

**Exploring the lived experiences of women in larger bodies who access and use
contraception in Ontario**

by

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A thesis

presented to the University of Waterloo

in fulfillment of the

thesis requirement for the degree of

Master of Science

in

Public Health and Health Systems

Waterloo, Ontario, Canada, 2021

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Background: Contraception is widely used by women to prevent pregnancy and for other health-related reasons. In Canada, many contraceptive users may be living in larger bodies. While there is a growing interest in the reproductive health care experiences of women in larger bodies, less attention has been paid to contraception. Research suggests that women in larger bodies may receive inadequate contraceptive counselling and care; however, women's voices are rarely captured in this research.

Objectives: This study aimed to understand the lived experiences of women in larger bodies who access and use female-oriented contraception in Ontario. Specifically, this study examined: (1) How is contraceptive use embodied by women in larger bodies; (2) How do women in larger bodies navigate contraceptive care; and (3) How can women in larger bodies' experiences with contraception be improved?

Methods: This phenomenological study explored the lived experiences of 19 women in larger bodies who accessed and used female-oriented methods of contraception in Ontario within the last five years. In-depth interviews were conducted with participants and the data were analyzed by applying a feminist lens to interpretive phenomenological analysis.

Results: There was significant diversity in women in larger bodies' lived experiences with contraception. The notion of control was central to participants' embodied experiences with routine contraceptive use, whereas experiences with contraceptive care were shaped by feelings of (dis)empowerment. While many participants felt supported in some capacity, women in larger bodies also suggested that their contraceptive counselling and care needs were not always met.

Finally, three major stages of participants' experiences with emergency contraception were detailed, revealing the significance of personal context in shaping their surrounding experiences.

Conclusion: This study highlights the complexity and diversity of women in larger bodies' lived experiences with routine and emergency contraception. The findings suggest that non-judgemental, patient-centred approaches to contraceptive counselling and care are needed to better support women in larger bodies.

Acknowledgements

This experience has been as challenging as it has been rewarding, and I am indebted to many individuals for whom without this thesis would not have been possible.

To the University of Ottawa researchers who sparked my interest in sexual and reproductive health and the friend whose experience inspired this project several years ago – thank you.

To my committee, whom I am honoured to have learned from – this thesis has benefitted immensely from your guidance and support. I am endlessly grateful for my supervisor, Dr. Elena Neiterman. Your mentorship, unwavering encouragement, and thoughtful insight have been instrumental to my success and I truly feel like I hit the jackpot by having the opportunity to work with you in several capacities throughout my time in this program. Thank you for your patience, generosity, and for being my cheerleader and confidante. I am also grateful for my committee members, Dr. Sharon Kirkpatrick and Dr. Samantha Meyer. Thank you for sharing your expertise and providing invaluable feedback on my work. Although I wish we could have met in person, I am appreciative of the kindness you always extended to me while we corresponded virtually over the past year and a half.

To my cohort, which comprises of some of the most brilliant and compassionate individuals I know – I will always cherish the memories we made together in Waterloo and I look forward to being reunited one day. Thank you for your friendship and for showing me how fun graduate school can be. To those who kept in touch throughout the pandemic – you have been an invaluable outlet and source of support throughout this process. I cannot thank you enough for all the times we commiserated, encouraged one another, and laughed together.

To my loved ones, both family and friends alike, who cheered me on from near and afar – thank you for always supporting me, for knowing when and when not to ask “how’s your thesis going?” and for reminding me that I need to take time for myself sometimes. To those closest to me – thank you for listening to my many rambling monologues as I worked through my thoughts aloud, for understanding when I needed space, and for always trying to help me whenever you could. To my parents in particular – thank you for everything you have done and continue to do for me.

Finally, to the 19 individuals who participated in this study – I would like to give a heartfelt thank you for graciously offering your time and entrusting me with your stories. Thank you for your vulnerability, honesty, and enthusiasm. I am so incredibly grateful to have met and learned from each and every one of you – your experiences bring this research to life. I dedicate this thesis to you.

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List of Abbreviations

BMI	Body Mass Index
COC	Combined Oral Contraceptive Pill
COVID-19	SARS-CoV-2, also known as the coronavirus disease 2019
Cu-IUD	Copper-Bearing Intrauterine Device
HIV	Human Immunodeficiency Virus
IPA	Interpretive Phenomenological Analysis
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraception
LNG-EC	Levonorgestrel
LNG-IUD	Levonorgestrel-Releasing Intrauterine Device
OCP	Oral Contraceptive Pill
OHIP+	Ontario Health Insurance Plan Plus
Pap	Papanicolaou
PCOS	Polycystic Ovarian Syndrome
SOGC	Society of Obstetricians and Gynaecologists of Canada
STI	Sexually Transmitted Infection
UPA-EC	Ulipristal Acetate

Chapter 1: Introduction

Family planning is considered to be one of Canada's most significant public health achievements (1). Contraception plays a key role in family planning, as it enables women to control their fertility and plan pregnancies (2). In 1960, the approval of the first oral contraceptive pill (OCP) in the United States marked a major milestone in women's rights and helped pave the way for the women's movement for reproductive autonomy and sexual liberation throughout the decade (2,3). Following the decriminalization of contraception in 1969 (4), Canadian society has been shaped by changes in family size, expansion of women's educational and professional opportunities, strides made towards gender equality, and overall improved quality of life (3,5). The reproductive justice movement continues to advocate for marginalized populations by connecting reproductive rights with social justice when approaching issues related to sexual health (6).

There is a growing interest in examining the reproductive health care experiences of women in larger bodies (7–14). In 2020, approximately half of Canadian women between 18 and 49 years of age reported a body size characterized as “overweight” or “obese” based on body mass index (BMI) classification (15). Having a larger body size may impact women's reproductive health across the lifespan, as higher BMI is believed to contribute to menstrual cycle abnormalities, fertility issues, pregnancy complications, and certain reproductive cancers (16–18). Some studies have further indicated that higher BMI is associated with reduced contraceptive efficacy (19,20) and increased rates of unintended pregnancy (21). While individuals in larger bodies have frequently described negative or stigmatizing reproductive health care experiences (7,9–13), much of this literature focuses on pregnancy and therefore provides little insight into women in larger bodies' experiences with contraception.

Unfortunately, clinical contraceptive research has regularly excluded women with higher BMIs (20), and while a recent scoping review proposed that women in larger bodies may have unmet contraceptive counselling and care needs, women's perspectives were often noticeably absent from the literature (22). Using qualitative inquiry, this study seeks to understand women in larger bodies' lived experiences with contraceptive use and care. This thesis contextualizes and builds upon the current body of knowledge by uplifting women's voices and suggesting how they can be better supported. In doing so, the recommendations derived from this research propose how to improve women in larger bodies' experiences with contraception.

Chapter 2: Literature Review

2.1 Contraception

In 2019, more than 70% of all women of reproductive age (15 to 49 years) in Canada were estimated to have used contraception (23). In addition to fertility control, contraception may be used for a variety of other reasons, such as sexually transmitted infection (STI) prevention, menstrual cycle regulation, reducing the risk of gynaecological cancers, as well as treating menstrual symptoms and conditions (24). Several different contraceptive methods are available in Canada for routine or emergency use, nearly all of which are designed for female anatomy and physiology (i.e., female-oriented) (4).

2.1.1 Methods of Contraception

In general, contraceptive methods may be categorized as hormonal, non-hormonal, natural, and emergency contraception (25). Modern contraceptives can also be broadly distinguished by their short-acting, long-acting, or permanent function (23). Hormonal methods are among the most effective routine contraceptives and are prescribed by health care providers (26,27). Hormonal contraception is typically short-acting and includes methods such as OCPs, contraceptive injections, patches, and vaginal rings (23,26). OCPs are the most common method of female-oriented contraception in Canada, estimated to be used by nearly 30% of women of reproductive age (23) and previously reported by over 50% of young women aged 15 to 24 years during their most recent heterosexual encounter involving vaginal intercourse (28). In comparison, long-acting reversible contraception (LARC) refers to highly effective hormonal or non-hormonal contraceptive devices (e.g., intrauterine device [IUD]) that are inserted by health care providers (25,26). Hormonal methods include the subdermal implant and the intrauterine

system, also known as the levonorgestrel-releasing IUD (LNG-IUD); the copper-bearing IUD (Cu-IUD) is the only non-hormonal LARC (25,26).

Non-hormonal barrier and natural contraception are less effective than short-acting hormonal and LARC methods (29). Non-hormonal barrier methods of contraception are short-acting and include internal or external condoms, spermicide, diaphragms, prescribed cervical caps, and contraceptive sponges, whereas natural contraception involves behavioural techniques such as fertility awareness and withdrawal (23,25). Finally, permanent contraception refers to highly effective surgical procedures such as vasectomy, as well as tubal ligation or occlusion (25,29).

Emergency contraception is used to prevent pregnancy after unprotected sexual intercourse or when routine contraceptives may have failed (25,30). The main methods of emergency contraception include emergency contraceptive pills and the Cu-IUD (31). The Cu-IUD is believed to be the most effective method, followed by ulipristal acetate (UPA-EC), levonorgestrel (LNG-EC), and lastly, high doses of OCPs (i.e., Yuzpe method) (32). Emergency contraception is generally most effective when initiated as soon as possible within the first 72 hours following unprotected sex (32).

Apart from the approval of UPA-EC (e.g., ella®) as a prescription drug in 2015 (33), emergency contraception has been available in Canada for many years (34). LNG-EC is the most commonly used emergency contraceptive (e.g., Plan B®) and is widely available without a prescription (25,30). According to the 2015-2016 cycle of the Canadian Community Health Survey, one-tenth of sexually active Canadian women between 15 and 24 years of age reported using emergency contraceptive pills in the last year (28). The prevalence of lifetime emergency contraceptive use among Canadians is believed to be even higher (28).

2.1.2 Provision of Contraception

Canada is the only country with universal publicly funded health care that does not include pharmaceutical care (35). At the federal level, Health Canada is responsible for approving and regulating contraception (5). Prescription coverage is delivered at the provincial level as a mix of government and private insurance plans that differ between and within the provinces and territories (35). In addition, the cost of female-oriented contraception varies greatly (36). While non-prescription barrier methods may cost between \$4.00 and \$30.00 per unit, prescription methods can range from \$11.00 to upwards of \$300.00 each (36).

Across Canada, Ontarians had the lowest out-of-pocket prescription drug expenses in 2017, with nearly 90% of prescription drug costs covered by public or private drug plans (35). Ontario has several publicly funded prescription programs for individuals with a valid Ontario health card, including Ontario Health Insurance Plan Plus (OHIP+) for residents under 25 years of age without private insurance and the Trillium Drug Plan for Ontarians with high prescription costs relative to their household income (37,38). These plans may provide partial or full coverage for over 50 generic and brand-name contraceptives, such as OCPs and LNG-IUDs, through the Ontario Drug Benefit program (39). In comparison, private insurance plans (i.e., through full-time employment benefits) typically cover up to 80% of prescription costs and do not always include contraception (40). Furthermore, women are less likely to be insured by private drug plans due to their overrepresentation in part-time and contract employment positions (35). Based on this information, while some women in Ontario are eligible to receive prescription contraceptives without charge, many may still incur out-of-pocket expenses.

2.1.3 Barriers to Contraception

There are various individual and system level barriers that may interfere with women's ability to access high-quality contraceptive care and use contraception in a consistent manner (5,41). Such barriers may relate to cost, sexual health education, health care provider knowledge or practices, and access to primary care (41). With respect to emergency contraception, patient-centred barriers may be attributed to the perceived risk of pregnancy, method awareness, as well as stigma and social concerns related to confidentiality or judgement (42–46). Information gaps and misconceptions may also exist regarding mechanism of action, availability, effectiveness, and side effects (43–46). To exemplify this, some women in Canada mistakenly believe that emergency contraception is an abortifacient (45,46). Additionally, health care providers may have incorrect, insufficient, or outdated emergency contraception knowledge and practices (34,47–49). For instance, a study of Ontario pharmacists revealed that approximately half of participants stored LNG-EC behind the counter despite its over-the-counter status (34). While many pharmacists reported doing so to promote counselling, they did not necessarily recognize how this practice may impede access to emergency contraception (34). These barriers underscore the need for improved provider practices and increased knowledge among women and health care providers alike.

Overall, some Canadian women may have unmet contraceptive needs. In particular, Indigenous women, northern or rural residents, youth, new immigrants, and women with low-income are believed to face unique challenges when accessing and using family planning services (41,50). It is also important to acknowledge that the ongoing SARS-CoV-2 (COVID-19) pandemic has created exceptional circumstances that may further limit access to contraception, such as shortages of health care appointments, staffing, and supplies (51). Likewise, previous

research has suggested that women in larger bodies may face barriers to contraceptive use and care (22); however, this topic has not been assessed in the Canadian context.

2.1.4 Women's Experiences with Contraception

As previously noted, contraception has become a symbol of female sexual liberation and autonomy (3). However, by feminizing contraceptive counselling and use, the burden of pregnancy prevention is often placed on women and their bodies (52–54). According to Bertotti (55), “fertility work” is similar to other forms of domestic labour, as it requires women to dedicate time while their bodies bear the physical and emotional responsibilities of using contraception. Therefore, women’s agency to control their fertility may be at odds with the burden and responsibility of using contraception (52,53).

Women have articulated the importance of finding a method of routine contraception that is a good fit for their personal circumstances and bodies (54,56–58). For many women, finding a good fit requires awareness of different contraceptive options, which is closely related to exposure to information and education (54,56,57,59–61). As such, women have previously expressed a desire for comprehensive, patient-centred contraceptive counselling to empower them to select a method of contraception that fits their individualized needs (61,62). Keeping this in mind, there are many factors that women may consider during contraceptive decision-making, such as method properties (e.g., efficacy, side effects, convenience), availability, cost, and a variety of personal considerations (56–58,60,61,63). For example, some women may consider their partners’ preferences, whereas others may value embodied knowledge from other women, health care providers, or their own experiences (53,59,61,63,64). Women may also associate contraceptive methods with certain identities, such as the vaginal ring as an “in between” transition from OCPs to an IUD (65) and the IUD with motherhood (54).

Upon initiating use, contraceptive (dis)satisfaction has been discussed with regards to women's embodied experiences of side effects (54,58). Embodiment refers to the dynamic relationship between one's felt and lived experiences within the body, highlighting how the body is simultaneously shaped and experienced as a subject of being (66). Women have described the value of non-contraceptive benefits, such as menstrual regulation or acne control (58,67). However, the literature has more often cited women's dissatisfaction with undesired side effects (54,58,67–69). For instance, women have reported feeling “fat” or “crazy” when using hormonal contraception, which negatively impacted their self-esteem and personal relationships (67). Contraceptive users have also interpreted their embodied experiences with undesired side effects as a lack of bodily control, which often prompted method discontinuation (58,67,68). These findings suggest that women may ultimately prioritize bodily control over reproductive control (68).

Unfortunately, women still face and internalize stigma surrounding their sexual and reproductive health, including contraceptive use (50,61,70). Specifically, several studies have reported stigma associated with emergency contraception, and women have described feeling judged or embarrassed when accessing this care (44,45,71–74). Women have expressed a range of emotions following the use of emergency contraception, including relief, anxiety, and conflicting feelings (45,74). For some women, emotional turmoil or discomfort lingered until their next menstrual cycle began (74). This research suggests that the embodied experiences of emergency contraceptive use might be distinctively different from routine contraceptive experiences, as women may internalize emergency contraception-related stigma in addition to the stress or uncertainty that they feel about a possible unintended pregnancy.

2.2 Larger Bodies

2.2.1 Conceptualization of Larger Bodies

As I broadly refer to “larger bodies” throughout this thesis, it is essential to consider how larger bodies are conceptualized. While terms such as “overweight” and “obese” are not universally defined, they are most commonly characterized by BMI (75), a ratio of body weight in kilograms to height in metres squared wherein “overweight” refers to a BMI ≥ 25 , and “obese” as a BMI ≥ 30 (76). However, BMI is an imperfect measurement that risks inaccurate classification because it fails to assess body composition and does not account for population variance (e.g., ethnicity, age) (77,78). As such, some researchers have advocated for moving beyond BMI classification in favour of more comprehensive approaches to characterize body weight status (77,78).

Although living in a larger body has long been perceived as a personal problem caused by individual-level behaviours, there is now a greater emphasis on approaching obesity from a systems perspective (79). For instance, Obesity Canada recently published clinical guidelines that conceptualize obesity as a multifactorial complex chronic disease and provide recommendations for reducing weight bias in clinical practice (80). This approach reflects research that has identified how “upstream” factors, such as biology, genetics, as well as physical, socio-cultural, economic, and political environments, contribute to body weight (81,82). In addition, fat activists situate weight bias and the “war on obesity” as feminist and social justice issues shaped by stigma, fatphobia, and intersectional systems of oppression, including racism, ableism, classism, and sexism (83–85).

My own conceptualization of larger bodies is consistent with feminist social constructionism, whereby I believe that bodies are both corporeal and figurative, as they are constructed in physical and cultural contexts (86). I further believe that one's self-perceptions and bodily subjectivities are shaped and established by the current cultural messaging, beliefs, and meanings prevalent in society (87). In keeping with these beliefs, I conceptualize larger bodies and terms such as "overweight" and "obese" to be socially constructed and value-laden, reflecting a body size or weight that is above the norm of current Western standards (87). As such, my definition of larger bodies moves beyond BMI classification and considers that if one perceives their body to be larger than the societal norm, their interpretation of their experiences will reflect this. This conceptualization of larger bodies is used throughout this study.

2.2.2 Weight Stigma: Embodiment and Reproductive Health Care Experiences

Weight stigma is the social devaluation or rejection of bodies that differ from the standards set by societal norms (88). This stigma may include negative stereotypes, attitudes, or acts of discrimination towards individuals who are considered "fat," "overweight," or "obese" (89). Some research proposes that women are disproportionately affected by weight stigma, which is globally prevalent throughout the media, personal relationships, as well as in health, education, and employment settings (84,90). Weight stigma has been particularly rampant throughout the COVID-19 pandemic, as demonstrated by the widespread use of social media hashtags like "#quarantine15," messages related to high-risk populations, and the vilification of people in larger bodies for "purging" the health care system (91,92). Weight stigma represents a significant public health concern, as anti-fat attitudes and discrimination impair the quality of care that individuals in larger bodies receive, contribute to the delay or avoidance of health care, and negatively impact quality of life, including mental, physical, and social health (88,93–95).

Research indicates that some individuals in larger bodies feel defined by their bodies and alienated from others (96–99). Larger bodies have previously been embodied as objects, wherein individuals have become estranged from and within their bodies (99–101). For example, individuals in larger bodies may be hypervigilant of their bodies or feel that they are under constant public surveillance, resulting in self-scrutiny, concealment, or body avoidance (96,99–101). To illustrate this, some women in larger bodies have described attempting to “compensate” for their weight by focusing on enhancing their personas, whereas others have tried to mask their bodies through clothing or posture (98,100,101). Moreover, a recent study demonstrated how weight stigma can become embodied when behaviours are assigned moral value, as participants wrongly predicted weight gain and described feeling heavier after engaging in “bad” conduct (e.g., consuming food with high caloric value) (102). In comparison, women in larger bodies who engage in body acceptance have reported improved body image and more satisfying sexual experiences (103). These embodied experiences suggest that weight stigma, as well as the physical and lived bodies, are intrinsically linked.

Weight stigma is well-documented in health care (93,94) and impacts women across the reproductive health continuum (10,11,14,104). Women in larger bodies have often described feeling shamed or embarrassed during reproductive health care visits (7,9–12,14). For example, individuals who were labelled as “overweight” or “obese” when seeking fertility or prenatal care in Ontario described how their bodies were problematized and scrutinized by health care providers, which detracted from the quality of their care (9). Furthermore, an American study found that a lack of size-appropriate equipment, uninvited weight-loss advice, and disrespectful treatment by health care providers were all associated with delaying or avoiding reproductive cancer screening (104). Although women in larger bodies have frequently conveyed negative

maternal health care experiences (7,9–13), some women have valued health care providers who “looked beyond the scale” and made them feel heard, cared for, and “seen behind the fat” (8,11). Overall, the current body of knowledge indicates that women in larger bodies may face significant challenges when accessing and using reproductive health care services.

