportunity to ask questions about my involvement in this project and to receive additional details I requested.

YES NO

I understand that if I agree to participate in this project, I may withdraw from the project at any time up until the report completion, with no consequences of any kind.

YES NO

I have been given a copy of this form.

YES NO

I agree to be audio recorded. If I opt to use video, video will also be recorded.

YES NO

Follow-up information can be sent to me at the following e-mail or address:

YES NO

I understand that quotes from my interview may be used in the final thesis document, publications, presentations, and reports.

YES NO

Signature (**or note of verbal consent**): _____

Name of Participant (Printed): _____

Date: _____

Resources

The following table offers some available resources in northern BC related to sexual and reproductive health and sexual violence.

Resource	Contact Info
Foundry: a multi-service health and wellness centre that offers virtual and in-person services for youth up to age 24 in BC.	https://foundrybc.ca/princegeorge/undrybc.ca/princegeorge/
Crisis Prevention, Intervention & Information Centre for Northern BC: a peer support service that has 24-hour phone lines staffed by crisis line workers.	https://crisis-centre.ca/ 24-Hour Crisis Line: 250-563-1214 1-888-562-1214
Prince George Sexual Assault Centre: a free counselling and support service for people who have been affected by sexual abuse.	https://www.pgsac.org/
Options for Sexual Health Care: a free service with clinics across BC that provide confidential sexual health care rooted in reproductive choice.	https://www.optionsforsexualhealth.org/

Appendix E

Preliminary Screening Survey

Thank you for expressing interest in this study. To assess for eligibility, please answer the following questions. The researcher will review your responses and inform you via email if you are a candidate for this study as well as the next steps.

1. Did you seek hormonal contraception from a health care provider within the past year, access hormonal contraception within the past year, or both?
    a. Sought hormonal contraception within the past year
    b. Accessed hormonal contraception within the past year
    c. Both sought and accessed hormonal contraception within the past year
2. Did you attend secondary school (high school) in northern British Columbia?
    a. Yes
    b. No
3. If the answer to the above question is "No", in what city/country did you attend secondary school?
4. Do you identify as a gender or sexual minority?
    a. Yes
    b. No
5. Do you identify as a racial/ethnic minority?
    a. Yes
    b. No

Appendix F

Semi-Structured Interview Guide

Introduction

INTERVIEWER: Hello. Welcome and thank you for agreeing to participate in this interview.My name is Breanna Siemens. I am a student in the Master of Science in Nursing program at UNBC. I am conducting a research project on undergraduate students' experiences of accessing hormonal contraception in northern BC. When I refer to hormonal contraception, I am referring to methods of birth control that contain estrogen or progestin and require a prescription. Some examples are: oral contraceptives (or "the pill"), emergency contraception (i.e. Plan B), hormonal intrauterine devices (i.e., the Mirena), the patch, the Depo-Provera injection, contraceptive implants (i.e. Nexplanon), or a vaginal ring (i.e. the NuvaRing). Your experiences and opinions are important to me. In my everyday life, I am a teacher and a nurse, but in this interview, I am here to learn from you, as you are the are the expert on your own life. Your participation in this interview will help me better understand the factors that influence access to contraception for undergraduate students like yourself and the quality of services that provide contraception. With better understanding of these factors, we can inform policies and procedures that affect access to contraception. I am especially interested in learning about your perceptions and experiences regarding:

- Healthcare services that offer contraception counselling and prescriptions for contraceptives
- Barriers and facilitators to accessing hormonal contraception and
- Your primary concerns when seeking services that provide hormonal contraception

All interviews are recorded. However, everything you say will be kept private, and your name and the names of others will not be used in reporting the findings of the study. The recording will be stored safely in a locked facility until it is transcribed, after which it will be destroyed. The interview will take no more than an hour and participation is completely voluntary. You can choose to skip any questions that you don't want to answer, or take a break if you need to. You may withdraw at any point in time during our conversation. If you wish to withdraw after the interview, this will be accommodated if the interview data has not already been analyzed and reported. We do not think there is anything in this study that could harm you but we recognize this is a sensitive topic and information on local support services you can access if needed are provided in the package. Before we begin, do you have any questions for me?

Introductory Questions: Utilization of Services

INTERVIEWER: First, I would like to ask you a few questions about how and when you access health care services for contraception.

1. How long have you been a postsecondary student? What do you study?
2. Where is your home community?
3. Do you usually access health care services that provide contraception on campus, off campus, or virtually?
    - Why is that? Types of services accessed in each? Which one would you prefer?
4. How often do you access health care services for contraception?
    - Do you feel this this sufficient or insufficient contact to meet your contraception needs? Why?

Experiences Seeking Contraception:

INTERVIEWER: Now I would like to ask you more specifically about your experiences seeking services that offer hormonal contraception.

1. Tell me about the last (most recent) time you visited a health care provider for hormonal contraception.
    - How did you decide which service to access?
    - Was this your first visit regarding hormonal contraception? If not, how did this visit compare to your first visit?
    - Can you describe the experience? What happened? What type of provider did you see (i.e. role, gender, experience, age, etc.)? What was communicated or what messages were understood? How did you feel at the time? How do you perceive it now? Did you feel like your needs were fully met? Do you plan to return to this service? If so, how do you feel about returning? If not, why not?
2. Are there any other visits to a healthcare provider for contraception that stick out in your memory?
    - What happened? How did you feel? How did this shape your perception about contraception? How did this shape your perception about healthcare?

Priorities when Seeking Contraception:

1. What are your primary concerns, or priorities, when choosing a service that provides hormonal contraception?
    - Why is that important to you?

Barriers and Facilitators to Seeking Contraception:

1. Have you experienced any barriers that have prevented you, or made you more hesitant to, access services that provide hormonal contraception?
    - How did you feel?
    - (if they did end up accessing) What made you decide to access the service?
2. What aspects of a health care service would make you more likely to choose that service over another when seeking hormonal contraception?
    - Why?

Qualities of Healthcare Providers:

1. What qualities do you think a health care provider who prescribes hormonal contraception should have?
    - Why is that important to you? Have you ever had a provider who embodied these qualities? Tell me about that.

Closing Questions:

1. Before we wrap up this interview, is there anything else you would like to share about your experiences seeking hormonal contraception?
2. Now that you know what the research is about, is there anything that I should have asked but didn't?

Conclusion

INTERVIEWER: That's all I have for you today. Thank you again for your time and energy. Your thoughtful responses are valuable in better understanding undergraduate students' experiences of accessing hormonal contraception. My contact information can be found in

the package you were given at the beginning of the interview. Please don't hesitate to reach out to me with further comments, questions, or concerns.

Appendix G

Themes

Theme	Description
Ease of accessibility	• Fragmented, siloed care delays access • Long wait times for appointments and follow-ups • Rural and small communities face greater provider scarcity • On-campus and school-based clinics offer greater convenience • Transitions between home and university create care gaps • Universal access exists, but equity and consistency are lacking
Social Perception	• Hormonal contraception is more accepted when used for medical reasons • Cultural and religious norms create stigma and secrecy • Fear of being perceived as promiscuous influences decision-making • Participants value nonjudgmental, open discussions about sexuality
Gender of Provider	• Female providers are preferred for reproductive health due to shared anatomy • Perceived greater empathy and understanding from female providers • Comfort increases when female support staff are present during appointments • Some participants prioritize knowledge and sensitivity over gender
Patient-Provider Relationship	• Trust and provider continuity enhance contraceptive experiences • Participants value trauma-informed, respectful, and nonjudgmental care • Rushed or impersonal encounters cause confusion and mistrust

	• In-person appointments seen as safer and more educational than virtual ones • Breaches of confidentiality, especially in small communities, are deeply harmful
Bodily Autonomy	• Participants want control over starting, stopping, or switching methods • Decisions often self-driven and informed by research or peers • Some reject hormonal methods due to side effects or bodily discomfort • Responsibility for contraception still largely placed on women
Contraceptive Effort	• Seeking contraception requires multiple appointments and follow-ups, as well as scheduling, research, and pharmacy visits • Emotional and physical effort, including side effects and procedural pain • Lack of system coordination increases patient workload • Advocacy often required to receive appropriate care
Gender-Affirming Care	• Contraceptive needs intersect with gender-affirming care • Participants value the use of correct pronouns and inclusive language • Gendered healthcare environments can be uncomfortable or dysphoric • Navigating dual systems (e.g., hormone therapy and contraception) is complex • Affirming care enhances trust, safety, and decision-making

Appendix H

Step 4: Recurring Codes, or In-Vivo Themes

Theme	Quote	Discourses
Ease of accessibility	But coming here, it does get a little frustrating when you have to wait for an appointment with the doctor, and you have to wait for blood tests. But I do think it's better. I think it's better when you are going through all these stages of referrals and getting to see all these different types of doctors and receiving all the different opinions.	Siloed care is fragmented and delays care Siloed care allows for access to specialized services and increased options
Social perception	Personally, no, because I've really come to a point where I don't care what people think of me. And the worry of someone thinking I'm a slut is much lower on my list of worries than getting pregnant.	Women have to choose between being perceived as promiscuous or risking pregnancy
Gender of provider	I will trust a female doctor over a male doctor the slightest bit, just because they understand what they are specializing in. They have the, I guess, the parts that makes me feel like, okay, when I speak about cramps or issues with my period she knows what is going on. She knows what I've experienced, whereas if I'm talking with a male doctor, he's educated, he's smart. He knows what he's talking about, but there's just that lack of experience as a woman that just makes me feel more comfortable with the female doctor.	Female providers are more credible than male providers when it comes to sexual and reproductive health
Patient-provider relationship	Yeah, I guess, especially when I'm talking on the phone back home, over here, I do get that fast reply from a provider if I'm booking an appointment. If I say I need to see them, I will say, they will say, “Yeah, I can meet you tomorrow.” But again, it's not that same connection you build with them, I feel.	Virtual appointments are convenient and easier to schedule In-person appointments are worth the inconvenience