2.3 Contraception and Women in Larger Bodies

Despite some evidence that sexual activity is similar across weight categories (105), clinical research on contraception has typically focused on a relatively small range of body sizes (20). There is also little known about women in larger bodies’ lived experiences with contraception, as the literature on this topic is predominantly quantitative (22). While limited, the current body of knowledge provides insight on contraceptive efficacy and safety; patterns of use among women in larger bodies; contraceptive decision-making and factors that may influence (non)use; and contraceptive counselling provided to women in larger bodies.

2.3.1 Efficacy and Safety

The impact of body size on contraceptive efficacy and safety remains under-studied and poorly understood (20,106). Although the findings are mixed (107), there is limited research supporting the reduced efficacy of certain contraceptives among women with higher BMIs, such as the contraceptive patch (20,108). Furthermore, combined hormonal contraceptives (e.g., combined OCP [COC] containing estrogen and progestin) may be contraindicated due to an elevated risk of thromboembolic and cardiovascular events (106). The current safety and efficacy-based research evidence thus indicate that progestin-only hormonal contraceptives (e.g., injections) and LARCs are preferred for women in larger bodies (20,106,107).

The Cu-IUD remains the most effective method of emergency contraception for women of all body sizes (109). Regardless of its popularity, LNG-EC may have reduced efficacy when used by women with higher BMIs (19). Limited data also suggest that UPA-EC may be less effective for women in larger bodies, albeit these findings are statistically insignificant (19). As of 2014, all Canadian LNG-EC packaging must include a warning of reduced efficacy among women who weigh over 165 pounds and ineffectiveness in women who weigh over 176 pounds (110). Although emergency contraception should not be discouraged based on body size, when possible, the Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends UPA-EC as the emergency contraceptive pill of choice for women with a BMI ≥ 25 and the Cu-IUD for women with a BMI > 30 (111). Nonetheless, women in larger bodies should still be counselled on all methods of emergency contraception to make an informed decision (20).

2.3.2 Patterns of Contraceptive Use

Consistent with data from the general population of Canadian women at risk of pregnancy (112), OCPs are often the most commonly reported method of female-oriented contraception used by women in larger bodies (22). However, numerous studies have shown that women with higher BMIs may be more likely than women within the “normal” range (i.e., BMI 18.5 to 24.9) to use LARCs or undergo tubal ligation and less likely to use other hormonal contraceptives (113–118). While these findings seem to suggest that women in larger bodies use more effective methods of contraception, some findings indicate that this population may also be more likely to rely on less effective methods, discontinue new prescriptions, or not use any contraception (113,115,117,119,120).

There is a scarcity of research on women in larger bodies’ experiences with emergency contraception (22). A recent study revealed that the volume of online pharmacy requests for

UPA-EC from American women with a BMI ≥ 30 increased significantly after weight warnings were temporarily added to European LNG-EC labels in 2013 (121). Based on the findings from a search engine scan of “emergency contraception effectiveness weight” completed before and after the advisory was introduced, the researchers proposed that this shift may, in part, reflect the increased information available online (121). Similarly, data from a national survey conducted in the United States between 2013 and 2015 revealed that fewer than one-third of women who reported LNG-EC use in the last year also reported a height and weight characterized by a BMI ≥ 26 (122). Further research is needed to better understand the contraceptive practices of women in larger bodies and how they interpret information pertaining to weight-related efficacy (22,121).

2.3.3 Contraceptive Decision-Making and Factors Influencing (Non)Use

When selecting a method of contraception, women in larger bodies may consider factors such as side effects and ease of use (114,123–125). For instance, a focus group study revealed that women in larger bodies were concerned about weight gain that may accompany the use of hormonal methods (125). While these participants did not believe that their weight limited their contraceptive options (125), findings from another study suggested that women in larger bodies may consider LNG-EC’s weight-related efficacy when selecting UPA-EC (121). Finally, method dissatisfaction and side effect profile may also prompt women in larger bodies to discontinue use or seek a new contraceptive method (120,126), which is consistent with the broader literature on women’s experiences of contraceptive side effects and decision-making (54,58,67,68).

In addition, personal, provider, or access barriers may limit women in larger bodies’ use of contraception (22). Women with higher BMIs who do not use contraception have previously reported perceived subfertility (117,124,126,127) and researchers have suggested that access or socioeconomic disparities, such as income, may impact women in larger bodies’ ability to use

contraception (116,120,126). Finally, some researchers have implied that perceptions of stigma or low self-esteem may deter women in larger bodies from seeking contraceptive care (113,117,119).

While one study found that women in larger bodies were less likely than their lower BMI counterparts to report recently accessing contraceptive care (113), the proposed barriers noted above have not yet been formally examined. However, anecdotal evidence from medical weight stigma studies indicate that women in larger bodies may encounter weight discrimination related to contraceptive use (7,10,128). In 1990, Packer (128) found that several women with higher BMIs struggled to access contraception because their gynaecologists held prejudiced attitudes that they were not sexually active (128). More recently, two Canadian women reported prolonged LARC use because their health care providers refused to remove their contraception (7,10). While one woman's delayed LNG-IUD removal was related to her doctor's unwillingness to perform a Papanicolaou (Pap) test due to her weight (7), another woman was repeatedly denied her reproductive rights because her doctor believed that pregnancy would be a "disaster" at her size, resulting in emotional trauma that induced distress when she subsequently sought care from another health care provider (10).

2.3.4 Contraceptive Counselling Provided to Women in Larger Bodies

Contraceptive counselling helps women select a method of contraception that they can use confidently and correctly (129). Counselling appears to positively influence contraceptive decision-making among women in larger bodies, as it is associated with choosing highly-effective methods of routine contraception, such as LARCs (123,124,126,127,130). Yet, women with higher BMIs may receive inadequate contraceptive counselling (120,123,124,126,127,130–132). Becnel et al. (131) proposed that the low proportion of non-sexually active adolescents in

larger bodies who reported ever receiving contraceptive counselling could, in part, reflect weight bias among health care providers.

Contraceptive counselling may not always be effective. Two studies reported that women in larger bodies were prescribed or accessed COCs despite contraindications and guidelines, which could suggest poor provider counselling and care (120,132). Similarly, researchers have proposed that health care providers may focus on other aspects of women in larger bodies' health care or have insufficient time to discuss relevant weight-related considerations during contraceptive counselling (114,119). In addition, there may be inconsistencies in the emergency contraceptive counselling and care provided to women in larger bodies. A greater proportion of American LNG-EC users with a BMI ≥ 26 reported recent emergency contraceptive counselling when compared to users with lower BMIs (~ 40 vs 18%, respectively) (122). While it is unclear what information was provided during this counselling, given that LNG-EC may have lower weight-related efficacy, these findings could indicate outdated provider knowledge or barriers to accessing more effective methods of emergency contraception (122). In contrast, Cleland et al. (121) found that multiple women in larger bodies reported that a health care provider had advised them to seek UPA-EC instead of LNG-EC based on their weight. Although some Ontario pharmacists may routinely discuss weight with emergency contraception clients (34), others have reported feeling uncomfortable doing so (49). To illustrate this, Vogel (133) shared her unsettling experience purchasing LNG-EC from one Canadian pharmacist without any discussion after being refused Plan B® at a different pharmacy due to her body size. Overall, the current literature suggests that women in larger bodies may have unmet contraceptive counselling needs; therefore, there is a need to examine these women's experiences and capture their perceptions of the counselling and care they receive (22).

2.4 Summary

In summary, there are several methods of contraception available in Canada for routine or emergency use. Women are often the users of contraception and try to find a method that is a good fit for their individualized needs, but may encounter unwanted side effects and various personal, provider, or systemic barriers. Women in larger bodies remain a significant yet under-researched population of contraceptive users. Apart from a few options, many methods of contraception are believed to be safe and highly effective for women in larger bodies. While the current body of knowledge suggests that these women may face unique challenges and receive inadequate contraceptive care, women in larger bodies' voices are rarely centred in contraceptive research. To date, there is a glaring lack of qualitative studies focused on women in larger bodies' lived experiences with contraception and a dearth of Canadian research on this topic. Considering this gap, the perspectives of women in larger bodies who access and use contraception are needed to better characterize this population's experiences with contraception and identify avenues to improve their care.

Chapter 3: Study Objectives

This research examined the following question: “What are the lived experiences of women in larger bodies who access and use female-oriented contraception in Ontario?” To answer this question, I also addressed the following sub-questions:

- 1) How is contraceptive use embodied by women in larger bodies?
- 2) How do women in larger bodies navigate contraceptive care?
- 3) How can women in larger bodies’ experiences with contraception be improved?

These research questions aimed to provide a greater understanding of women in larger bodies’ lived experiences with contraception and contraceptive care, the meanings they ascribed to their experiences, and to suggest how to better meet the contraceptive needs of women in larger bodies.

Chapter 4: Methods

4.1 Research Design

Qualitative research aims to understand a particular phenomenon from the perspective of those being studied (134). Given the notable lack of qualitative research exploring women in larger bodies' experiences with contraception and contraceptive care, this study adopted a qualitative methodology to address the research questions stated in Chapter 3. Using a phenomenological approach, I conducted 19 in-depth interviews with women in larger bodies who accessed and used female-oriented methods of contraception in Ontario within the last five years.

4.2 Theoretical and Methodological Orientation

To focus on the meaning of women in larger bodies' lived experiences, an interpretive phenomenological approach with a feminist lens was adopted. Phenomenology is a qualitative research approach, methodology, and philosophy that studies the meaning of embodied human phenomena by considering how individuals make sense of their experiences (134–136). There are two major schools of phenomenology: descriptive and interpretive (135). While descriptive phenomenologists describe key features of phenomena, interpretive approaches aim to uncover and interpret meanings hidden in ordinary life (137).

4.2.1 Interpretive Phenomenology

Also known as hermeneutic phenomenology, interpretive phenomenological approaches use evolving methods to allow researchers to explore nuances in the data and remain open to new understandings (138). To do this, researchers seek to examine unexplored or overlooked dimensions of a phenomenon (138). This approach originates from Heidegger's concept of the

lifeworld, which refers to how individuals' realities are indubitably and fundamentally shaped by the contexts in which they live (137,139). Hermeneutic phenomenologists interpret phenomena and experiences through the lifeworld, thus considering the influence of an individual's personal history and social identities in shaping their experiences (139).

4.2.2 Role of the Body

Phenomenology is closely related to the concept of embodiment, which can be traced back to the works of Merleau-Ponty (140). Phenomenologists consider the body to exist in terms of the lived and physical bodies (141). While the biological sciences can describe the physical body, the lived body is central to human experiences (141). For instance, experiences are grounded in literal and metaphorical "bodies of meaning," through which the body is interpreted and embodied actions hold significance (66). As such, embodiment can be explained as a lived process that shapes one's self-concept and understanding of others (66). Moreover, reflexive embodiment refers to the dual existence of the body as a state of being and, on occasion, an object of possession (142). Embodiment has been used to describe the experiences of individuals in larger bodies (100–102) and women's experiences with contraception (54,58,64), and was considered throughout my analysis.

4.2.3 Feminist Lens

Given the feminization of contraceptive use (52–54) and to appreciate participant diversity, pay attention to social inequalities, and be mindful to notions of stigma, I approached my research with a feminist lens (83). Researchers have previously investigated the gendered experiences of weight, whereby the concept of "fatness" has often been feminized (83,98,143). Feminist research approaches aim to affirm and give voice to women's experiences (144), while

also examining issues related to power and otherness (134). Similarly, the experiences of individuals in larger bodies can be understood in relation to reduced social power (83). According to Calogero, Tylka, and Mensinger (83), a feminist lens can be used to illuminate the nuanced forms of bias and oppression faced by individuals in larger bodies. Further, this lens provides a holistic understanding that “fat” identities and experiences are highly individualized and cannot be separated from one’s other social identities (83). Thus, the feminist lens strengthened my analysis by challenging me to think critically about each participant’s identities, how their experiences were constructed, and the ways in which their positionality influenced how they understood these experiences.

4.3 Study Sample, Recruitment, and Data Collection

4.3.1 Study Sample and Eligibility

Participation in this study was open to women over 18 years of age who met the two-pronged eligibility criteria. Firstly, participants had to identify as living in a larger body. Secondly, participants must have accessed and used female-oriented routine and/or emergency contraception in Ontario within the last five years. These eligibility criteria were chosen to reflect the study goals and to account for relevancy within the Canadian context with respect to the introduction of the weight advisory on LNG-EC labels (110), the market approval of UPA-EC (33), and for recruitment purposes.

4.3.2 Recruitment

Participants were recruited by sharing the study poster and website (see Appendices A and B) on social media profiles, groups, and other online platforms (e.g., Kijiji). Snowball sampling techniques were also used by encouraging participants to share recruitment materials

and study information to reach individuals within their social networks who may have been interested in participating. All recruitment materials provided a project description, outlined the inclusion criteria, emphasized that participation was voluntary, and listed my contact information.

I took a staggered approach to recruitment by evaluating participant uptake every few weeks before planning to share recruitment materials further (e.g., in a new Facebook group). Participants were asked to confirm how they learned about the study to track recruitment success. Of note, several participants offered information about other groups, organizations, or platforms where recruitment could be shared for greater visibility. Although few of these avenues were explored due to ample interest in participation, the suggestions were greatly appreciated and demonstrated participants' excitement about this research. When someone contacted me to express interest in participating, they were sent a letter of information and consent form via e-mail to review the study eligibility, processes, and procedures (see Appendix C). Upon confirmation, interviews were scheduled with individuals who wished to participate.

4.3.3 Data Collection

Each interview was arranged at a date, time, and platform selected by the participant. Thirteen interviews took place online via videoconference (e.g., WhatsApp, MS Teams, Zoom), and six participants preferred to connect by telephone. Unstable Internet or telephone connection sometimes posed a challenge, and, as a result, one participant's interview took place over the span of two different days. Prior to beginning each interview, I addressed all inquiries, obtained verbal consent to participate in the study (see Appendix D), and offered participants the opportunity to select their own pseudonym.

Consistent with phenomenology, participants took part in in-depth interviews (137). Guided by broad questions, the in-depth approach allowed participants to discuss what was most important to their experiences, which in turn enabled me to gain a comprehensive understanding, capture unique perspectives, and explore interesting or unanticipated responses (134,145). The interviews began with a general introductory question that asked participants to describe themselves. At this time, I also collected demographic information pertaining to participants' age, ethnicity, location (e.g., rural or urban), education level, and sexual orientation. This information helped me explore participants' social identities and examine how individual experiences may have varied by social context. The rest of the interview focused on participants' lifelong experiences accessing and using contraception to understand how women in larger bodies felt about their experiences with contraceptive use, how they perceived their contraceptive counselling and care, and the meanings that participants ascribed to these experiences. Reflecting on their experiences, participants were also asked to compare contraceptive care to other health care and suggest how their experiences could be improved in the future. The complete interview guide can be found in Appendix E.

Interviews were conducted between November 2020 and February 2021. The length of the interviews ranged from 36 minutes to nearly four hours, with most interviews lasting between 1.5 and two hours. All interviews were audio-recorded with participant permission and transcribed verbatim. Participants were offered a copy of the results upon study completion.

4.4 Ethics and Considerations

This study received ethics clearance from the University of Waterloo Office of Research Ethics (ORE #42481). Prior to beginning each interview, I spoke with participants for a few minutes and told them a little bit about myself, as well as my research interests and experiences.

By building rapport, I hoped to help participants feel more relaxed, establish trust, and promote sharing (134). In addition, the interview questions were constructed to be open-ended to facilitate a conversational dialogue where participants could share their experiences candidly (145,146).

Some participants shared upsetting experiences during the interviews. While participants often assured me that they felt comfortable discussing these experiences, in other instances, I asked permission before posing follow-up questions. In consideration of participants' feelings, I was attentive to body language, tone of voice, and offered to pause the interview if I sensed that a participant was upset. Along with a feedback letter to thank them for their participation (see Appendix F), participants were made aware that an information page with community resources, supports, and services was available if desired (See Appendix G).

4.5 Participants

Nineteen participants took part in this study. A detailed description of each participant's demographic information and contraceptive history can be found in Table 1 at the end of this section and Appendix H, respectively. Participants were between 23 and 39 years of age, with most being in their twenties (n=11). The majority of participants identified as heterosexual or predominantly heterosexual (n=13), exclusively white (n=12), and urban dwelling (n=16). This sample was highly educated, with all participants having attended at least some post-secondary education, four of whom had attained a Master's degree. While all participants identified in some way with the term "woman" by nature of the inclusion criteria, one participant stated that they were not cis-gender, but rather identified as "femme." Although I did not confirm participants' pronouns, this participant indicated that they use they/them pronouns and thus, the language used to present their experiences throughout this thesis reflects this.

It is further worth remarking that many participants disclosed other intersecting aspects of their identities throughout the interviews. For instance, a number of participants noted their mental health disorders (n=8), religious backgrounds (n=5), sexual inactivity (n=3), and immigration status (n=1). Many participants disclosed medical condition(s) (n=14), the majority of which included a diagnosed gynaecological condition that impacted menstruation, such as polycystic ovarian syndrome (PCOS), endometriosis, or adenomyosis (n=8). Finally, many participants reported having access to private or public insurance at some point throughout their experiences (n=15), but some admitted that cost became a concern or barrier to routine contraceptive use when they were uninsured (n=4). Similarly, some participants also described instances where they did not use emergency contraception, in part, due to the price (n=4).

Within the sample, 10 participants had a history of both routine and emergency contraceptive use, eight participants had just used routine methods, and one participant had only ever used emergency contraception. Among the 18 participants who had experience with routine female-oriented contraception, methods used included OCPs (n=17), LNG-IUD (n=6), vaginal ring (n=4), contraceptive injection (n=2), Cu-IUD (n=1), and incidentally, tubal ligation (n=1) and spermicidal film (n=1). As the spermicidal film was only used on a single occasion, female-oriented non-hormonal barrier methods of contraception were largely underrepresented in this study sample. All but two women in larger bodies who ever used emergency contraception had multiple experiences doing so (n=9). In addition to LNG-EC (often Plan B®), one participant was once prescribed two oral medications as an alternative emergency contraceptive pill. None of the participants had used UPA-EC or a Cu-IUD for emergency contraception. Aside from female-oriented contraception, all sexually active participants mentioned the use of external

condoms and one participant described using dental dams and nitrile gloves to protect against STIs.

Twelve participants were using hormonal contraception at the time of the interview. Of note, all current users were able to access their contraception since the beginning of the COVID-19 pandemic, and while some participants received virtual and/or in-person contraceptive care during this time (n=5), a few others stated that their care had been delayed or avoided (n=2). Four women were only using external condoms, one participant was prescribed an endometriosis medication that acted similarly to an OCP, and as previously mentioned, another had a tubal ligation. Lastly, one participant was not using any method of contraception.

Table 1. Participant demographics

Pseudonym	Age in years	Ethnicity	Geographic location	Level of education	Sexual orientation
Alice	23	White	Urban	Bachelor	Heterosexual
Antara	32	Indian	Urban	Bachelor	Bisexual
Barbara	23	Egyptian-Latina	Urban	Bachelor	Heterosexual
Beyoncé	24	Jamaican-Filipino	Urban	Bachelor	Heterosexual
Gia Grace	33	White	Urban	Bachelor	Heterosexual
Gwen	26	White	Urban	Bachelor	Unsure
Ivy	24	White	Urban	Undergraduate student	Lesbian
Kendra	31	White	Urban	Master	Heterosexual
Lilieae	31	White	Urban	Bachelor	Heterosexual
Luna	24	White	Urban	Master	Bisexual
Marie	31	White-Latina	Urban	Bachelor	Heterosexual
Mavis	26	Trinidadian-Brown	Urban	Bachelor	Heterosexual
Quinn	26	White	Rural	Some College/University	Queer/Pansexual
Roxanne	39	White	Urban	College	Predominantly heterosexual
Sapphire	34	White	Urban	College, some University	Heterosexual
Sloane	23	White	Rural	Bachelor	Queer
Steph	26	White	Rural	Master	Heterosexual
Sultana	33	South Asian	Urban	Bachelor	Heterosexual
Tuck	24	Persian-Caucasian	Urban	Master	Predominantly heterosexual

4.6 Data Analysis

Data analysis was guided by Smith and Osborn's (146) interpretive phenomenological analysis (IPA). This iterative analytic method provides clear guidelines and focuses on understanding the meaning of participant experiences (146). As previously noted, I applied a feminist lens to my analysis to pay particular attention to inequalities that may have shaped participants' lived experiences.