Bodily autonomy	Well, my boyfriend was actually really supportive. He said, “You shouldn’t get the IUD just because of me. Don't do that just because of me.” And I said, “Yeah, well, I'm not just getting it because of you. I'm getting it because I'm choosing to get it.” And realistically, I don't think if there was a male birth control he would have taken the male birth control. So I'm biting the bullet. I'm making the decision to take the contraceptive. But he was very supportive, and that was really helpful.	Pregnancy prevention is ultimately the female’s responsibility Men should have more responsibility for pregnancy prevention
Contraceptive effort	With limited research on birth controls, even somebody like myself, who is used to studying health sciences, I still had to go pretty deep into Google Scholar and I'm finding a lot of things that I still don't understand. And a lot of people don't have that privilege of resources as well. So fully understanding how they work and what that means for your body is tricky.	Contraceptive decision-making is mentally taxing
Gender-affirming care	It was kind of a little bit of a struggle with accepting that you can be non-binary and still go on HRT, because I thought that it wasn’t a valid thing, like I thought that I had to be a trans man in order to go on hormones. So it was a very back and forth thing for me.	Hormone replacement therapy is required to identify as trans Hormone replacement therapy does not define a trans person

Appendix I

Step 6: Identifying Discursive Patterns

Discourses	Discursive Patterns
A provider's knowledge is more important than their gender Providers are not sufficiently informed on women's health Female providers are more credible than male providers when it comes to sexual and reproductive health Female providers are more empathetic and compassionate than male providers A female presence in an appointment is valued even if they are not the provider Reproductive decision-making is a universal experience among women	A uterus is a credential a man cannot acquire: gender concordance as a driver of trust
Choosing to take contraception is an act of empowerment Choosing not to take contraception is an act of empowerment Daily contraception requires too much time and attention The ability to independently discontinue contraception at any time is desirable Women are forced to choose between pregnancy risk and health risk Side effects of contraception outweigh the benefits The benefits of contraception outweigh the discomfort Contraception use carries a high risk of negative health consequences	I don't want to take contraception, but I don't want to get pregnant: the paradox of reproductive agency
Romantic or sexual partners partners have a role in contraceptive decision-making Contraceptive decision-making should be done independent of one's romantic or sexual partner Hormonal contraception facilitates safe sex	My body, my choice…but also my responsibility: negotiating the gendered division of

Hormonal contraception facilitates condom use resistance Pregnancy prevention is ultimately the female's responsibility Men should have more responsibility for pregnancy prevention	labour in contraception
Health care providers can be trusted with sensitive information Patient-provider confidentiality is not guaranteed A provider's opinion on contraception is sought and valued Contraceptive counselling promotes informed decision-making The contraception decision was already made, but a provider is necessary to fulfill it A sense of humour, warmth, respect, and relatibility decrease feelings of vulnerability Providers are nonjudgmental around contraception and have one's best interests in mind Providers have their own agenda when it comes to contraception care A breach of trust in a patient-provider relationship is hard to recover from It is necessary to continue seeing a family physician despite a breach of trust due to physician scarcity It is too intimidating to question a physician Self-advocacy is necessary in contraception-seeking Short appointments are too rushed to fulfill contraception needs Providers have more urgent matters than a contraception appointment Providers have a role in contraceptive responsibility and accountability It is the patient's responsibility to ask questions and do their own research Long-term relationships with a provider increase trust	Recognize my vulnerability, but don't take advantage of it: perceptions and manifestations of power in patient-provider relationships

Consent is an active and ongoing process Consent is a signature on a piece of paper Providers have a role in contraceptive responsibility and accountability	
Women tolerate pain better than men Women's pain is not taken as seriously as men The discomfort associated with contraception is well-known The discomfort associated with contraception is downplayed	I deserve adequate pain control, but I'm afraid of being an inconvenience: the medical gaslighting of women's pain
Campus services offer more confidentiality and privacy than services in home communities Hormonal contraception is acceptable if it is for purposes other than pregnancy prevention There is no shame in sexuality Sexuality is a private matter Women have to choose between being perceived as promiscuous or risking pregnancy	I have nothing to be ashamed of, but I don't want anyone to know: navigating sexual stigmas in a sex-positive culture
Sexual health education should be provided at home Parents cannot be trusted to provide accurate sexual health education to their children It is the responsibility of the public school system to provide sexual health education The public school system is selective in the content it includes in sexual health education Effectiveness is a priority in contraceptive decision-making Social media is a helpful resource for contraception information Social media is an unreliable source for contraception information Personal narratives of experiences with contraception are dissuasive Personal narratives of experiences with contraception are persuasive Contraceptive information is conflicting	Science informs my decision, but people shape my perspective: the intersection of embodied experience and empirical evidence

Siloed care is fragmented and delays care
Siloed care allows for access to specialized services and increased options Primary care providers are ideal access points for contraception
Primary care providers are in limited supply and are overscheduled
Accessing contraception is time-consuming and frustrating
Universal contraception is a facilitator to access
Contraception is handed out without appropriate screening and assessment
Contraception access is universal, but not equitable
Virtual appointments are convenient and easier to schedule
In-person appointments are worth the inconvenience
Contraceptive decision-making is mentally taxing

It was too easy and overly complicated at the same time: invisible costs of no-cost contraception