Preliminary analysis began by taking notes during the interviews to capture key topics and interesting experiences to explore further. Following each interview, I wrote a journal entry to provide a detailed summary where I reflected on the participant's experiences and documented my own observations or interpretations (e.g., emotionality, technical issues, reflexivity). After transcribing each interview, I imported the data into NVivo-12, a data management software commonly used by qualitative researchers (147). The interviews were discussed with my supervisor on a regular basis to make analytic interpretations and propose early findings.

When data collection was completed, I shared all interview transcripts with my supervisor to verify preliminary interpretations and my subsequent analysis. Given the breadth and depth of the interviews, I decided to make adaptations to Smith and Osborn's (146) analytic process to manage the data better. The eight steps that I took to analyze my data are as follows:

1. Writing preliminary analytic summaries. Analytic summaries were created for each participant to provide a quick, contextual outline to refer to throughout data analysis and to orient myself before examining the complete dataset. Working with one interview at a time, I familiarized myself with the data by reading through the transcript several times (146). I took notes describing important aspects of the participant's experiences and began identifying themes (146).

Once I had a good understanding of the participant's story, I wrote a brief summary highlighting pivotal features of their experiences (e.g., one-half page to one page in length) and described three to five key themes of meaning that captured the "essence" of their experiences. I then moved on to the following transcript and repeated this process. When all the preliminary analytic summaries were completed and I felt immersed in the data, I began to individually analyze the transcripts more formally.

2. *Multiple reading and note revision.* I again read the first transcript multiple times (146). While doing this, I reviewed my preliminary analytic summary and notes, expanding upon this text and jotting down new insights when applicable.

3. *Broad coding (Parent nodes).* When I felt comfortable with the data, I coded the transcript for broad topical meanings to help organize the data (i.e., parent nodes). These codes were often similar to the interview guide topics (e.g., routine contraceptive use, health care encounters).

4. *Micro coding (Child nodes).* After completing broad coding, I returned to the beginning of the transcript and coded succinct themes that captured the meaning of what was being said (146). These themes were coded within the context of the broader codes (i.e., child node as a subcode to the parent node), thus allowing me to distinguish and gain a deeper understanding of different dimensions of meaning. For example, feelings of anxiety pertained to different circumstances, such as when using emergency contraception, during health care encounters, or when describing a side effect.

5. *Memo drafting.* Rather than listing all micro coded themes from the transcript, organizing them into higher-order themes, and tabling the results (146), I streamlined my analysis by drafting a memo containing major analytic interpretations in discussion with my supervisor, who

acted as a second coder for the analysis of the first seven transcripts. The memo was further compared with the participant's corresponding preliminary analytic summary, journal entry, and notes for verification.

6. Moving on and going back. Once I completed the coding and had drafted a memo, I moved on to the next transcript. Steps two through five were repeated for each interview transcript.

7. Mapping the themes. After all coding and memos were completed, I examined the dataset as a whole. I first grouped all the broad codes into three separate categories, which are reflected in the topics of Chapters 6 to 8 (e.g., embodied contraceptive use). Then, one at a time, theme maps were developed for each category by extracting all child nodes from the parent nodes within the category and connecting, grouping, and integrating them together to form higher-order themes. Considering the iterative nature of IPA, transcripts and coded data (i.e., participant quotes) were reviewed throughout the mapping process, and coding adjustments were made where necessary (146). Furthermore, close attention was paid not only to the depth of the data, but also to the participants represented in each code and theme.

8. Translation. Major themes were prioritized in my findings in consideration of the richness of the data, interesting commonalities or differences among and across participants, and relevancy to the overall meaning of participants' experiences (146). Codes and transcripts were reviewed to verify my interpretations as I translated my findings into thesis chapters. Care was taken to ensure that each participant was adequately represented in the findings, both in terms of themes of meaning and exemplary quotes.

4.7 Reflexivity and Positionality

Reflexivity is a crucial aspect of phenomenological studies, as it considers how the researcher influences the interpretations of participants' lived experiences (148). IPA acknowledges the active role of the researcher through a "double hermeneutic," whereby the researcher aims to interpret and make sense of the accounts shared by participants, who are trying to make sense of their own experiences and lifeworld (146). The iterative nature of IPA allows researchers to navigate participant experiences while also examining their own sense-making (146).

I approached this research with my own attitudes, values, identities, and lived experiences that shaped my understanding and interpretation of participants' stories. My curiosity and investment in this research topic stemmed from my passion for sexual and reproductive health and a close friend's experience with emergency contraception. In addition, I have previously identified as living in a larger body and have a personal interest in body inclusivity. I engage with body liberation content (e.g., by activists, academics), which has helped me grow personally and academically. Nonetheless, as a young, white, middle-class, neurotypical, straight-sized, able-bodied, heterosexual, cis-gender woman with insurance coverage to support nearly ten years of consistent hormonal contraceptive use, I recognize that I carry substantial privilege in conducting this research and that these privileges, along with my positionality, impacted how I created meaning in the accounts of participants' experiences.

Interpretive reflexivity moves beyond positionality statements and attempts to demonstrate how researchers create meaning in participants' lived experiences (149). I incorporated reflexivity into my analysis by taking reflective notes when journaling after each interview and throughout the analytic process (150). While I originally planned to use reflexive

commentary in the findings to explain my role in constructing meaning (150), as I immersed myself in this research, I became increasingly opposed to doing so as I did not wish to detract from participants' accounts by highlighting my own. Nevertheless, throughout data collection and analysis, I often found myself reflecting upon the interviews and thinking about my own lived experiences with contraceptive care, use, and health care more broadly. As I am a contraceptive user who has previously identified as living in a larger body, my embodied experiences not only helped me relate to my participants in some ways, but also shaped my understanding and interpretation of their stories. Furthermore, my supervisor and I engaged in reflexive discussions wherein we considered the ways in which our own lived experiences with contraception were similar or different from those of my participants. While we took note of some similarities, such as my adolescent use of hormonal contraception for menstrual regulation, there were also several differences, for instance, as I have not experienced stigma when accessing health care. Thus, this exercise helped me to navigate and consider my role in influencing data collection and interpretation, while also allowing me to critically reflect upon my own lived experiences.

Chapter 5: Participant Stories

There was significant diversity in the stories shared with me by women in larger bodies. While the interviews focused on participants' experiences with and feelings about contraception and contraceptive care, the conversations varied based on the range and complexity of their experiences. As such, women's stories revealed the deeply personal nature of participants' journeys with contraception and health care more broadly. Acknowledging the challenge of fully capturing this nuanced mosaic of lived experiences in my results, this chapter will preface the study findings by highlighting the diverse stories of five participants. By outlining the lifelong relationships that participants fostered with contraception, health care providers, and their own bodies, I aim to create a foundation for my subsequent analysis to showcase diversity, uplift women's voices, and meet participants where they are.

5.1 Mavis

Mavis is an "easy-going" 26-year-old Trinidadian-Brown woman who had very few health care experiences growing up. Mavis learned about a variety of contraceptive methods in high school, including how Plan B® may be less effective for larger body sizes. She accordingly "went through life" knowing that she should prioritize consistent use of routine contraception. When Mavis was 22-years-old, she entered a committed relationship and decided to schedule an appointment at a young women's health clinic to discuss initiating contraceptive use.

During the appointment, the doctor inquired about Mavis' medical and sexual history, took her blood pressure, and requested that she complete Pap and blood tests. The doctor provided Mavis with "a lot of resources" and they discussed various contraceptive options together to determine which method she would be most comfortable using. Mavis ultimately

selected OCPs, which she believed could be worked into her daily routine on a long-term basis. Overall, Mavis thought that her needs were “catered to” as a first-time contraceptive user; she felt informed and supported throughout her contraceptive care.

When Mavis returned to the clinic for a three-month follow up, her blood pressure was slightly higher and she had gained weight. The doctor gave Mavis “the clear” to continue using contraception, but she felt somewhat anxious knowing that her blood pressure would be closely monitored at each subsequent appointment. Mavis gained a total of 30 pounds within the first six months of use, but she “didn’t mind” it due to the positive role that contraception played in her relationship. In addition, OCPs regulated her “very irregular” menstrual cycle – something that Mavis never imagined possible.

Mavis was fully insured under OHIP+ until she turned 25-years-old and began paying for her contraception out-of-pocket. While the cost was manageable, Mavis had to change OCPs twice due to pharmacy supply shortages, which once left her unable to access contraception for five consecutive weeks. Given that her body had become “used to” OCPs, Mavis observed new “changes” during this time, such as prolonged bloating, migraines, and acne. Desperate for “any prescription that they could give [her],” she promptly accepted the pharmacist’s offer to dispense an available alternative brand so she could begin using contraception again.

When she was no longer eligible to receive care at the young women’s health clinic, Mavis was referred to a busy male gynaecologist. She recalled an initial “learning curve” because the gynaecologist was used to older patients who had more experience with Pap tests, but Mavis began to feel more comfortable after requesting that he be more forthcoming with her. While Mavis mainly saw this doctor for cervical screening, he regularly confirmed that she was still monogamous and using her OCPs properly. Since completing her university studies, Mavis

has relocated and now sees a family doctor in her current city. Although their conversations about contraception have been limited thus far, Mavis feels generally satisfied with her care.

Overall, Mavis characterized contraceptive care as a lengthy process with several “steps.” In any case, she was grateful that contraception empowered her to “live [her] twenties like, kind of by [her] timeline” and control where her “path is going.” Although she faced some minor inconveniences along the way, Mavis reflected positively on her experiences:

I feel like I was super lucky in that I was, you know, [from] the time that I began [using] contraception and the support that I got, both from health care professionals and from people in my personal life, I think, honestly, I’ve had a great experience with it. Regardless of whether I’m in a larger body, I really feel like I had a great experience with contraception from beginning to even now.

Looking towards the future, Mavis plans to continue using OCPs until she and her partner are ready to start a family.

5.2 Tuck

Twenty-four-year-old Tuck is an “outgoing” Persian-Caucasian woman who grew up in a religious Middle-Eastern family where she was raised primarily by her father. Tuck has had the same family doctor since childhood, when she “hated” going for appointments, as she explained:

I was a fat little kid who would sit there and they would talk about me in front of me – about me being fat and stuff! So, there’s definitely, like, going to the doctor gets associated with, like, being ashamed of your body and, like, how you exist and stuff.

This sense of shame carried into her adolescence, when Tuck avoided health care because she feared that her family doctor would initiate “scary conversations” and call her a “failure” because she was “still fat.” Her internalized stigma was further deepened by a discomfort with sexual and reproductive health, which was never discussed at home and was compounded by “inadequate”

public school sex education. Consequently, when Tuck was a teenager, she convinced herself that her amenorrhoea, or absence of menstruation, was “normal.”

When Tuck’s father realized that he had never purchased menstrual products for his 17-year-old daughter, he took her to a hospital and she was diagnosed with PCOS based on her symptoms and blood test results. Tuck was referred to a gynaecologist who told her about various contraceptive methods and recommended OCPs to manage her PCOS. The gynaecologist then explained the daily regimen, when to expect her menstrual period, and advised Tuck to let her know if she had any issues. Although she did not necessarily have the opportunity or desire to ask questions, Tuck recalled thinking: “this is what I have to take to make everything better.”

Contraception successfully induced Tuck’s menses and controlled her PCOS symptoms when used consistently. Despite characterizing herself as “doctor averse,” she always felt very comfortable with her pharmacist, who was a close family friend and provided additional information about how the OCPs worked. Tuck continued to see her gynaecologist for PCOS management, but her appointments often felt rushed. Much to her surprise, when she phoned the office to renew her OCPs a few years later, Tuck was informed that she had been discharged from the gynaecologist’s care and her prescription was transferred to her family doctor’s office. Annoyed, Tuck knew that she would eventually have to return to see her family doctor.

Tuck had insurance coverage, but admitted that the prescription-status of OCPs posed a significant personal barrier to her contraceptive care. Internalized stigma “very clearly” impacted how she engaged with the health care system, and Tuck described several instances where she made an expressed effort to continue avoiding her family doctor. Tuck usually renewed her prescription over the phone or with an on-call doctor at the office, but said she became “sneaky” when she did not feel comfortable doing so:

I would go to, like, [a clinic] where I don't have any history with them and let them know, like, "Hey, my birth control is expiring," and (exhales) you know, mislead them maybe to a certain extent and say, "Hey, I can't get an appointment with my family doctor for a while and I don't want to be off the pill. Like, it's a PCOS treatment that I'm on." Um, and then they would write a prescription that I could get refilled maybe one or two more times from [them] instead of my actual doctor's office because I – sometimes I wanted to avoid going to the doctor.

While most of the clinic encounters felt "a little rushed" and involved minimal discussion, some doctors asked why Tuck had not yet completed a Pap test. As she was not sexually active and feared being "forced" to have this exam to access contraception, Tuck sometimes felt that these questions involved "more prodding than maybe necessary."

Tuck is now more comfortable with her body and no longer avoids her family doctor. In her early twenties, she became concerned that she still "knew so little" about her own body and started to learn more about sexual and reproductive health online. After deciding that she was "tired of being scared" and needed to "grow up," Tuck vowed to overcome her internalized stigma and eventually scheduled an appointment with her family doctor during the COVID-19 pandemic. Tuck has recently felt "a little icky" swallowing pills, but wanted to continue using OCPs because she worried that her body may not react as well to other hormonal contraceptives. During the virtual appointment, Tuck engaged in a "pretty one-way conversation" where she told her doctor about her PCOS diagnosis and management. She requested a prescription renewal for her OCPs along with an in-person appointment for STI screening and a Pap test, as she had started to engage in more sexual activity. After confirming that Tuck was content using OCPs, the doctor obliged and wrote a prescription without asking any further questions.

Tuck is grateful to have access to contraception and while she used to intentionally limit her health care encounters, she now feels that the discussions surrounding her PCOS and

contraceptive care have “probably [been] lacking.” Knowing that her family doctor “won’t bring it up,” she plans to initiate and engage in more conversations about her sexual and reproductive health care in the future.

5.3 Gia Grace

Gia Grace is a 33-year-old white woman who described herself as “laid-back” and well-travelled. Throughout her life, Gia Grace sometimes felt that being a plus-sized woman was a “double negative” in health care, as her concerns have been questioned, dismissed, or simply attributed to her weight. At the end of high school, Gia Grace went to see her family doctor about extreme menstrual cramping. Upon stating that she tried pain relief medication to no avail and was missing school as a result, Gia Grace was prescribed OCPs. Her doctor briefly explained that contraception would alleviate her pain and improve her acne, but he provided very “vague” information about pregnancy prevention. Although Gia Grace was not sexually active yet, she wanted to be prepared and was disappointed that her doctor seemed to assume that she did not *need* that information. Regardless, Gia Grace only used OCPs for about six months before deciding that contraception “wasn’t for [her],” as she frequently forgot to take her pills and had not experienced any symptom relief.

Since becoming sexually active, Gia Grace has used external condoms for contraception. A few years ago, she was curious about IUDs and scheduled an appointment with her new family doctor to discuss contraception. The doctor listed several methods and gave Gia Grace a website link where she could find more detailed information. Despite feeling supported and informed throughout the appointment, Gia Grace would have appreciated personalized advice about which options may have been best for her. After doing her own online research and learning about other women’s embodied experiences with IUDs, Gia Grace felt like she was “going into a black hole”

of information and concluded that “a lot of people had bad experiences.” As Gia Grace had never been in a committed long-term relationship, she continued to feel comfortable using condoms and did not perceive a need for additional contraception. However, there have been a few instances where she has used emergency contraception following unprotected sexual intercourse.

Gia Grace accessed LNG-EC for the first time three years ago after realizing that a condom had ripped. Anxious and unwilling to accept the risk of an unintended pregnancy with someone who she did not want to raise a child with, Gia Grace immediately went to the pharmacy to purchase emergency contraception. She requested Plan B® from a young male pharmacist who asked if she had used it before and awkwardly provided her with a “brief overview” of the medication. Feeling slightly more relaxed, Gia Grace proceeded to the check-out and returned home to take her emergency contraception. She worried that the side effects would be “even more elevated” due to her menstrual history, but fortunately, the cramping was tolerable. Despite the lack of tenacious side effects, Gia Grace’s mind raced for two weeks as she awaited menstruation:

I’m like, what happens if this doesn’t work? (Chuckles) And just, uh, overthinking the scenario of what happens if it doesn’t work. And how do I tell my family, and how did I get myself in this position? I need to be more responsible. Just all those – these little things played out in my head.

When her next menstrual cycle began a few days later than anticipated, all the tension that Gia Grace had been holding in her body finally relaxed. Overcome with joy, she and her partner were relieved that everything had worked out.

The following year, Gia Grace was in a relationship and asked her partner to ejaculate inside her when they were not using a condom. While she felt calm and confident knowing that

she could access emergency contraception again, Gia Grace had to reassure her partner, who quickly became “panicky” and “paranoid.” When she went to the pharmacy a few hours later to request Plan B®, the pharmacist delivered a quick “spiel” and gave her a generic brand. Gia Grace left feeling prepared and at ease, but her partner’s ongoing panic made her feel “more stressed about his reaction” than the possibility of becoming pregnant. Gia Grace carried a sense of guilt throughout this experience and wondered if she should pursue routine contraception, but she felt validated and unsurprised when her next menstrual cycle began.

Months later, Gia Grace visited an acquaintance’s home when she was intoxicated. As neither of them had a condom, Gia Grace was pressured into having unprotected sex and expressed immediate regret afterwards. She went to the pharmacy the next morning with a heightened sense of urgency and much to her surprise, the pharmacist informed her that Plan B® was no longer kept behind the counter. Despite feeling horrible about the incident, Gia Grace was pleased that emergency contraception was now treated like a “regular” over-the-counter medication that could be accessed without “discomfort or shame.” She placed Plan B® in her shopping basket and browsed for a few more items before checking out. Still upset, Gia Grace went home, read the instructions on the box, and took Plan B®. She did not experience any cramping this time, but her anxiety persisted and Gia Grace recalled “waiting down the days” until she was finally able to relax when she began menstruating.

Last year, Gia Grace was watching television and discovered that Plan B® may have reduced efficacy for women in larger bodies. Shocked to learn about the weight warning from a television series rather than from a health care provider, Gia Grace became angry and upset, as she exclaimed:

I instantly was like, wait what? (Chuckles) And I, like, Googled the hell out of it and then finding all this information, like, why did no one say anything? Thankfully, like, for whatever reason, it was fine for me those three times I used it, but [...] I don't feel like that was ever properly articulated to me, and at any time.

Adding to her frustration, none of her friends knew about this warning and posts on online groups and forums revealed that other women's experiences were "all over the place." In hindsight, Gia Grace thought she may have been offended if the pharmacist had commented on her weight and stated that she should have read the package insert, but she still believed that it was the health care provider's duty to fully inform patients about any medical risks. Following this experience, Gia Grace now thoroughly reads all her medication information prior to use.

5.4 Ivy

Twenty-four-year-old Ivy is a white lesbian woman who described herself as an "awkward, Autistic person." Unfortunately, Ivy has often felt judged, patronized, and dismissed by health care providers. Her long-time family doctor has also expressed confusion about her sexuality and was sometimes "rude" as a result, such as inquiring about her partner's genitals. Following many negative health care experiences that have only worsened with age, Ivy has become distrustful of doctors and now limits her health care to transactional encounters. Nonetheless, Ivy used routine and emergency contraception throughout her adolescence, when she was "quite small," and into adulthood, now as a woman in a larger body. In general, these experiences have left Ivy feeling over-monitored and under-informed by health care providers.

Growing up, Ivy attended a Catholic school where she received a poor-quality sex education. She was "pretty young" when she had unprotected sex for the first time, so an older friend purchased emergency contraception on her behalf. Though she felt slightly embarrassed

by the lack of privacy, Ivy quietly accessed Plan B® from her neighbourhood pharmacy several times throughout her adolescence. The pharmacist always verified that she knew how to use emergency contraception, but Ivy did not fully understand its purpose at the time, as she admitted: “I wasn’t like .. 100% sure what it did. Like, was it like an abortion? Like, I had no idea.” She recalled being “pretty freaked out” during these experiences, but would hope for the best and move on.

Ivy began using routine contraception when she was 15-years-old. Without much discussion, her family doctor prescribed OCPs and simply directed Ivy to “take the pill.” She experienced constant nausea after initiating contraceptive use, but her doctor suggested that this disturbance was unrelated. Ivy was frequently given short-term OCP prescriptions, which forced her to return to her family doctor’s office every few months. This provision of care posed a barrier to consistent contraceptive use, as Ivy was sometimes unable or did not want to pick up her prescription renewal. In spite of the “horrible” side effects and inconvenient access, she continued to use her first brand of OCPs on-and-off for several years.

When Ivy began dating her current partner a few years ago, she had just relocated and was unable to access her contraception. Ivy and her partner sometimes used external condoms during this time, but there were two instances where she needed emergency contraception following unprotected sex. On each occasion, Ivy and her partner went to a pharmacy the next day to purchase Plan B®. Despite having insurance to help pay for the OCPs, cost had previously prevented Ivy from accessing emergency contraception so she was grateful when her partner offered to pay the second time. Although she felt remorseful and worried about becoming pregnant while living in a larger body, Ivy described both pharmacy encounters as merely transactional. She felt nauseated after taking Plan B®, but was unsure if this symptom was

attributed to the emergency contraception or her fear of pregnancy. Having learned from a friend that Plan B® may be less effective for women in larger bodies, Ivy experienced “gnawing” anxiety until her next menstrual cycle, as she thought: “Oh shit, maybe it didn’t work, maybe you waited too long, you know? Maybe what you heard about it not working for some people is true.” Conversely, in her most recent experience, Ivy had to prioritize other ongoing issues and soon “forgot” that she had taken Plan B® until she began menstruating.

When she later discontinued her first OCP, Ivy’s nausea improved and she realized that her contraception had indeed contributed to her symptoms. Ivy had a friend who used a different brand of OCPs, so she decided to see if this contraceptive would be a good fit for her. Considering her new location and the strained relationship with her family doctor, Ivy typically accessed health care from nearby walk-in clinics. She requested the new OCP at the end of an appointment, which “pissed off” the doctor due to the clinic’s one-issue-per-visit policy. Ivy panicked when the doctor stated that he usually did not prescribe contraception without a vaginal exam, as she would sooner forgo health care altogether. He finally agreed to write a prescription, but Ivy was surprised when the pharmacist told her that she had only been prescribed one package: a single month’s worth of contraception.

After experiencing nausea, emotional changes, bloating, and menstrual disruption with her new OCP, Ivy recalled thinking: “maybe birth control is just not good for me.” Ivy continued using her OCPs, albeit imperfectly, until she sought emergency care for what she thought was a “stomach bug” and learned that she was pregnant. Ivy decided to have an abortion, which was a difficult experience for her and her partner. Contraception was discussed twice throughout her abortion care, as she was first provided with brief information about various methods and later selected OCPs again. Owing to her Catholic education, Ivy knew little about contraception and

sometimes felt that health care providers were “condescending” as a result. While her contraceptive options and their respective risks were never thoroughly explained, Ivy appreciated that the doctor at the abortion clinic was “straight and informative.” Nonetheless, Ivy was unwilling to try a different contraceptive method because IUDs and all alternative options sounded “really scary.”

Ivy’s body now feels “better than normal” using her third brand of OCPs. Along with a regulated menstrual cycle, Ivy does not have any side effects and rarely experiences menstrual cramping. However, Ivy became increasingly frustrated that doctors only offered her short-term prescription renewals and felt patronized by a pharmacist who “didn’t seem convinced that [she] knew what [she] was doing.” Unsatisfied with her contraceptive care, Ivy decided to enrol in a virtual health care service. This platform enabled her to access contraception “in surplus” without interacting with health care providers, as she exclaimed: “they just send birth control [to] my door. And I don’t have to worry about it, it comes every three months, they give me three packs!” Even though Ivy now accesses and uses OCPs consistently, the threat of another unintended pregnancy persists in her thoughts. Adding to this concern, Ivy’s family doctor and peers have cautioned her against starting a family until she loses weight and she confessed:

I’ve been told horrible things about – and I know that they’re not all true, rationally. Like I’ve – I’ve, you know, looked it up and I know rationally that it’s not all true. But I’ve heard terrible things, that you’re, like, a horrible mother if you get pregnant while you’re, like, obese and stuff. Or like, if you’re overweight that you have a really hard time, and, you know, it’s not good for your baby, and I’m like, “Oh shit!” and that’s, like, really scary to me.

As she fears the emotional impact of another abortion and how her body size may threaten future family planning, Ivy continues to experience anxiety surrounding her contraceptive use and refrains from penetrative sex when she would normally be “ovulating.”

5.5 Alice

Alice is a “nerdy” 23-year-old white woman whose journey with contraception began when she was 11-years-old. Alice experienced heavy, irregular menstrual periods that “made for some awkward conversations” when she was questioned about her frequent washroom visits and had to tell her teachers: “I don’t want blood all over your classroom.” In addition to profuse bleeding and cramping that felt like “a bowling ball trying to like break out of [her] skin,” Alice also experienced significant mood swings, headaches, and digestive issues that accompanied her menses. Consequently, her mother scheduled an appointment with their family doctor and requested a prescription for Alice to begin using OCPs. Suffering and terrified, Alice entered the realm of contraception from a place of desperation to regain control of her body.

Contraceptive use initially provided some relief, as the OCP “reduced the symptoms, but it didn’t get rid of them.” Alice used this contraceptive for several years until her menstrual cycle began to change and her symptoms became increasingly painful. Upon sharing her concerns with her family doctor, Alice was referred for a pelvic ultrasound and prescribed a different OCP. When the ultrasound did not detect any irregular pathology, her doctor “played the roulette” to find a contraceptive that would control her symptoms. In doing so, however, Alice often felt excluded from conversations about her own body. Throughout the next few years, Alice’s doctor cycled her through two more OCPs with little discussion or success, as she recalled:

Um, typically what would happen is he’d say, “You’re going to try this one.” And then the discussion would be done, no matter what I wanted. [...] [T]here was no open for discussion, there was no “Okay, which one do you want to try? Um, here’s the side effects, here’s what you’re likely to experience based on the experiences we’ve had, the tests we’ve done with your body here.” None of that happened. None of it. It was just, “You’re going to try this. We’re going to see what happens. Have fun.” My concerns were not valid.

Besides the OCPs “not working,” Alice was distressed by her increasing body size. Having always been a “bigger girl,” Alice repeatedly requested a prescription that would not impact her weight, but was told that weight gain was inevitable. Given the scant dialogue surrounding her contraceptive care, Alice had to ask her pharmacist or browse the Internet for information about each new prescription. It was not until university that Alice saw another doctor and learned that she had a contraindication for all the OCPs that her family doctor prescribed (i.e., COCs). She then used a progestin-only OCP for a few years, albeit it did “nothing” to manage her symptoms.

Alice was adamant about using external condoms when she became sexually active. After spending the afternoon with a new casual partner a few years ago, Alice panicked when she realized that she had unprotected sex. Her partner lied about using contraception, as Alice declared: “He never took a condom off. He wasn’t wearing a fucking condom!” She tried to take her OCPs at the same time every day, but knew that she had missed a pill earlier that week. In tears and unsure what to do, Alice phoned her mother, who tried to comfort her and suggested that she seek emergency contraception and STI screening. After calling to confirm that Plan B® was available, Alice drove to the pharmacy with a friend. When she requested Plan B®, the pharmacist responded, “Which one of you is it for?” and asked for her weight. He proceeded to tell Alice that she could purchase Plan B® if she wished, but warned that LNG-EC was “pretty much not effective at all” for women who weighed over 165 pounds. Alice became “a mess of emotions,” as she not only felt embarrassed that “lots of people” overheard their conversation, but also explained:

I was really scared because now my failsafe’s gone. I’m angry ‘cause, like, I didn’t choose my weight at that point, like I – I’d been fighting it and fighting it, but like, I was still gaining weight. Um, and like, at my height 165 [pounds] would be – it’d be very, very, very, very thin. Um, so I just, I was like, “Okay, so now, like big girls – do you mean because

I'm fat or because I'm tall?" Like, which – which one? Like, and honestly, I felt a little jealous of women that were smaller. I mean, why is everything built for them, why not – why is there nothing that I can use to protect myself? Because it's not just smaller girls that face things like this. We do too, but there's no – no Plan B for us, I guess.

The pharmacist did not present any alternative options, so Alice purchased Plan B® “just in case.” She left “feeling lesser because of the size of [her] body” and returned home to take the emergency contraception, call her mother, and cry herself to sleep.

Alice did not experience side effects upon using Plan B®, which made her believe that it was not working. Consequently, she felt afraid, tense, and anticipated the need to take a pregnancy test. However, she no longer cared about menstruation when her human immunodeficiency virus (HIV) test results were inconclusive and she was sent for repeat testing. Having felt like a helpless, anxiety-ridden, “rundown version” of herself throughout the entire experience, as it was “almost like the world didn't care what happened to [her],” Alice was relieved when her second HIV test came back negative a few months later.

Throughout the next year, Alice's menstrual pain worsened significantly and she became desperate for a new method of contraception. Her family doctor finally offered her a choice: Alice could try another OCP or she could be referred to a gynaecologist for an IUD consultation. Her doctor also noted that she had basically “gone through all [the OCPs],” so Alice sensed that she did not *really* have a choice between the two and opted for the IUD.

Alice was “terrified” when she arrived at the gynaecologist's office, but was soon put at ease by the “comfortable” waiting room and “genuinely nice” staff. After discussing the options with the gynaecologist, Alice felt confident in her decision to select an LNG-IUD and have it inserted that day. Although she was embarrassed by the lack of privacy when she picked up the

prescription at the pharmacy, Alice returned to the office and was calmed by her gynaecologist's helpful explanation of the insertion process. She experienced discomfort during and following the procedure, but the cramping was far less painful than her regular menstrual symptoms.

Despite some weight gain and initial uncertainty about how her body would react, Alice now describes her LNG-IUD as a "Godsend." Her menses are still "highly irregular" and "very, very, very painful," but Alice is grateful that she is no longer "incapacitated" by her symptoms and needs not worry about a daily regimen or emergency contraception. Nonetheless, she continues to feel frustrated that she cannot control her body size and wishes for better access to highly-effective emergency contraception for women in larger bodies. Under the care of her gynaecologist and a new family doctor who helped to diagnose her with PCOS, Alice now feels genuinely supported in her contraceptive care.

5.6 Summary

The five participant stories presented in this chapter provide a glimpse of the considerably diverse contraceptive experiences captured in this study. The social identities and personal contexts that formed the basis of participants' lived experiences often became interwoven into their accompanying contraceptive journeys. Moreover, health care providers evidently played a crucial role in women in larger bodies' experiences, as participants described how health care encounters shaped the ways they engaged with and felt about their contraceptive care and use. Throughout the next three chapters, I will attempt to delineate some of the similarities and divergences in women in larger bodies' lived experiences with contraception by presenting broad themes that hold significant meaning for various participants, while using subthemes to highlight nuanced experiences. Chapters 6 and 7 are dedicated to routine contraceptive use and care, respectively, and Chapter 8 focuses on emergency contraception.

Chapter 6: Embodied Contraceptive Use

To understand how contraceptive use becomes embodied by women in larger bodies, this chapter will examine participants' lived experiences with routine contraception. Participants reported using female-oriented routine contraception for the first time when they were between 11 and 23 years of age, with the majority initiating use before the age of 20 years. There was variation in how women in larger bodies came to use contraception, with some participants requesting it themselves and others being directed by their health care providers or parents. Many participants were originally prescribed contraception for non-contraceptive purposes, including menstrual management or acne control, and several women initiated contraceptive use for pregnancy prevention. Some women tried routine contraception for a limited period of time before deciding to discontinue use, but many participants were long-term users.

Women in larger bodies' experiences with routine contraceptive use varied greatly, ranging from "horrible" to "amazing," with many experiences falling somewhere in between. The overarching theme of control was common across all women's lived experiences, with participants sharing a common understanding of contraception as a means to prevent pregnancy and regulate menstruation. Some participants also viewed contraception as a source of security, freedom, or empowerment that gave them control over their bodies and their lives. The extent to which control was emphasized and whether it was achieved depended on the context surrounding the use of contraception. Given the complexity and diversity of participant experiences, I will explore women in larger bodies' journeys with routine contraceptive use and control. Participants' experiences were highly personal and the meanings they assigned to their contraceptive use sometimes changed over time, and therefore, the findings are not meant to represent fixed or mutually exclusive ways of understanding, but rather predominant themes of

meaning in a fluid and evolving relationship. In this chapter, I present five themes: (1) Feeling Out of Control; (2) Negotiating Control; (3) Feeling Empowered; (4) Experiencing (In)Convenience; and finally, (5) Feeling “Normal.”

6.1 Feeling Out of Control

As previously mentioned, women in larger bodies used contraception to gain a sense of control, whether that be for menstrual regulation, family planning, or otherwise. Throughout the interviews, however, several participants described largely negative experiences with contraception and their bodies more broadly. Consequently, participants found themselves in a state of disarray where they felt out of control surrounding their contraceptive use.

6.1.1 Menstruation Run Amok

Many women’s experiences with contraception were shaped by their menstrual cycles and symptoms. Numerous participants indicated that they had “painful” or “irregular” menses characterized by cramping, unpredictable bleeding, or heavy flow, often manifesting as a combination thereof. For some participants, this pain was debilitating. The notion of “erratic” menstruation was exemplified by Antara, who was prescribed OCPs for PCOS management when she was a teenager. Describing her menses and early experiences with contraception, Antara shared:

I used to have really bad cramps, to the point where I had to call in sick to work. Um, yeah, and then, at times I also would have fever and uh, like, it wasn’t a pleasant thing for me. Like, having my periods was [a] very bad experience, I’m kind of happy I don’t get it [now]. But at the same time, kind of worried as well. [...] First pill, yes, the cramps did improve, my periods, um, were heavy, um, and I used to get really sick as well. I would throw up, very dizzy, the feeling of weakness, um, and fever. Like I would, you know, you could get the fever from exhaustion. Yeah, I would have, like, I wouldn’t get sick, but just be running a fever

or my body would be really warm. Um, headaches. Just – just a very discomforting feeling.

Although Antara’s cramps improved, some of her “discomforting” menstrual symptoms nonetheless persisted with her first OCP. Thus, while several women used contraception to help manage their menstrual cycles, participants sometimes experienced partial or no relief.

Unfortunately, some participants were perpetually unable to control their menstrual irregularities. A few women described an arduous journey as they tried to find a method of contraception that would alleviate their affliction with their bodies. For instance, Sloane’s mother encouraged her to seek OCPs for acne treatment when she was 15-years-old, but Sloane also experienced “really, really awful periods” that could not be regulated, let alone contained, by contraception. Sloane had “full periods” if she missed a single pill and continued to experience breakthrough bleeding even after switching to a different OCP. She briefly tried other methods but felt too anxious using the vaginal ring, which also caused discomfort during sex, and her LNG-IUD spontaneously expelled from her uterus within the first 12 hours of its insertion. Sloane ultimately returned to OCP use until her symptoms became unbearable and she insisted: “I can’t live with these periods and this pain anymore!” With the help of medical imaging, Sloane has since been diagnosed with adenomyosis and endometriosis. Her symptoms are now being managed with a non-contraceptive hormonal medication, albeit the pain quickly returns if she misses a few doses. Overall, Sloane’s unrestrainable menstrual cycle and symptoms were central to her experiences with contraception and will likely continue to impact her reproductive health in the future.

6.1.2 Feeling at Odds with the Body

Many women felt that contraception was sometimes, if not always, at odds with their bodies. Participants experienced side effects that were disruptive to their physical and mental health, often resulting in method dissatisfaction and discontinuation. Participants described a myriad of symptoms that they attributed to their contraception, including but not limited to depression, anxiety, weight gain, menstrual disruption, migraines or headaches, acne, pain, nausea, and decreased libido. In this way, the opportunity to gain control of their bodies came at a cost. While some women were able to manage or minimize these disturbances, others were left feeling out of control due to the tenacity or severity of their side effects.

Some participants noted physical changes that negatively impacted their wellbeing. This concern was expressed by Alice, whose story was introduced in Chapter 5. Alice noticed that she gained weight with each contraceptive she used, an effect that persisted “regardless of what [she did] to mitigate it.” Reflecting on what it meant to face this side effect time and time again, Alice declared:

I don't want to be any bigger than I already am. I am already fighting with my body to get it back down to [a] healthy weight [...] having to fight my birth control to be able to do that is very frustrating. And it kind of makes me feel, when I put on a lot of weight because [of] my birth control, that in order to protect myself, I have to be less aesthetically pleasing in society and I have to kind of hide my body more and I don't like that. I really fucking hate it, honestly.

Frustrated and painfully aware that contraception was constantly at odds with her body, Alice felt that she did not have any options that would not give her “an even bigger body.” Weight gain had a deteriorative effect on her body image, as Alice felt that she had to “hide” her body from the public eye. Thus, despite being content with her current LNG-IUD, Alice feared the future,

as she knew that when her IUD is removed and she transitions to her next contraceptive, she will still be unable to prevent her weight from increasing.

Some women experienced new or elevated mental health effects that left them feeling distressed about using contraception. Participants who disclosed anxiety or mood disorders tended to feel more profoundly impacted by changes in their mental health. For instance, Sultana suggested that OCPs “nullified” the effect of her antidepressants. Sultana was prescribed OCPs for pregnancy prevention when she was in university, but discontinued use after feeling that contraception did “more harm than good.” In addition to gaining a significant amount of weight, Sultana professed that she was greatly concerned about her rapidly declining mental health:

[I]t impacted my, like, depression as well – like very severely. Like, I had to, like, drop out of the semester, um, because I was just, like, not feeling anything. I was, like, very numb. I was not going to school, um, I was not, like, taking care of all the things that I should. So um, after that, like, I just decided that, like, it was not something that I wanted to, like, pursue. It – like, I was like, “Okay, you know what, if I’m, like, having sex with my partner, I would rather just, like, stick to condoms,” at that point in time.

Contraception impacted Sultana’s depression so intensely that she was unable to complete her coursework, and she later admitted feeling suicidal during that time. While she recognized the preventative benefits of using OCPs, she believed that they were acting directly counter to her antidepressants and hence, her overall wellbeing. One decade later, Sultana was offered OCPs to manage her newly diagnosed PCOS; however, given her history, she firmly stated that she would only accept an LNG-IUD. Sultana’s IUD was recently inserted and her body was on a “heavy bleeding cycle” at the time of the interview, but she was glad that she had not experienced any “severe” mental health effects. Together, Alice and Sultana’s experiences exemplified the harmful impact that some women felt contraception had on their physical and mental health.

Finally, three participants suggested that their bodies had rejected contraception. Upon using a new contraceptive, these participants experienced acute physical effects that they interpreted as their bodies' noncompliance with contraception. For instance, Barbara repeatedly stated that her body "did not like" contraception. After briefly using OCPs during her adolescence, Barbara initiated use again when she was 20-years-old, but quickly became worried that she had developed blood clots. She recalled:

I never had a problem before and then my legs would start hurting in the middle of night, I would get cramps, my heart would race. I, you know, I used to get headaches – I never had headaches before. You know, I thought it was like blood pressure, they tested me, they said my blood pressure was high – I never had blood pressure problems before. So, at that point I assumed, "Okay, it's the pill."

Emphasizing the personal novelty of these symptoms, she concluded that her body had rejected the OCPs and later stated: "you shouldn't feel horrible taking medicine that you know is going to help you." As a result, Barbara discontinued her contraception and decided that it would be "safer" to use external condoms exclusively.

In comparison, Quinn and Sloane struggled for years in search of a method of contraception that worked well for their bodies. Quinn continued to experience extreme OCP side effects and, as previously noted, Sloane was unable to control her menses and anxiety. Both participants hoped that LARC would provide a solution to their respective issues, but their optimism was curtailed by the displacement or expulsion of their IUDs. Quinn tried the Cu-IUD on two occasions, only to be met with pain and disappointment each time. They explained:

Um, both times I had my IUDs inserted were inc – extremely traumatic [...] like, my body was just so not willing to cooperate. Like, they had a hard time getting it in, I remember bleeding a lot. Um, I felt terrible, I thought – I honestly just remember feeling like a trapped animal on the table. And then a couple of weeks later, I could feel it in my cervix – that

like bottom part of the T on your little, your IUD. And so, I went to [the hospital] and I got a nurse practitioner and she did a very rough manual exam on me as she said, “Well, I can’t feel it, it’s fine.” And I said, “No, I know it’s there, I know it’s out of place, it’s not [fine].” [She replied,] “No, no, it’s fine.” And then sure enough, a couple of days after that, I was having cramping and pain and I was – like I could feel the base of the IUD, just the opening of my cervix, and I went back [to the hospital] and I was like, “Somebody needs to take this out of me because I am very uncomfortable.”

Quinn felt that their body was “not willing to cooperate” with contraception and had earlier stated that both IUDs “came out in no time on their own.” As such, Quinn believed that their body was at odds with intrauterine contraception, which led to their uterus rejecting it completely. However, this perception was not limited to Cu-IUDs. Following these experiences, Quinn used a vaginal ring for four days, but established that they were “super allergic” to it upon experiencing significant pain and tissue damage. After trying “pretty much everything available” without success, Quinn eventually concluded that their body “rejected everything, essentially.” The perception of contraceptive rejection was upsetting to participants, as the failure to find a suitable method of contraception may have, in a way, signified the unruliness of their bodies.

6.1.3 Distrust, Defeat, and Damage

Some participants did not fully trust their contraception because they did not believe they could truly achieve control through its use. A few participants described how the vaginal ring invoked concern about imperfect placement or timing of use. In contrast, when Barbara used OCPs for pregnancy prevention, she admitted: “I still used condoms because [...] I don’t believe in a pill being a wonder worker, you know – you know, that can do everything. I don’t believe that at all.” Barbara wished that there were more contraceptives “catered towards larger bodies,” as her options were limited to “invasive” IUDs and untrustworthy OCPs, which compelled her to rely on her partner’s use of external condoms following her experience with OCP side effects.

Coupled with distrust, a few participants felt defeated following their dissatisfactory experiences with contraception. Both sentiments were expressed by Quinn, who finally obtained a tubal ligation after a long and “complicated” journey with routine contraceptive use. Reflecting on their time using reversible methods of contraception, Quinn confessed:

I wanted to trust in the contraceptives I was using. I really wanted to have found a solution that would help me to really confidently have sex and not be terrified the entire time that it was going to be making a baby or having, you know, causing a pregnancy. So yeah, like, I would say, like, yeah, there was just a lot of tension in my body before [the tubal ligation], because I didn't completely trust my – my contraceptive. It's like sitting on, like, I don't know, a swing in a school playground where you're like, “I am an adult and in an adult body. I don't know about this swing; I'm just going to sit on it and see what happens.” And that's kind of what contraceptives felt like to me, where it was like, “Uuugh! They told me it would be fine, but we'll see.”

Through the swing analogy, Quinn not only expressed a distrust in contraception to uphold its purpose, but also a distrust in their own body to respond well to contraception. What is more, Quinn knew that LNG-EC may be less effective for their body weight, which left them feeling frightened and stuck between “a rock and a hard place constantly,” as Quinn woefully proclaimed: “there was nothing available to me to keep me from getting pregnant [...] it was like abstinence or abortion. And there was nothing in between for me because I was fat.” As this quote suggests, participants who struggled to manage their symptoms or side effects sometimes expressed pessimism or resentment towards their contraception or their bodies. In Kendra's case, OCPs contributed to her anxiety rather than alleviating her menstrual cramping. Although she continued to use contraception for a few years because she was “naïve” and unaware of other options, Kendra recalled thinking: “maybe there's no solution to it, like this is just my body; this is the pain.” By centring themselves and their bodies, Quinn and Kendra also alluded to their perceived responsibility, in part, for their bodies' dissatisfactory responses to contraception.

Finally, two women who were no longer using contraception implied that they had been damaged by lingering side effects. While the impact of the anxiety that Kendra associated with her experience with contraception was “still with” her seven years later, Antara experienced new, heightened, and improved side effects after concluding a nearly 16-year-long journey with OCPs. Antara had experienced a range of side effects throughout her use of contraception, but noticed significant changes in her wellbeing when she discontinued OCPs two years ago. At first, Antara endured a very difficult transition period, as she explained:

[T]here was weight gain, but there was also really, like, for the first few months, my headaches were really, really frequent. Like, every other day I had a headache. [...] And that also, like, I was very moody. It caused extreme mood swings, like, I would realize that this is a mood swing, I know this was happening. Um, depression, um, sudden out – like – like emotional outburst. Like, you know, when you get upset and, uh (sighs), you just become emotional at everything. Like, you start crying for no reason and stuff like that. So, the first few months were really difficult after I got off the birth control pill.

By describing her mood changes as “sudden” and having “no reason,” Antara suggested that her emotions were out of control. Moreover, she later noted that she had previously experienced episodes of low moods; however, she felt that the “striking difference” was that she was diagnosed with anxiety and depression after discontinuing contraception. Overall, these physical and mental health symptoms made Antara “regret” her long-term contraceptive use, as she believed that “the damage [was] done” and her body needed to “recuperate.”

6.2 Negotiating Control

Common across many participants’ journeys with routine contraception was the process and experience of negotiating control through the use, and sometimes subsequent adjusted use, of contraception. Again, control did not come without a cost, as long-term users typically

tolerated certain side effects or inconveniences in consideration of their sexual and reproductive health needs. For instance, several participants noted that they disliked or struggled with user-dependent contraceptive regimens, such as the daily use of OCPs. When women felt that they could not achieve adequate control with their method of contraception, they tended to adjust their contraceptive use to regain a sense of control.

6.2.1 Prioritizing Needs

Women often negotiated control by considering what they could and could not tolerate, thus prioritizing their needs. By weighing the benefits with the costs, participants rationalized their ensuing decision to continue using contraception. For instance, using contraception properly and consistently became a “dire” need after Roxanne and Ivy both experienced an unintended pregnancy while misusing their OCPs. Roxanne had been using contraception to manage her heavy menstrual periods since she was 13-years-old, but her priorities sharply shifted towards pregnancy prevention following her abortion. After switching to the contraceptive injection for greater reliability, Roxanne began inquiring about sterilization in her early twenties. Her requests were largely unsuccessful until recently, and as a result, she subsequently used several methods of contraception, including vaginal rings, OCPs, and an LNG-IUD. Roxanne was never keen on hormonal contraception and struggled with user-dependent regimens; however, she feared another abortion and hence continued to prioritize pregnancy prevention through routine contraceptive use. Likewise, Ivy had a history of unpleasant side effects and inconsistent access to contraception, but she maintained OCP use following her abortion. Although both women are currently content with their respective contraceptive methods, Roxanne and Ivy still experience some anxiety surrounding their contraceptive use, which

suggests that women may continue to negotiate control over their bodies while prioritizing their needs.

Other women discussed prioritizing their needs with respect to menstrual management. For instance, following years of on-and-off use due to long-standing concerns about weight gain, Beyoncé began using contraception consistently after she was diagnosed with PCOS and her symptoms eventually became too much of an “irritant.” Additionally, several participants negotiated control by tolerating menstrual disruption while their bodies adjusted to a new contraceptive. While Sapphire considered herself an IUD advocate, she did not initially like her intrauterine contraception, as she explained:

At the beginning with the IUD, it was about three to six months before I decided I liked it. It was very um .. like, lots of cramps and stuff at first, but they – they told you that, like she said, “It’s gonna be weird for a few months, and maybe unpleasant, but then it’ll be good. Trust me.” So I just stuck it out and she was right. Um, so yeah, it was really, um, unpredictable periods and spotting and stuff and cramps, and for the first few months, and then it levelled out.

By “st[i]ck[ing] it out,” Sapphire prioritized her long-term needs over her initial menstrual disturbances and was eventually able to benefit from her new contraceptive. This sentiment was reported by some of the other IUD users who described enduring uncomfortable or agonizing insertions and menstrual side effects before ultimately feeling satisfied, as Roxanne recalled, “the actual [IUD insertion] process was one of the most painful experiences I’ve had in my life.”

In a few other instances, participants were prompted to prioritize their needs when side effects or disturbances developed over time. This negotiation of control was demonstrated by Steph, whose OCPs managed her endometriosis symptoms for many years. She recently began experiencing new menstrual disturbances following intentional weight loss, which made her

believe that “the pill is not as effective” anymore. Steph is now less satisfied with her contraception; however, she also experiences medical anxiety and internalized weight stigma from years of what she described as feeling “brushed off” or stigmatized during health care. Considering that her menstrual health is still “significantly” better with contraceptive use, she has not addressed her concerns. While this decision suggests that Steph prioritizes the menstrual benefits that she is afforded through OCP use, it also emphasizes how weight stigma has impacted her experiences with contraception, as she admitted: “if I didn’t have [medical anxiety], I would definitely be on a different pill right now or even a different form of contraceptive.”

6.2.2 Perceiving (In)Stability

Some women negotiated control to gain stability that they believed had been lost to method-related inconveniences or side effects associated with the use of contraception. A few participants attempted to endure side effects before ultimately seeking a new contraceptive to correct their embodied sense of disarray. For instance, when Luna began using OCPs for acne treatment when she was 19-years-old, she wanted to ensure that her contraception would be minimally disruptive to her mental health and ongoing intentional weight loss. While her needs were met, Luna also began to experience breakthrough bleeding, as she described:

I would have my period for like two weeks, but it was, like, it wasn’t [a] full-blown period. Um, it’s like I would have two weeks where I would have absolutely no breakthrough bleeding or anything, and then for two weeks I would have, like, very light spotting, but enough that I didn’t want to wear my underwear. Um, so it was enough that I felt like I needed to wear a pad, and wearing a pad for two weeks just really is uncomfortable and inconvenient.

Given her discomfort, Luna eventually wanted to correct her menstrual cycle disruption.

However, her symptoms persisted when she tried a higher dose pill, which prompted her to

switch to a third and final OCP that stifled her breakthrough bleeding. Although she now believes that these menstrual changes may have been associated with her weight loss, Luna valued the acne treatment that contraception provided and thus negotiated control over her body by trying new prescriptions in search of an OCP that curbed her side effects to stabilize her menstrual cycle.

For other women, gaining stability was more complex. When Beyoncé began using contraception for pregnancy prevention at 18 years of age, she believed that she would have “the most control” with OCPs. Yet, she struggled with the daily regimen and eventually switched to the vaginal ring for greater convenience. As previously described, Beyoncé also tried to gain stability by using contraception on an on-and-off basis to manage the weight gain she experienced with both methods. Stating, “it’s almost like my chest deflates!” when she temporarily discontinued her contraception, Beyoncé explained that her weight was “a personal concern, more than a health concern per se.” To complicate matters further, Beyoncé’s PCOS meant that when she stopped using contraception to stabilize her weight, her menses were irregular. Regardless of her need for consistent contraceptive use for menstrual regulation and pregnancy prevention, Beyoncé negotiated this control for several years to maintain some stability in her body size.

6.3 Feeling Empowered

Several women described feeling empowered by contraception, as it liberated them to take control of their bodies and their lives. Some participants were content with their first method of contraception, while other women navigated the use of various contraceptives before finding one that adequately met their needs. As such, empowerment was not necessarily a destination, but rather a journey.

6.3.1 *The “Better” Body*

After finding a good fit, numerous women explained how contraception ultimately improved their relationships with their bodies. Feeling “better” while using contraception was often associated with symptom control and minimal unwanted side effects. For instance, the last chapter featured Tuck’s experience using contraception for PCOS management. Tuck felt “lucky” that her body responded “really, really well” to OCPs and thought that contraception had “done exactly what it’s supposed to do,” including the regulation of her hirsutism and menstrual cycle. Similarly, women were pleased with the non-contraceptive benefits that their contraception provided. Although Sapphire did not begin using contraception to manage her menstrual periods, menstrual regulation became central to her experiences, as she declared:

I have horrible, horrible periods. Just awful. And [contraceptives] really help. With the IUD actually, I haven’t had an actual period in, like, a couple years now [...] which I love (chuckles). Like once in a while, like, maybe like every six months or something, I’ll have, like, a little bit of cramping as though I’m going to [get my period], but not nearly as bad, but then I don’t have it. [...] And when I was on the pill, it – I still got my periods, but they were much more regulated and very short, and um, really, really helped with cramps and stuff. So, I like being on it all the time. Whether or not I’m having sex or not.

While many participants were negatively affected by bothersome side effects at one point or another, Sapphire’s experience demonstrated the positive impact that contraception had on some women’s bodies.

6.3.2 *Feeling Confident*

Contraception empowered some women to feel confident in themselves and their relationships. When participants had trust in their use of contraception, it faded into the background and allowed them to live their lives more fully. The notion of confidence was

sometimes discussed with respect to non-user dependent methods of contraception, which freed women from worrying about correct or perfect use. Some participants noted how these contraceptives provided them with “peace of mind.” For instance, Liliae began using contraception for pregnancy prevention when she was 16-years-old and selected the contraceptive injection for its high efficacy, “get it and forget about it” regimen, and ability to suppress her menstrual periods. Liliae happily received the injections for many years, but recently had an LNG-IUD inserted after experiencing hair loss that may have been attributed to her contraception. Undeterred by the contraceptive injection’s possible side effect and the initial pain from her IUD insertion, Liliae was very content with both methods overall. Reflecting on her experiences using contraception, she gushed:

I feel great, honestly [...] I don’t really have, like, mood swings and I just feel more like myself. I haven’t really – yeah, I’ve had no other side effects so, like, I feel great. Like, the peace of mind is fantastic, the fact that I don’t have to worry about menstruating is amazing – like, super happy about it.

Contraception empowered Liliae to feel confident in her body and her ability to prevent pregnancy. By indicating that she was able to “feel more like [her]self,” Liliae additionally suggested that contraception not only enhanced her health, but her embodied sense of self and personal life as well.

The multifaceted benefits of contraceptive use were further illustrated by Mavis, who was introduced in Chapter 5. Mavis began using contraception to prevent pregnancy, but also explained that contraception had improved other aspects of her life:

I think that contraception’s really been a great factor in our relationship. You know, I’ve been able to talk openly with my partner about when we plan on going off of contraception. And I’m lucky to have a partner who’s really supportive of my decision to be on birth control and who’s

really supportive of, eventually, my decision to be off of birth control. So, I think that it's – it's just really allowed me to, um, you know, be in a very healthy relationship.

While most participants discussed contraceptive use as a highly intrapersonal phenomena, Mavis' experience demonstrated how it also helped her to feel confident in the “very healthy relationship” that she fostered with her partner, who played an active and supportive role in family planning discussions.

6.4 Experiencing (In)Convenience

While many participants had complex or polarizing experiences, two women suggested that contraception was merely an (in)convenience that held little significance or meaning in their lives. Gwen began using OCPs to suppress her menses during a summer job when she was 16-years-old. As she enjoyed avoiding the “ugh! Grossness of, like, having a human body,” Gwen continued using her contraception. She is still taking OCPs now at 26 years of age, but she is not sexually active and has “never really paid any attention” to her contraceptive use beyond noting some occasional menstrual spotting. Thus, although Gwen has momentarily considered re-evaluating her long-term contraceptive use, she will likely continue to take a *laissez-faire* approach as long as she benefits from the convenience that OCPs afford her through menstrual suppression.

Alternatively, contraception represented more of an inconvenience for Gia Grace, whose story was highlighted in the previous chapter. In consideration of her unchanged menstrual symptoms and “hectic” personal schedule, Gia Grace decided to discontinue OCPs, as she explained: “it didn't feel, like, necessary to go through the struggle of going to the pharmacy, getting the meds, reminding myself daily if it wasn't helping me in the end.” It was interesting to

learn that Gia Grace did not try a different method of contraception; however, by referring to accessing and using OCPs as a “struggle,” she implied that using contraception was inconvenient. Parallel to this sentiment, Gia Grace recently decided against initiating contraceptive use, as she confessed:

I was just overwhelmed with the decisions and trying to find the best route, and didn't want to be, like, trying one avenue and it didn't work, and then try something new. Because I've done that for other things and it's just so frustrating when something doesn't work out, then you have to try multiple other sources and, like, ways to do it to get what you want. And in the end, if condoms are working for me, why would I go through that headache?

Evidently, Gia Grace anticipated that it would be challenging to find a satisfactory method of contraception. By referring to the process of selecting and using contraception as a “headache,” Gia Grace suggested that she valued the convenience of external condoms over any labour (e.g., emotional, physical, financial, or otherwise) that she may need to endure to use female-oriented methods.

6.5 Feeling “Normal”

Lastly, participants who used contraception on a long-term basis often explained how, for better or for worse, contraception became part of their lives. Women in larger bodies consequently described a sense of normalcy surrounding their experiences with routine contraceptive use.

6.5.1 Normalizing Use

Regardless of the method or how “perfectly” it was used, the act of using contraception was often normalized by long-term users. As such, while they may not have had control over how their bodies responded to contraception, participants achieved a different sense of control

through the integration and subsequent routinization of contraceptive use into their everyday lives. For instance, though it took time for Luna to find an OCP that did not disrupt her menstrual cycle, using contraception was always “minimally invasive and annoying,” as it became part of her nightly routine with the help of an alarm. Likewise, Antara used OCPs for nearly half of her life and explained: “I was on it for so long, it was like, it was normal, it was like having food. [...] [I]f you’re hungry, you eat it. Like this is, like, a pill you take every day.” Comparing her OCPs to eating food, Antara suggested that using contraception became instinctive. This attitude was echoed by Gwen, who took multiple medications each day. Emphasizing the mundanity of using contraception, she shared:

I feel like I’ve been on it for so long and it’s for something that’s so, like, like, low impact in my life. Like, it’s just like, “I just don’t have a period” that it’s just – it feels so normal. Like, I have a lot of other medical conditions. [...] I take lots of different pills, every day (chuckles). Um, and so it’s just, like, it’s part of life – you know, I take three pills in the morning, two pills at dinner and then one pill before bed, and it’s just kind of, like, part of life.

Gwen had been using her OCPs for the last decade of her life, and hence contraception had become an integral, albeit unremarkable, part of her daily routine.

6.5.2 *The “Normal” Body*

In addition to normalizing the act of using contraception, several participants described how their bodies also felt “normal” at some point throughout their experiences with contraception. Some women began to feel a newfound sense of normalcy when they believed that their bodies had adapted to the hormonal influx that accompanied contraceptive use. For instance, after successfully managing her symptoms for a few years, Tuck hoped that contraception had “fixed” her PCOS and decided to see how her body would react if she

discontinued her OCPs for one month. Much to her disappointment, Tuck's hirsutism became "noticeably" worse during this time, which induced feelings of bodily disarray that prompted her to return to contraceptive use. Thus, while most participants reported missing an OCP dose from time to time, some women felt that the bodily changes they observed during longer lapses in use confirmed that the perceived bodily control and corresponding sense of normalcy they had become accustomed to were dependent on contraception.

While many participants could clearly articulate how their bodies responded to contraception, as seen throughout this chapter, some women also expressed ambiguity. A few participants noted that they were not particularly in-tune with their bodies, as Roxanne asserted: "my body and I, we don't really speak the same language." Nonetheless, long-term users sometimes became so acclimated to contraceptive use that its effects seemed to have become partially intertwined with their natural bodies – meaning that these participants could not distinguish whether certain changes they experienced were caused by contraception or otherwise. For instance, some women discussed uncertainty with respect to changes in their weight, emotionality, or mental health. Liliae explained that her weight had "ballooned" in her 15 years of contraceptive use and identified weight gain as a known side effect of hormonal contraception, yet she believed that several other circumstances could have also contributed to the observed changes in her body size. Moreover, as some participants' contraceptive use spanned a large portion of their lives, a few women could not imagine their bodies without it. When reflecting upon how her body felt when using contraception, Steph mused:

I feel like, because I've been on it for so long, I've been on it for like, almost half my life. I honestly can't remember what it was like to feel in my body not being on it. So, I personally don't – and like I – because I started to take it, like, right when I hit puberty, I don't know what it's like to be, like, in a – an adult woman's body without it.

Emphasizing that she could not recall her body being any other way, Steph's experience suggested that in some ways, long-term users may have come to understand contraception as part of their regular living bodies. In each of these examples, participants acknowledged their uncertainty but did not seem to investigate any further, thus demonstrating the minimal disturbance or low personal significance of this ambiguity, as their bodies truly just felt "normal" when using contraception.

6.6 Summary

When asked what contraception meant to them, most women discussed bodily control in terms of prevention and regulation. However, by highlighting different dynamics in women in larger bodies' embodied experiences with routine contraceptive use and control, this chapter revealed that the meanings that participants assigned to their lived experiences were usually more complex. While contraceptive use often became normalized over time, women's sensations of control over their bodies varied within and across participants, ranging from embodied feelings of unruliness to empowerment. Some participants had strong impressions of control or disarray, whereas others negotiated control over their bodies throughout their lived experiences with contraceptive use. For a few women, contraception was merely an (in)convenience that held little significance in their lives. Given that many participants were long-term users who had used more than one contraceptive, the findings demonstrated the dynamic nature of women in larger bodies' embodied experiences with contraception.

Chapter 7: Routine Contraceptive Care

Grounded in the context of embodied contraceptive use, in this chapter, I examine women in larger bodies' experiences navigating routine contraceptive care. Participants described their experiences accessing female-oriented contraception and receiving care in a variety of health care settings, such as independent or group practices, walk-in clinics, university health centres, hospitals, sexual health clinics, and pharmacies. In doing so, participants interacted with both prescribing and dispensing health care providers, including family doctors, nurse practitioners, gynaecologists, endocrinologists, and pharmacists. While several participants believed that contraceptive care was relatively simple to access, some felt that it involved more discomfort, screening (e.g., questions, Pap test), and surveillance than other health care.

Much like the previous chapter, my analysis revealed significant diversity in women's experiences accessing and using contraceptive care, with many participants describing both positive and negative interactions with health care providers. Consequently, I found that women in larger bodies' experiences with contraceptive care were shaped by feelings of (dis)empowerment. In this chapter, I present four predominant themes of meaning: (1) Experiencing Stigma; (2) Feeling Dismissed; (3) Taking Control; and (4) Feeling Supported.

7.1 Experiencing Stigma

Common across many participants' lived experiences was an overarching sense of stigma. Though most women did not explicitly refer to stigma, many participants described instances where they felt judged, embarrassed, or otherwise uncomfortable, which I interpreted as experiencing stigma. Participants sometimes experienced stigma in intersecting and overlapping ways, as highlighted in some of the stories shared in Chapter 5. Some participants

felt stigmatized by their health care providers or peers, whereas others succumbed to their own internalized stigma. To introduce this theme, I describe some contextual considerations that help situate women in larger bodies' experiences with stigma throughout their contraceptive care.

In general, many participants thought that contraception, or sexual and reproductive health more broadly, was uncomfortable to discuss. Some participants acknowledged, as Roxanne said, the “innately sexual” nature of contraception and, supposedly, its surrounding conversations. This sense of discomfort was distinct from other health-related topics, as some women noted that it was a cultural or social taboo to talk about menstruation, contraception, sexual activity, or female anatomy. For instance, Sloane explained that she was raised in a “small town and a very conservative religious family,” and as a result, she was not exposed to conversations about sexual health until she attended university. Similarly, discomfort with sexual and reproductive health was sometimes attributed to a lack of comprehensive sex education.

Although the interviews focused on contraception, weight was discussed by nearly all participants. Some women stated that their weight had never come up during contraceptive care, whereas others shared relevant experiences or pondered whether perceptions of their bodies had shaped the contraceptive care they received. For instance, certain participants believed that living in a larger body added a layer of complexity to accessing contraception. Mavis noticed “a tie between a larger body size and high blood pressure when it comes to prescribing contraception,” as her blood pressure was monitored more closely than her smaller-bodied friends, including those who were hypertensive. Despite making a “conscious effort” to relax before her appointments, Mavis experienced some anxiety about her blood pressure and occasionally wondered if she would be refused contraception if her reading was too high. Weight-related experiences were not always perceived negatively; however, like Mavis, a few participants

suggested that they may have received different contraceptive care had they been living in smaller bodies. For instance, Barbara was briefly prescribed OCPs when she first began menstruating at age 14 years because her doctors incorrectly *assumed* that she would have PCOS based on her body size. While she reflected more positively on her recent contraceptive care, in general, Barbara believed that medical education reinforced a “prejudice” towards individuals in larger bodies and expressed that some doctors seemed to look at her like she was “the disgustingest person in the world.” In this way, while the notion of weight stigma was sometimes relevant to contraceptive care, it was more frequently discussed in the broader context of women in larger bodies’ health care experiences.

Several women noted that weight was at the forefront of most of their other health care encounters, and many participants recounted at least one experience where they believed that their care was impeded by health care providers’ attitudes towards their bodies. Negative health care encounters ranged from observing “very subtle microaggressions” to more clear instances of weight bias, stigma, and, unfortunately, discrimination. To illustrate, Quinn explained:

As a fat person, the amount of fatphobia and gaslighting and, like, emotional abuse that I have encountered just trying to get basic care for things outside of reproductive health have made me avoidant of doctors. Um, I’m very, very, very skeptical of new health professionals. [...] Um, you don’t tend to have a trust for doctors when, again like, the only thing they ever wanted me to have when I was a kid was diabetes. And then that same doctor who diagnosed me with hypoactive thyroid also told me to my face, as an eight-year-old, that I was morbidly obese and told my Mom to stop sending me to school with lunch. Um, I have a real fear and distrust of doctors, so all of these years – I’m only now starting to really take care of my thyroid health because I’m doing it for me and I have a nurse practitioner who doesn’t – who doesn’t let fatphobia tinge her practice.

Such statements demonstrated the ways in which negative attitudes towards larger bodies impacted how some participants navigated and interpreted their interactions within the health

care system. Thus, weight stigma played a pervasive role throughout numerous women in larger bodies' overarching lived experiences.

Lastly, it is important to acknowledge that several women in larger bodies faced compounding stigmatization due to their intersecting identities. Additional discomfort was sometimes reported by participants who perceived an ethnic, cultural, or religious stigma, and those who described stigmatizing health care or contraceptive care experiences related to their sexuality, non-monogamy, mental health, or neurodivergence. Overall, experiencing stigma contributed to feelings of disempowerment among women in larger bodies.

7.1.1 Internalizing Stigma

Shaping the foundation upon which women in larger bodies' experiences with contraceptive care were built, previously established negative attitudes and stigma impacted how participants engaged with health care. Internalized stigma was commonly discussed with respect to women in larger bodies' stigmatizing experiences within the broader health care system, which subsequently influenced how they approached their contraceptive care. For instance, various participants shared how they exercised precaution when seeking new health care providers; experienced anxiety, discomfort, distrust, or exhaustion during medical appointments; or actively avoided health care unless necessary. Gwen, who had not spoken with a doctor about her contraceptive use since she was prescribed OCPs 10 years ago, admitted: "my absolute terror of doctors, which I think is largely caused by, like, being a fat person, has a really big impact on the way in which I interact with contraception." Even though Gwen used contraception for the convenience of menstrual suppression and was grateful that her experiences had been "smooth and unintrusive," she expressed some ambivalence by acknowledging that she should perhaps be receiving more contraceptive care. Gwen explained:

I don't know many fat people who like going to doctors, because it's just not the best experience most of the time. I hate getting weighed, I don't weigh myself except when they make me do it at the doctor's [office]. I don't like [it] – so for me, it's just always really, like, an anxiety-inducing, stress-inducing kind of thing. Which is, again, one of the reasons why I'm not like, "hmm I should sit down and talk to them about my contraceptive options!" Like, obviously I should, but like, I'm terrified of doctors, and I'm fine!

Given that she attributed her fear of doctors to her identity as a fat person, Gwen suggested that internalized weight stigma has, in part, contributed to her medical anxiety. Moreover, she also stated that she attended mandatory appointments for her other health conditions, but would never “voluntarily go talk to a doctor unless [she was] deeply unwell,” including contraceptive care. This attitude was affirmed by a handful of other participants who, at one point or another, avoided contraceptive care due to the impact of their other health care experiences.

In addition to weight stigma, participants also described internalized feelings of stigma related to stereotypes or social norms surrounding their contraceptive use. As previously noted, some participants were uncomfortable discussing sexual and reproductive health in general, whereas others felt that contraceptive care was particularly vexing because it revealed their engagement in sexual activity. Given their internalized discomfort, some participants refrained from sharing certain personal information, asking questions, or raising their concerns during contraceptive care. Kendra became sexually active when she was already using contraception for menstrual cramps, yet she was “shy” about telling her family doctor that the OCPs were also serving as “protection.” Stating that she did not feel comfortable discussing “anything sexual” with her doctor at the time, Kendra pointed out:

I didn't really want to talk to this 60-year-old man about, kind of, Tinder [dating application] and whatnot, and casual dating and one-night stands and stuff. And like again, this is like, I've switched doctors since, but it

was I think also that thing of like, this was the doctor that I had my entire life. So it just kind of felt like – it’s like talking to my Dad about it.

While Kendra expressed discomfort with regards to discussing her sex life with an older man, she also revealed the non-monogamous nature of her sexual relationships at the time. She later emphasized the importance of finding a doctor who was “open and non-judgemental” about casual dating, and hence it is possible that Kendra felt embarrassed or feared that she would be judged for her non-traditional sexual activity. Likewise, Sloane admitted that she used to be reluctant and ashamed to tell her doctors when she was having sex with multiple partners.

Women’s personal sense of stigma sometimes further resulted in avoidant behaviours or self-concealment when accessing their contraception. Tuck had long “jump[ed] through hoops” to bypass her family doctor when renewing her OCP prescription due to her internalized stigma and in reflection, she remarked: “I’d say the majority of my life, accessing health care has felt, like, uncomfortable because I’m fat and uncomfortable because I’m uncomfortable with talking about sex and reproductive health.” In comparison, Beyoncé frequently took pregnancy tests prior to initiating OCP use, so she often experienced “guilt and shame” when accessing contraceptive care. Although she did not necessarily recall any negative health care encounters with regards to her contraceptive use, she explained: “I’ve always kind of felt like there’s judgment because of my – my sexual activity or, um, what kind of led me to – to need or want contraception.” Propelled by her internalized stigma, this shame was not confined within the walls of her family doctor’s office. Beyoncé further explained that she masked her prescription when accessing contraception from the pharmacy:

Beyoncé: I don’t know why but I guess there’s still a little bit of embarrassment. And I can’t really pinpoint the reason for that. Um, and also, there’s a little bit of secrecy around the fact that I’m going to get birth control. Um, yeah.

Interviewer: And what do you mean by, like, secrecy?

Beyoncé: Like I'll make sure I get a bag to put the prescription in – or the uh, the – yeah, like, the medication and so it's not obvious what it is.

By concealing her prescription from the public eye, Beyoncé also hid her engagement in sexual activity and the embarrassment that she felt, thus avoiding any judgement that she may have anticipated. Somewhat parallel to this behaviour, Barbara accessed contraception from an “anonymous” clinic where she opted to pay for her OCPs out-of-pocket to avoid exposing her contraceptive use by using her father's insurance. Overall, internalized stigma prevented participants from fully and openly participating in their contraceptive care, which sometimes impacted the quantity and quality of care they received.

7.1.2 Perceiving Stigma

Several participants perceived stigmatizing behaviour from health care providers during their contraceptive care. Some women observed non-verbal cues, such as judgemental tone, staring, or agitated body language. For example, Roxanne was very perceptive to her health care providers' behaviour. In 26 years of contraceptive use, Roxanne interacted with many different health care providers, none of whom seemed particularly comfortable discussing her sexual health. Roxanne noticed that doctors rarely met her eyes when she initiated conversations about contraception, which resulted in “incredibly awkward” contraceptive care. She explained:

I'm generally pretty uncomfortable. I mean, you know, you take body language cues and stuff. If I say to a doctor, you know, “Oh and I have to, I have to talk about birth control,” then they kinda – and they kind of, like, they get – like they shift their position in the chair and everything and they get all uncomfortable and stuff and it's like, “Oh, okay.” So, if the doctor is uncomfortable speaking about these things, then like, I, you know, I tend to be pretty blunt, and just kind of lay it out there (chuckles). But if the doctor is feeling uncomfortable then I'm like, “Ooh” – I try to be careful about what I say. I don't always – I don't always bring up all the – all of the concerns that I have about things.

Because it's like we just – both of us kind of want the conversation to be over.

Admittedly, Roxanne became more reserved when she sensed that doctors were uncomfortable discussing her contraceptive care. By taking note of their fidgeting, Roxanne mirrored this uneasy body language in her own communication, as she asserted: “it's hard to have a level of trust when the person won't even look you in the eye.” Although she generally “la[id] it out there,” the stigma that Roxanne perceived hampered her ability to openly discuss her sexual and reproductive health. This barrier, in turn, negatively impacted the quality of care she received, as she may have avoided raising all her contraceptive-related concerns to avert further discomfort.

Alternatively, some women described stigmatizing questions or comments made by health care providers during their contraceptive care. The nature of such remarks included, but were not limited to, perceptions about participants' bodies, sexual activity, or agency. For example, weight was often discussed with respect to gynaecological conditions, such as PCOS, concerns about weight gain, and contraceptive efficacy. A few participants understood why these conversations were initiated and believed that their doctors did so in a sensitive manner, whereas others viewed comments about their bodies to be irritating and uncalled for. Steph's first family doctor focused on menstrual symptom management during her contraceptive counselling; however, she also warned Steph that her menstrual periods “may be worse” because of her weight. As a young girl recently diagnosed with endometriosis and newly menstruating at the time, this comment made Steph feel particularly insecure, as she explained:

I was 14, like, that's such a – like a young and vulnerable age [...] when I went to that appointment, like, I had just gotten my period like a few months before, like, it's something really new. I find, like, girls are like pretty self-conscious when they – when they first get their period. So it was just like, I don't know, it was just weird and super unhelpful [to

discuss my weight] because I felt, like, so self-conscious after [...] like, it wasn't the worst, like, most negative experience, but it definitely could have been better. Like, I felt like it wasn't very encouraging.

By weaponizing her weight, Steph was made to feel even worse about her body than she already did when she sought care for her irregular menses. Thus, in addition to the internalized stigma that some participants had established prior to accessing contraceptive care, Roxanne and Steph's experiences demonstrated how participants' perceptions of stigma during contraceptive care could become internalized as well, which further disempowered women.

Beyond inducing feelings of discomfort, verbal stigma sometimes led to contraceptive care avoidance. The impact of stigma was poignant for Antara and Sultana, who both perceived an ethnic or cultural stigma from health care providers with similar South Asian backgrounds. When they were each in their early twenties, a pharmacist told Antara not to have sex "just because" she was using contraception and Sultana felt pressured by health care providers who projected their religious values during her care. Reflecting on her first experience with contraceptive care, Sultana shared:

Um, it was very condescending, the doctor whom I had, um – and maybe it's like also, like, a part of the cultural background too. So like, um, lots of people at least don't talk about [contraception] in, like, the South Asian community, but because like, lots of people are severely, like, religious or like, have like, very like, um, cultural – like blind spots. Um, so one of the things is that, like, at least my experience with some of the doctors in the [city], was that, like, the first question they will ask [is] like, "Are you married?" And I was like that's – that's, like, not okay for you to ask me, like, I'm asking you about like my contraceptive options, so. And then they will ask like, "Why do you need it?" So that – that was my other thing that, like, I should not have to answer, but like, that – that was my very bizarre experiences with some of the doctors .. the first time around.

Characterizing the comments as "condescending" and "not okay," Sultana suggested she felt

stigmatized by the doctors' intrusive questions. In light of their experiences, Antara escaped further scrutiny by waiting until the pharmacist was not working or asking her sister to pick up her prescription, and Sultana avoided contraceptive use until she found a more respectful doctor.

Lastly, one woman described a stigmatizing contraceptive care experience that had a distinctively negative impact on her mental health and wellbeing. When Sloane was 19-years-old, she was referred to an "aggressive" older male gynaecologist for an LNG-IUD. She phoned the gynaecologist upon realizing that her IUD had been expelled merely hours after its insertion and was advised to return to the office for an examination. After sitting in the waiting room for more than three hours the next day, Sloane was finally taken in for her appointment and recalled:

I showed [the IUD] to him and he was like, "I don't know what's wrong, there's something wrong with you, you must be infertile, there's something wrong with your uterus," blah blah blah. And like, I'm crying and anxious, and – I can't control that my body expelled the IUD, like, I don't know what happened. And I just felt really shamed and uncomfortable. So after, I was – I just shut down, it wasn't good.

Not only was Sloane blamed for her spontaneous IUD expulsion, but she was also told that she "must" be infertile. This experience exemplified some of the hostility that women in larger bodies described facing both within and beyond contraceptive care.

7.2 Feeling Dismissed

Many participants reported situations where they felt dismissed by health care providers, leading to perceptions of suboptimal contraceptive care and unmet care needs. Women's perceptions of dismissal stemmed from a variety of experiences that ranged from feeling hurried to having their reproductive autonomy denied. This finding was specific to experiences with prescribing providers, wherein the patient-provider dynamic sometimes made participants feel powerless.

7.2.1 Heard...But Not Always Listened To

Many participants described one or more instances where health care providers did not listen to their expressed contraceptive needs or concerns. While some women believed that “the doctor knows what’s best,” participants became frustrated when they felt their voices were being undermined or neglected. Participants commonly described feeling dismissed when inquiring about certain contraceptive methods, expressing concerns about side effects, and articulating their lived experiences with contraceptive use.

The extent to which women in larger bodies were not listened to varied. Some participants sensed that they were not trusted or believed by their health care providers, whereas others felt utterly ignored. Sapphire, for example, recounted an “annoying” contraceptive care discussion that she had with her previous family doctor. When Sapphire explained that she was experiencing decreased libido and noted that it was a common side effect of her OCPs, her doctor simply responded: “no, that shouldn’t be happening.” He obliged when she eventually requested to try a different brand, but Sapphire concluded that their interaction “sucked.” In comparison, some participants described how health care providers attempted to persuade them to use a method of contraception that did not reflect their stated needs, disinterest, or previous experiences with harsh side effects. For instance, after undergoing a tubal ligation following several failed attempts to find a contraceptive that worked for their body, Quinn was still encouraged to use contraception for PCOS management. When their gynaecologist recommended OCPs, Quinn objected and gave a “whole spiel” explaining their experiences with contraception. Despite emphasizing how “bad” they always felt while using OCPs, Quinn’s concerns were brushed off and they were ultimately prescribed OCPs on two more occasions:

I told her, I was like, “Listen, this is going to do bad things to me and I really don’t want to do it.” (Sighs) And this is, like, an OBGYN [gynaecologist] who I’ve observed a lot of fatphobic behaviour from, so I wasn’t surprised that she didn’t listen to me. [...] I know my body but, you know, who cares?

By minimizing their complicated history with contraception and OCP side effects, Quinn’s gynaecologist invalidated their lived experiences, which may have, in part, reflected fatphobic attitudes. As they later described feeling “tired and exasperated” following these conversations, Quinn’s experience demonstrated how they were disempowered by interactions with health care providers who refused to consider, let alone acknowledge, their embodied expertise.

Unfortunately, this encounter was not the first time that Quinn’s voice was disregarded during contraceptive care. Participants who expressed interest in permanent contraception were frequently met with disapproval from health care providers, which ranged from “subtly shutting it down” to “almost being chastised” for making such a request. All three participants who requested surgical interventions recalled being told that they were either “too young,” they “may change their minds,” or that “nobody would sign off on it.” Such responses were frustrating and sometimes hurtful to hear, as participants oftentimes felt that discussions about permanent contraception were unproductive or disrespectful of their autonomy. Liliae recently began initiating conversations with her family health team about having a hysterectomy in the future, but noted:

I don’t know that they’re necessarily taking my point of view into consideration. Again, we’ve not really had in-depth conversations about it as of yet – I was just kind of, very early .. feeling out the waters with it, sort of thing. Um, but even with that early on, I feel like the conversation very definitely could have been like, “Let’s talk about it, like, this should be an option. Let’s see whether or not it’s the best option or if there’s a better option,” and that’s not the way the conversation went.

Although Liliae generally felt well-supported throughout her contraceptive care and understood why her health care providers had reservations about referring her for a hysterectomy, she was frustrated that they were unwilling to have an open discussion about this option. Parallel to disagreements about permanent contraception, Sultana recalled leaving a contraceptive care appointment empty-handed after the doctor told her that she was “too young to decide that, like, if [she] really wanted an IUD.” These experiences further demonstrated how some participants felt as though their voices were disregarded from conversations surrounding their own bodies.

Finally, some participants felt discouraged and defeated when health care providers failed to support their contraceptive needs. These sentiments were embodied by Luna, whose family doctor often made her feel like her health concerns were unimportant. Luna was dismissed when she inquired about the breakthrough bleeding that she experienced with her first OCP, so she “put up with it” and avoided contacting her doctor for “a really long time,” as she confessed: “I felt so anxious about, um, being too annoying or even putting undue strain on my doctor when there might be people out there who have worse problems.” Luna internalized her doctor’s dismissive behaviour and began to believe that her irregular bleeding, albeit “incredibly inconvenient,” did not warrant his time. In a similar manner, Alice “gave up” after repeatedly making unsuccessful requests for contraception that would not induce weight gain and exclaimed: “it made me feel like I wasn’t being listened to, like, I didn’t – my concerns weren’t valid. [...] [T]he best way I can describe it, is I felt like I was talking to a brick wall about my health.” By comparing her doctor to a brick wall, Alice suggested that her attempts to address her concerns were futile, as she was consistently ignored throughout her contraceptive care.

7.2.2 Rushed Out and Uninformed

Although some participants acknowledged that their health care providers were understandably busy, many women described instances where they felt rushed and insufficiently informed when receiving contraceptive care. Several participants expressed unmet informational needs, as they asserted that they had limited contraceptive options presented, little explanation provided, or few opportunities for discussion. Some women noted that when they were younger, they did not have enough interest or understanding to probe further and truly participate in their contraceptive care. While participants who initiated contraceptive use at a young age typically received brief or paternalistic care during adolescence, this trend sometimes carried into adulthood. This authoritarianism was reported by Roxanne, who frequently sensed that she was “pushed through” her contraceptive care appointments and believed that the options were never “fully explained.”

Participants who were presented with limited options sometimes described a take-it-or-leave-it attitude from health care providers, which in turn made women feel like they did not truly have a choice in their contraceptive care. For example, various participants recalled appointments where they were only offered OCPs, with a few women even admitting that they were unaware of any other options at the time. Kendra received brief, “cold” care from her family doctor when she sought help to manage her menstrual cramps in her early twenties. After sharing her symptoms, Kendra was promptly offered OCPs, upon which she reflected:

I found that there was no kind of alternative options that were presented to me. Like, you know, learning, obviously more now [about] like, IUDs and all those other options, those were never presented to me. And it was kind of just like, “This is the one that I recommend. Either you’re on it or you’re off,” and I kind of just the, you know, again, like, the band-aid solution of – and I guess maybe it’s also, you know, the way my doctor happened to be set up at the time, that it was kind of like, “You’ve got

your 15 minutes. If you're having issues, let's talk [about] them, but that's [it], like, you know, your 15 minutes are up. Next patient."

Kendra's experience demonstrated how some participants felt obligated to accept their health care providers' recommendations when they did not have the opportunity to discuss a variety of options and make an informed decision. Moreover, by referring to contraception as a "band-aid solution," Kendra suggested that while her concerns were readily addressed, her care was not thorough. This sentiment was echoed by a few other women who believed that hormonal contraception was prescribed to provide a quick fix in lieu of further investigating their menstrual concerns and hence, the hormones were merely masking their symptoms.

The depth of the counselling reported by participants who described rushed or brief contraceptive care varied. Some participants were sent off with no more than a brand name and a prescription, whereas other women were offered basic information about their options or the contraceptive method they were prescribed. Numerous participants additionally recalled instances when they received biased, incomplete, or inadequately explained information – particularly with respect to risks and side effects, as Ivy stated: "there are things that I feel like I should have been told that I was not told." Regrettably, women sometimes felt that they did not have enough time or were too uncomfortable to ask questions during their appointments.

Participants bridged the information gap by speaking with pharmacists, reading pamphlets or the package inserts, and engaging in "self-directed" learning. Throughout their experiences, several women discussed contraception with their friends and many sought information from various online sources, including sexual health organizations, forums, social media, blogs, videos, scientific articles, websites like WebMD, and even product monographs. While many participants valued other women's lived experiences, such as IUD "horror stories,"

they also emphasized the importance of finding credible sources that offered objective information.

Some women searched for information to learn more about a newly prescribed contraceptive, whilst other participants wished to proactively prepare for their appointments. Beyoncé sensed that she was expected to educate herself and reported fleeting discussions where she only received “general” contraceptive information, such as regimen explanations, from her family doctor. Despite doing online research and preparing questions to ask during her appointments, Beyoncé sometimes still felt inadequately informed. Considering her internalized sense of stigma and her doctor’s brief, impersonal care, Beyoncé reflected:

I would have loved to have my doctor, like, ask if I had any questions or if I understood everything or if I needed more information, uh, to make it more comfortable or easier for me, too. [...] Ask those questions if I have them now, so that I wouldn’t have to go home and, like, Google stuff afterwards (chuckles).

This sentiment was echoed by several participants who expressed a desire for open contraceptive discussions involving more options, information, resources, or personalized recommendations. Interestingly, some participants also placed the onus of education on themselves, stating that they should have been more informed or asked more questions during their contraceptive care.

7.3 Taking Control

While participants usually initiated contraceptive discussions with their health care providers, the last theme demonstrated that women were not always in control of the care they received. As a result, some participants felt compelled to take contraceptive care into their own hands. Control was sometimes sought when women sensed that their care had not been adequately prioritized. Liliae was sent for routine bone mineral density scans when she was

using the contraceptive injection, but had to urge her family doctor to compare her results. Although her scans were always within normal limits, Lilieae wanted to know if the comparisons revealed “small incremental changes” due to the risk of bone density loss associated with the injections, but it seemed like her doctor “didn’t seem to really, per se, care about it.” Similarly, other participants also emphasized the importance of self-advocacy during contraceptive care.

Some women described instances where they asserted themselves in response to dismissive or authoritarian health care providers. As previously noted, the notion of bodily autonomy was particularly important in the context of LARC or permanent contraception. Luna was interested in using OCPs or the contraceptive implant, but felt that her family doctor was “narrowing down the choices” by strongly recommending an LNG-IUD. Describing how she approached this conversation, Luna shared:

I felt like I kind of had to convince him in a certain way to take the IUD off the table and consider the implant and the pill. And I also, uh, wanted to make sure to tell him that, like, these are the things that I think would help me, based on, like, my courses and my sex education. These are the things that I think will solve my problem. But ultimately, you kind of are powerless in the end because you present all of the information and then the doctor is sort of like the judge that makes that final decision.

By referring to the doctor as “the judge,” this metaphor positioned Luna as a defendant on trial who had to plead her case to be awarded autonomy over her body. Interestingly, a few participants implied that disrespectful or paternalistic care might have been attributed to their gender or body size, as Quinn frequently discussed the relentless self-advocacy that they did in the face of fatphobia and “classic everyday misogyny” when seeking a tubal ligation. This sentiment was echoed by Sultana, whose doctors often tried to “push” her towards OCPs or pregnancy. As a result, Sultana characterized her contraceptive care as “terrible” and declared:

I don't know if it's just like, women don't get taken seriously when they're talking about their health, or if you are a person with a bigger body that you're not taken seriously when you're talking about your health. But like, doctors have like, so much, like, agency in terms of, like, how they want to proceed and what they want to proceed – you literally have to, like, fight for it. [...] [Y]ou have to like really, really like advocate for yourself, and like very, like, vehemently say no, like that's not something you want, or otherwise they will just, like, bulldoze you and not hear you at all.

Given that she later stated that it had been an “uphill battle” to finally access an IUD, Sultana's experiences revealed an imbalanced patient-provider power dynamic wherein she had to “fight” for her contraceptive care. Together, these examples demonstrated how participants used varying approaches to seek control over their bodily autonomy.

In addition to gatekeeping specific contraceptive options, some participants reported instances where health care providers restricted their access to contraception. This provider barrier was experienced by Sapphire, who requested an LNG-IUD after her current family doctor made OCP access “far too difficult” by requiring in-office prescription renewals every three months. Along with Sapphire, a few participants described taking control of their contraceptive care when they believed their bodies were being policed. Of notable importance, Gwen was the only participant to express opposing opinions. Gwen “loved” that she had always been able to renew her OCP prescription over the phone, but given her medical anxiety, she proposed that she may benefit from mandatory appointments to “make [her] stop and think about it.” In this way, Gwen would first need her family doctor to take an authoritarian stance to prompt her to truly take charge of her contraceptive care.

7.4 Feeling Supported

Many participants felt supported at some point throughout their experiences with routine contraceptive care, albeit “support” had different meanings to various individuals. At the least, women were grateful to access contraception, with some participants acknowledging both their own privileges and the challenges that other women may face in comparison. Feeling supported was also closely related to having a comfortable relationship with prescribing providers, and women frequently reported receiving better care from young and/or female health care providers. Nonetheless, some participants favoured a hands-off approach to their contraceptive care and a few women felt supported despite receiving minimal information from their doctors. For example, Liliae emphasized that she personally did not need much contraceptive counselling:

Given my level of knowledge and the level of research that I was doing beforehand, I was happy with the care that I was given and I didn't feel that anything was overlooked. But again, I knew about stuff so I didn't need to ask them for the information, versus like, I feel like there probably should have been information that they had volunteered and discussed without me having to bring it up sort of thing, and that other women could have benefitted from.

Liliae later proposed that her doctor may have “tailor[ed] those discussions” to her knowledge, thus exhibiting a form of personalized care. Likewise, by explaining how they were or would like to be supported, participants described a preference for patient-centred approaches to contraceptive care.

7.4.1 Collaborative Care

Participants felt supported when health care providers engaged in collaborative contraceptive care. Some women were grateful when health care providers were receptive to their requests or concerns and offered alternative options. Above all, participants wanted to be

included in the decision-making process. For instance, after years of dissatisfaction with the contraceptive care she received from her family doctor, Alice reflected positively on her experience selecting an LNG-IUD when she was referred to a gynaecologist:

So, we set up an appointment with the gynaecologist in town, and she went through – she was really good about saying like, “Okay, so what are your symptoms? How are the[y]? Okay, these are the two options. Here’s what I recommend, but if you don’t want that level of, like, hormones in you, because it is a stronger one and it lasts for longer, we can do another one. Like, let’s talk through the options,” which was fantastic, and I think also part of why I like my IUD so much is because, I actually – I didn’t get to choose it, but I chose it, if that makes sense. I felt like I was actually consulted.

Although Alice felt that she did not truly choose to use an IUD because her family doctor presented no real alternatives, as highlighted in Chapter 5, she was content that her gynaecologist empowered her to select the brand that would best fit her needs. This sense of control over decision-making was of great importance to participants, particularly among those who had previously felt excluded or invalidated during their contraceptive care.

Several women also desired or appreciated open, holistic discussions about contraception. Prior to making a method selection, some participants spoke with their health care providers and discussed a variety of factors, such as the options they were interested in or comfortable using, possible side effects, cost, current symptoms, and past experiences with contraception. Quinn described having positive experiences with health care providers who listened to their lived experiences, respected their knowledge, and “tried really hard to find solutions.” After experiencing intolerable side effects when using OCPs, Quinn went to a sexual health clinic and spoke with a nurse practitioner about LARC. Recounting this conversation, Quinn shared:

I have so much of this base information [about contraception, so] she didn’t have to explain tons to me, um, but I did ask some questions and

she asked me some questions to make sure that it would work best for me. Because I told her about my history of cramping and she wanted to kind of steer me in the direction of Mirena [LNG-IUD] because the copper IUDs can cause, uh, more cramping. And I said, “Well, not 100% comfortable with Mirena,” because again it’s super expensive and it still has [a] hormone in it, even though it’s localized, I just don’t want to risk anything in my body that’s gonna make my mental health garbage. Um, so we kind of talked about it and she – we decided on the copper IUD kind of together.

This experience involved an engaging conversation between Quinn and the nurse practitioner, where they selected a contraceptive method “together” in consideration of Quinn’s needs and lived experiences. Similarly, other participants noted that they felt supported when they believed that their doctors genuinely cared about them. Gia Grace emphasized that her current family doctor was “informative,” “attentive,” and never made her feel “rushed or pushed aside” during contraceptive discussions; a stark contrast from the care she received from her previous family doctor years prior. Moreover, following her endometriosis and adenomyosis diagnosis, Sloane was referred to an “incredible” gynaecologist in her home town. Sloane characterized their conversations about contraception and reproductive health as “very back and forth,” and explained: “she asks me questions and wants my input, whereas I found with other doctors, they just talk[ed] at me or told me things.” The distinction that Sloane had previously been spoken *at* rather than *with* is important, as participants felt respected and cared for when health care providers were engaging and demonstrated that they truly valued their patient’s perspective.

7.4.2 Information-Rich Care

Women appreciated health care providers who offered detailed information to empower them to make informed decisions and feel confident in their contraceptive use. Participants felt informed when they learned about different contraceptive options and received information about the method they were being prescribed. Several women also liked receiving resources,

such as pamphlets or websites, that they could refer to should they desire more information.

Mavis learned “a lot” about contraception from her doctors and enjoyed her first experience with contraceptive care, as she recalled:

[My doctor] was really great at explaining each aspect of birth control and letting me know that changes are gonna happen in my body, but if changes don't happen in my body, it's fine. And sort of talking me through the transition of it.

Given that this doctor worked in a “university town” and knew that Mavis was a first-time contraceptive user, she offered a wealth of information and provided Mavis with “the best care.”

In other instances, some participants sought targeted information about specific methods of contraception to support or confirm their choices. For example, after expressing interest in having an IUD inserted, Sapphire felt confident in her decision to pursue an LNG-IUD, as she explained:

I had spoken to my – my family doctor first about it, and um, she gave me a lot of information. And so, I was able to go and make the decision myself [to have an LNG-IUD inserted] and then also speak to the gynaecologist [to get more information] before it happened as well. And I feel like those two steps were good for anyone making that kind of change to their body because it is invasive and painful. So, it was good having those two steps that really forced you to think about it and decide what you want to do and be made well aware of um, the side effects and everything.

As the insertion was “invasive and painful,” having information in advance helped Sapphire make an informed decision and prepare for what was to come. This sentiment was echoed by other participants who valued personalized information and emphasized the importance of understanding all potential benefits, risks, and side effects associated with contraception.

Some participants felt well-informed throughout their contraceptive care, whereas others were grateful when they were finally offered comprehensive contraceptive information and

counselling. For instance, Antara received “barely any counselling” when she was initially prescribed OCPs by her family doctor, but felt supported by her endocrinologist, who gave her a “proper education” several years later. Nonetheless, a few participants did not receive detailed information from their prescribing providers, but rather reported that their pharmacists were, as Luna stated: “excellent in making me feel informed about what I’m taking.” Thus, while women were not always well-informed by health care providers at the time of decision-making, some participants were still able to obtain supplemental information from other trained professionals throughout their experiences with contraception.

7.4.3 Non-Judgemental Care

Women in larger bodies reflected positively on their contraceptive care when they did not feel judged. Numerous participants desired or shared their experiences with health care providers who strived to reduce stigma through the practice of inclusive care. Open-minded, non-judgemental contraceptive care was sometimes discussed with regards to creating a safe space to have conversations about sexual and reproductive health. For instance, some participants stated that they valued health care providers who did not make heteronormative assumptions or make them feel ashamed of their sexual activity. The concept of non-judgemental care also pertained to treating women in larger bodies with equity and respect. Barbara believed that weight was an inevitable topic in contraceptive care but explained that her perceptions of these discussions depended on the tone of the conversation:

[Weight] is something they have to talk about anyways, because some of the, you know, contraceptions, it is by weight class and [...] it’s the way they say it. If they say it’s by weight class, you know it’s not – it’s not rude like, “You’re too fat for this.” It’s something you know, it’s professional, because at the end of the day, not everything works.

As such, weight-related discussions were not always perceived as stigmatizing. Barbara further indicated that she valued doctors who did not automatically problematize her weight, but instead treated her as a “human being first” – a positive health care provider trait that was also identified by some of the other participants. Steph, for example, felt supported by her current family doctor, who “reduce[d] the stigma about being, like, a larger person” using contraception and reinforced the notion that she deserved “good health care, too.” However, as previously described, Steph continued to avoid contraceptive care as much as possible due to the impact of her past health care experiences. Nonetheless, a few participants’ feelings about contraceptive care improved when they began to overcome the internalized stigma concerning their bodies or sexual health, which Steph strived to work towards with the help of her doctor.

7.5 Summary

To summarize, women in larger bodies’ experiences with routine contraceptive care were shaped by feelings of (dis)empowerment. My analysis highlighted four major themes of meaning, revealing that while participants valued patient-centred approaches, women in larger bodies also described experiences where they received inadequate contraceptive information, care, and longed for more meaningful discussions with their health care providers. Overall, while several participants felt stigmatized or dismissed at some point throughout their experiences, some participants also described instances where they took control of their contraceptive care, and many women felt supported in some capacity.

Chapter 8: Emergency Contraception

In Chapter 2, I suggested that accessing and using emergency contraception may differ from routine contraception due to the distinct contexts in which they are used. While some commonalities were broadly identified, such as notions of control and (dis)empowerment, emergency contraception was unique with respect to the embodiment of these experiences and participants' health care encounters. Once again, women in larger bodies described diverse experiences that ranged from somewhat neutral to profoundly negative, differing both within and across participants. The use of emergency contraception was rarely planned, and hence, participants' experiences were often shaped by a heightened sense of urgency and the personal context surrounding their unprotected sexual encounters. In this chapter, I examine women in larger bodies' experiences with emergency contraception and articulate the meanings ascribed to these experiences. I present my findings within the context of three major stages of this phenomenon: (1) Reacting to Unprotected Sex; (2) Accessing Emergency Contraception; and (3) Using Emergency Contraception.

8.1 Reacting to Unprotected Sex

8.1.1 Freaking Out

Women were frequently alarmed or distressed following unprotected sexual encounters that could result in unintended pregnancy. The extent to which participants "freaked out" often depended on the context of the incident. Some women needed emergency contraception because of contraceptive misuse or failure, such as a broken external condom; others indicated that contraception had not been used, typically out of impulsivity or by choice. Notably, most participants were not using female-oriented routine contraception at the time of unprotected sex.

Participants usually experienced a certain degree of anxiety, fear, or remorse following an unprotected sexual encounter. Some women blamed themselves, feeling as though they should have used contraception or been more careful. Marie, for instance, divulged how she felt after an experience where she had sex with a regular partner and contraception had not been used:

I felt guilty for not having used a condom, I felt stupid because I knew better than to have unprotected sex, I felt scared that one stupid decision could hurt the life I'd built myself, and I felt upset about all of the above.

Like Marie, some participants dreaded how an unintended pregnancy could impact their lives.

Antara had multiple experiences using emergency contraception and described the worry that she expressed after each unprotected sexual encounter:

I had school, I had work, [...] it was a lot of anxiety about that as well. Anxious, I became very anxious. Uh, nervous, uncertain .. and then panic, like I need to get rid of this, I need to – I need to take care of this. Like, I'm not in a good place to bring – be pregnant.

Although she could not change what had happened, by referring to the need to “get rid” or “take care” of the situation, Antara articulated a sense of personal responsibility to seek emergency contraception and maintain control of her future.

Some women felt more upset or at ease due to the personal circumstances surrounding their unprotected sexual encounters. While participants sometimes described instances where they engaged in unprotected sex with regular or committed partners, casual encounters were also reported, which contributed to heightened feelings of discomfort and distress. For example, Kendra felt “awful” after a condom slipped off with a new casual partner. Kendra left for the pharmacy without discussing the incident with her partner, as she wanted to “take care of [the situation] just in case” and thought: “I probably don't want to ever see this person again.” Some women described instances where they sought emergency contraception after experiencing

sexual violence, resulting in intensified pain, fear, and urgency, as demonstrated by a few of the participant stories described in Chapter 5. Overall, the context surrounding unprotected sex had a pronounced impact on how distressed women in larger bodies felt as they entered the health care system to access and use emergency contraception, thus shaping how their experiences became embodied.

8.2 Accessing Emergency Contraception

Most participants accessed emergency contraception within the first 24 to 48 hours after sex. While many women experienced anxiety when doing so, they were typically confident in the decision to seek emergency contraception. Several participants cited the out-of-pocket expense when conveying their experiences, with many participants taking sole responsibility for the cost. Nonetheless, most participants agreed that emergency contraception was easy to access in terms of its pharmacy availability, albeit their feelings while doing so and perceptions of the care they received varied.

8.2.1 Feeling Embarrassed and Ashamed

Discomfort accessing emergency contraception often manifested as feelings of embarrassment or shame. Like routine contraceptive care, several participants described instances where they felt stigmatized when seeking emergency contraception. Internalized negative attitudes about sexual activity had a compounding effect on stigmatization, as participants entered the health care system, as Marie put it, “from a place of like, almost deficit.” Quinn, who advocated for sex-positivity, shared an experience where they sought emergency contraceptive counselling from a doctor following an unprotected sexual encounter, but admitted:

I just remember feeling like, just embarrassed and ashamed and like [...] the second it is just me and another professional, I just like – I feel like, all that internalized stuff comes out. Like, Catholic upbringing that I just, like, “Nope! You should feel ashamed, you’re gonna feel ashamed.” Like, “No, no, it’s fine, it happens.” Like, “No! Shame.” So I just felt, like, just really disappointed in myself too, like, you couldn’t fucking – like, we’re here again. (Chuckles) I was just mad at myself.

Citing the religious context in which they were raised, Quinn explained that despite their best efforts, shame was deeply embedded within their attitudes towards sex and thus continued to impact their experiences. Similarly, Beyoncé’s shame about her engagement in unprotected sex made her believe that others would judge her as well. Reflecting on her four experiences with emergency contraception, Beyoncé described going to the pharmacy to purchase Plan B®:

[I was] definitely not feeling good. Uh, it was a little bit embarrassing, um, I just remember feeling like, um, uh (chuckles) like the pharmacist knew that I’d made a mistake. [...] I guess I felt like a little bit [of] uh, shame around that.

Although Beyoncé stated that she had minimal interaction with the pharmacist on each occasion, she felt judged by virtue of requesting emergency contraception, as it revealed her “mistake.”

Furthermore, while many participants felt ashamed when they went to the pharmacy alone, a few women were accompanied by a friend or partner for support. Two participants recalled instances where they asked their partners to purchase emergency contraception on their behalf because they were too embarrassed to enter the pharmacy. Sultana, who preferred that her partners accessed Plan B®, highlighted the differences in their interactions with pharmacists:

I remember when one of my partners picked it up, like picked up the Plan B, he was like, “Oh, no one said anything” – to him. I’m like, “Well, good for you.” Like, lucky you (chuckles). [...] I am the only one who get[s] like, get[s] like the whole, the stare like top to bottom. And then [the pharmacists will] be like, “Okay sure,” like, “We can get it for you.” It’s just bizarre.

This quote is interesting, as both Sultana and her partner described relatively transactional encounters; however, Sultana observed non-verbal judgement from pharmacists when she requested emergency contraception. By stating, “I am the only one,” Sultana implied that although two parties are implicated in an unprotected sexual encounter, women bear the responsibility and moral judgements that are projected by others, or in this case, pharmacists. This sentiment was echoed by a few participants who perceived judgmental verbal and non-verbal microaggressions from health care providers involving condescending looks, tone of voice, or comments. For instance, Antara preferred to avoid the pharmacy in her neighbourhood, as she often felt shamed by a pharmacist who always asked her “a million questions.” The notion of privacy was also identified by some women who wanted to avoid being recognized. Indeed, participants generally felt more embarrassed when they had to interact with health care providers to purchase emergency contraception, which was frequently the case, as participants rarely reported accessing LNG-EC from the self-selection area of the pharmacy.

Additionally, two women described profoundly negative experiences where they felt humiliated and body shamed by health care providers. Though she felt anxious after her unprotected sexual encounter, Kendra had phoned a friend for support and was anticipating a transactional purchase when she proceeded to the nearest pharmacy. However, upon her arrival, Kendra was jarred when the pharmacist looked at her body, stated that Plan B® may not be effective due to her weight, and urged her to wait a few days to have a Cu-IUD inserted at a health clinic instead. Kendra believed that the pharmacist did not want to sell her Plan B® and characterized their 10-minute conversation as “the hardest thing [she had] ever, like, had to fight for.” While she noted that her friends never had any issues accessing emergency contraception, Kendra’s experience with the pharmacist made her feel ashamed of her body. She shared:

I've always been, like, overweight, I guess? I've kind of – since childhood, so it's always been like something that's on my mind, and I think it was just this, like, kind of, just kind of punch in the gut of like another reminder, um [...] I wasn't even close to a cut-off for what, like, they claim is – is kind of, um, the healthy weight. [...] I think I was also kind of embarrassed by that, to be like, well, if I go talk to my friends about this, then they'll all know that I'm over, you know, 200 pounds. [...] I think as I was getting more confident dating and stuff, reminding myself that like, your weight isn't a definition of who you are, kind of thing. And like, building that confidence and then, like, be reminded again. It was just – it was awful. [...] Like, all that stuff that I was learning [about BMI not being an indicator of health], kind of like, it just came right back to a number. So, it was just kind of, a lot of growth, kind of felt, you know, crushed at that moment.

Having previously stated that she cannot drive past the pharmacy now without thinking about that “terrible morning,” this quote highlighted the devastating impact that Kendra's experience had on her body image and self-esteem. Coupled with Alice's experience described in Chapter 5, these concerning findings emphasize the important role pharmacists play in the delivery of weight-related information.

8.2.2 Transactional Encounters

Despite the pervasiveness of the overarching anxiety that women experienced surrounding unprotected sex, several participants characterized their resulting health care encounters as merely transactional. These women often described brief interactions with pharmacists where they purchased emergency contraception with relative ease. Such transactional encounters were prevalent among participants who had used emergency contraception multiple times.

Participants sometimes recounted instances where pharmacists asked them how much time had elapsed since unprotected sexual intercourse, if they had used emergency contraception before, or whether they had any questions. In contrast, each of Beyoncé's experiences accessing

emergency contraception were relatively unnoteworthy, as she explained: “I just asked the pharmacist for Plan B. Um, I did not ask any other questions, and he didn’t ask me any questions. And [I] just paid and went.” Participants also described transactional encounters where they felt somewhat at ease, as women were sometimes more comfortable when they were accompanied by someone else, they were not in their own neighbourhood, LNG-EC was available in the self-selection aisles, or they did not perceive any judgement from others. When Ivy accessed Plan B® as an adult, she stated that the pharmacists “just sort of assume that you know what you’re there for,” and asserted:

I think with emergency contraception, it was quite, just, transactional. Especially since I went with my partner. They were just kind of like, “Alright, here. Do you know how to use this?” “Yes.” “Alright, cool.” Like, it’s a very different experience than getting the actual birth control pill. They – they seem to understand the urgency, and so they just hand it over (chuckles).

Given that Ivy felt anxious when accessing Plan B® in her youth and believed that routine contraception was too heavily monitored, she appreciated the transactionality and “urgency” surrounding her recent experiences accessing emergency contraception. Thus, although LNG-EC was typically kept behind the counter, participants still appreciated its availability as a non-prescription medication.

8.2.3 The Effects of Being (Un)Informed

There was variation in the breadth and depth of emergency contraceptive counselling and information provided to women by health care providers. While participant knowledge varied and some women had inaccurate or incomplete information, all participants had a basic understanding that, as Alice stated, “if something goes wrong, you take Plan B.” Participants often received some information from a pharmacist when they requested emergency

contraception for the first time, such as how to use it, side effect profile, timing-related efficacy, and for a few participants, weight-related efficacy. As a result, some women who had accessed emergency contraception more than once felt confident in their ability to use LNG-EC and did not necessarily seek out or feel that they needed much additional information on subsequent occasions. In comparison, two participants decided to seek specialized information and counselling from doctors when they needed emergency contraception again.

Several participants sought more information about emergency contraception on their own rather than from health care providers. Some women read the medication package insert, searched the Internet, or consulted with friends to discuss their experiences. Beyoncé recalled using an online search engine and reading the medication label to learn how to use Plan B® when she purchased it for the first time. She later noted:

I think if I had a better education around, for example, um, emergency contraception, um, beforehand, I wouldn't have been so, like, panicky the first time, and so worried. And it would have been less, um, I think embarrassing just to go, um, into a pharmacy and ask for emergency contraception.

In addition to feeling ashamed of her sexual activity, this lack of education further contributed to Beyoncé's embarrassment, which may have in turn prevented her from seeking information from the dispensing pharmacist. While most participants felt more assured after seeking further information, Barbara described an instance where she became confused. When Barbara needed emergency contraception for the first time, she was afraid of being recognized, so her partner went to the pharmacy to purchase Plan B® on her behalf. Unfortunately, he could not remember the pharmacist's directions upon his return and even after reading the Plan B® package insert "20 times," Barbara was still unsure when to take her emergency contraception, as she recalled:

There was so many instructions, so then maybe I'm thinking, you know, maybe I read it wrong. You know, maybe it's telling you, "Wait 24 hours to take it," you know, after your experience or whatever. But I don't know, I just didn't understand it.

Barbara asked a friend who had used Plan B® before, but received conflicting information, so she decided to take the medication right away and "let fate decide." Given that she did not feel comfortable speaking with a pharmacist, Barbara's first experience with emergency contraception was shaped by confusion and uncertainty. Together, Beyoncé and Barbara's experiences highlighted the importance of education about emergency contraception, as these participants felt disempowered by the combined effects of their sense of shame and gaps in knowledge when first accessing this medication.

Of notable importance, several women in larger bodies expressed strong sentiments about being (un)informed of LNG-EC's weight-related efficacy. All participants who used emergency contraception in the last five years were aware of the LNG-EC weight advisory at the time of the interview; however, this information was rarely communicated to them by pharmacists when they accessed emergency contraception. Women recalled learning about the weight warning from a variety of different sources, including school, the media, friends, the LNG-EC label, and sometimes, health care providers. Participants were often left feeling shocked, anxious, afraid, or upset, and Gia Grace expressed that this advisory "alienate[d] plus-sized women" by positioning their bodies as unworthy of care. She further declared: "this is something else that there appeared to be available to all women. But really, not all women." While some participants accepted this information, learning about the weight warning sometimes prompted participants to consult with other women or seek more information online. Two participants later inquired about LNG-EC's weight advisory during routine contraceptive care; however, these conversations were unhelpful,

as demonstrated by Sultana, who was merely advised that weight loss may help to alleviate her concerns about weight-related efficacy.

Some participants who had used LNG-EC after the Canadian label requirements were introduced in 2014 felt disillusioned knowing that their health care providers failed to share this information with them. This lack of communication directly impacted Marie's second experience with LNG-EC, as she "freak[ed] out" when she read the weight warning on the package insert shortly after leaving the pharmacy. Reflecting on the information (or lack thereof) that she received, Marie asserted:

[W]hen the pharmacist didn't tell me or, like, no one said anything or it's not, like, in big letters somewhere, that emergency contraception is not effective for people who weigh over 165 pounds, like .. again, that was just a big shock and it – I, yeah. I felt like that was insufficient. And, again, bordering on, like, negligent because, like, sure, I'm sure lots of people weigh under 165 pounds but also lots of people weigh more than that. [...] Yeah, I guess it's just in a society that, like, really values thinness, especially with women. It just highlights the issue and yeah, it really highlighted the issue but it's also like, okay but does that mean that people aren't – like certain people aren't well worth good health care?

By referring to the pharmacist's inaction as "insufficient" and "negligent," Marie suggested that health care providers had a responsibility to inform patients about the weight advisory, which was echoed by some other women. This experience further demonstrated how some participants perceived their bodies to be devalued by the health care system and society more broadly.

Unfortunately, many women appeared to be unaware of other options. While a few participants knew about either UPA-EC or the Cu-IUD, there seemed to be a common recognition among participants that Plan B® was *the* emergency contraception. Consequently, some women expressed a desire for better options or wondered, as Alice said, "if there is something for bigger women." For instance, Sultana learned that LNG-EC "works within, like, a

very ideal weight range” through her university courses. Although she characterized Plan B® as a “hit or miss,” Sultana used it several times thereafter and insisted:

I literally don't have any other choice though. Right? Like if there were other options, that would be nicer. If I had more options which were better, um, but I don't. [...] And then because I know that, like, it will not [work], so, rather than, like, waiting on the doctor and waiting for [a pregnancy test] I was like, “Okay, let's just take it anyway. Maybe it will work.” And it's just one of those things.

Much like other participants, not only was Sultana uninformed by her health care providers about the weight warning, she was also unaware that LNG-EC is not the only available method of emergency contraception. Furthermore, by emphasizing that it “will not” work for her, Sultana's lack of confidence in Plan B® intensified feelings of anxiety surrounding her emergency contraceptive use. This perception is significant given that some participants reported instances where they decided against using emergency contraception, in part, due to the weight advisory. While Kendra wanted to avoid another stigmatizing conversation about her weight, other participants felt that using emergency contraception would be futile. Quinn stated: “I'm gonna waste \$45 to take a pill that's gonna make me nauseous but not actually prevent pregnancy because I'm way too fat for it to be effective. So what's the point?” These experiences and perceptions further demonstrated the importance of disseminating accurate information about emergency contraception, as some women in larger bodies may feel discouraged by the LNG-EC weight advisory, particularly if they lack proper awareness of all other options.

Finally, several women underscored the importance of how weight-related counselling is approached. As previously described, Kendra and Alice felt publicly humiliated after learning from the pharmacist that Plan B® may not be effective based on their body sizes. Both women

valued informed decision-making, but wished that the weight warning had been shared in a more sensitive manner, as explained by Kendra:

I think just less of an emphasis on the weight, and that basically it wasn't gonna work for me. I think if it was, you know, again, [I'm] used to pharmacists going through the kind of potential side effects or what to look out for, [I] wish it was just kind of brought up like that. Like, I understand that, you know, she probably had to tell me that [body weight may impact the efficacy of LNG-EC]. But if she could have just shared that information and let me make my own choice from there, [that] would have been, kind of more, I think, would have been the better way to go about it and I would have at least known that and then I could have made my own decision, or just been aware.

Feeling as though her body had been weaponized, Kendra longed for respectful counselling to empower her to make an informed decision. The positive impact of supportive care was demonstrated by Barbara, who went to see a gynaecologist to discuss emergency contraception options following her most recent unprotected sexual encounter. Although the gynaecologist was surprised that Barbara was unaware of LNG-EC's weight advisory, Barbara felt that this doctor provided honest and non-judgemental information. Barbara learned about different emergency contraceptive pills and their potential weight-related efficacy; the benefits, risks, and barriers associated with each option; and the gynaecologist's recommendation. After learning that the ideal body weight range for ella® (i.e., UPA-EC) was also below her "weight class" and would take a few days to order, Barbara ultimately decided to purchase Plan B®. She still worried about whether LNG-EC would "work" for her, but this experience made Barbara feel well-informed, validated, and confident in her decision.

8.3 Using Emergency Contraception

Participants described taking emergency contraception shortly after leaving the pharmacy: sometimes in public, but often in private. Some participants attributed side effects to

their use of emergency contraception, whereas others discussed how their stress became embodied as they awaited menstruation. Overall, women's experiences using emergency contraception were often shaped by their emotions leading up until they knew that they were not pregnant.

8.3.1 Feeling Anxious and Unsure

In addition to lingering shame surrounding their unprotected sexual encounters, many participants continued to experience some anxiety after taking emergency contraception. While most women's anxiety was related to the possibility of an unintended pregnancy, a few participants recounted instances where they were also tested for STIs and HIV and thus experienced elevated uneasiness until they received their results. Several participants recalled feeling restless following the use of emergency contraception. For example, Quinn described "counting down the seconds" until their next menses, whereas Barbara kept "checking" to see if her menstrual period had begun and frantically updated her friend, spouting: "I didn't get it yet, I didn't get it yet!" Such feelings of stress or anxiety sometimes became embodied and were believed to have exasperated physical effects, such as nausea, tension, and delayed menstruation. Kendra felt that her risk of pregnancy was low based on her menstrual cycle tracking, but she became increasingly worried following her hurtful experience at the pharmacy, as she recalled:

I was, like, very anxious just to get my period and kind of put it all behind me. And again, like, anxiety plus periods don't always work well either, so it's kind of the, like, terrible effect of like, I think I ended up having a late period, just because I was so anxious about it, that my body kind of, like, the anxiety took over it. So yeah, it was – it was, like, a long three weeks of waiting.

Kendra's perception that her intense anxiety "took over" her body demonstrated the profound significance of some women's experiences with emergency contraception. In this way, the stress

that participants embodied represented the culmination of their feelings towards the unprotected sexual encounter, their health care interactions, and finally, their use of emergency contraception.

Participants' anxiety was further defined by uncertainty. When using emergency contraception for the first time, some women recalled feeling afraid, uneasy, or unsure about how the medication would impact their bodies. Multiple participants worried about or anticipated side effects, as illustrated by Barbara, who admitted that she expected "some whole big blood massacre" and "the worst pain ever." A few participants also noted that they were particularly concerned about their painful menstrual symptoms or irregular cycles. Beyoncé always felt nervous after using Plan B® due to her PCOS, as she explained: "I already have irregular periods (chuckles), so, um, there was I think that extra worry because it could be late anyway." As such, a missed or late menstrual period may or may not have been indicative of pregnancy.

Participants sometimes seemed unsure if they would menstruate at all, suggesting a lack of confidence in their use of emergency contraception or its efficacy. Some women recalled praying or accepting fate, as Sapphire explained: "just go and get the pill, and fingers crossed." Participants felt uncertain for various reasons, such as recognizing that emergency contraception was not 100% effective, fearing they took it at the wrong time, worrying when their bodies did not react as expected, or their looming awareness of the weight advisory on LNG-EC. This doubt was expressed by Sultana, who always anticipated but never experienced nausea after using emergency contraception. Sultana described how she felt while awaiting menstruation:

I was a bit more worried that like, um, I might have more side effects or, like, the typical effects that you usually have that comes as a result of Plan B. But that never happened, it just, like, left me more paranoid. As to, like, why it wasn't happening, um, I also knew that, like, Plan B does not necessarily, like, work well with, like, someone who has, like, a larger body. So um, even though I was taking it, I was just like, always like, worried.

Sultana's characterization of paranoia suggested that she was persistently disturbed by intrusive thoughts about the possibility of an unintended pregnancy. Likewise, most women who had been cognizant of LNG-EC's weight warning at the time of use described feeling worried that their emergency contraception may or may not work. A few participants' state of concern even prompted them to plan for or seek confirmation via a pregnancy test.

8.3.2 Feeling Relieved

Fortunately, none of the participants became pregnant following their experiences with emergency contraception. Several participants expressed some initial relief after using emergency contraception, as they believed it had empowered them to take responsible and appropriate action to prevent unintended pregnancy. For instance, although Antara felt nervous while awaiting her next menstrual cycle, she also acknowledged: "this is the best I can do and I'm doing it." As she further quipped, "It's Plan B, it's supposed to work!", this self-assurance helped calm her anxiety. Some participants' nonchalance was closely related to previous use of emergency contraception and the nature of their sexual relationships at the time. Reflecting on her second experience using LNG-EC, Gia Grace explained:

I knew I was going to expect something [in terms of side effects]. Um, just being prepared and having a sense of what it was like before. I – I prepared my body and my mind for what was coming and so I feel like I was just a lot more calmer and at ease about it.

By preparing her body and mind for the side effects of emergency contraceptive use, Gia Grace was able to keep her composure as she awaited her next menstrual period. Adding to this, two women noted that they took emergency contraception as soon as possible after unprotected sex to achieve maximum efficacy and offset some of the uncertainty they experienced due to the LNG-EC weight advisory.

A few participants seemed to perceive side effects, like nausea or cramping, as validation that emergency contraception was “working.” However, most women did not feel complete relief until they knew that they were not pregnant, which was typically confirmed by late or heavy menses. Irrespective of whether their next menstrual cycle began or they took a pregnancy test, women often enthusiastically articulated their happiness to learn that they were not pregnant. Interestingly, some participants did not necessarily attribute this outcome to their use of emergency contraception, as Marie expressed: “It’s just like joy and like, ‘Okay, whatever – whatever happened worked’, whatever it was (chuckles).” Similarly, other participants briefly wondered whether emergency contraception had been needed at all, but expressed gratitude for their continued freedom from pregnancy and moved on.

Finally, the extent to which participants expressed relief sometimes depended on the personal circumstances surrounding their experiences. A few participants recalled instances where they were distracted by other issues that had arisen and taken priority. For instance, Ivy had “other important shit going on” and merely thought “alright, cool” when she menstruated after her most recent experience using Plan B®. Furthermore, two participants described situations where they were slightly saddened to learn that they were not pregnant. While Sultana had used LNG-EC multiple times and was generally “very, very relieved,” she specified that there was one instance where she felt “a bit emotionally low.” Given that she had been engaged to her partner at the time, Sultana mused: “maybe subconsciously I wanted [to be pregnant]?” Conflicting feelings were also expressed by Quinn, who was initially disappointed after romanticizing the idea of becoming pregnant with their codependent partner in college. In contrast, Quinn’s most recent experience involved a casual partner who “didn’t care” about them, the use of two prescription medications that were believed to be more effective than LNG-

EC, as well as STI and HIV testing. Quinn felt like “1000 pounds had been lifted off [their] shoulders” when they menstruated, but continued to feel worried and ashamed until they received their test results. Ultimately, Quinn reflected:

[I was] [r]eally relieved. And then I felt guilty that I had really, like, so harshly judged myself with all of that internalized sex-negativity and slut-shaming, and all of those things. [...] I just felt guilty for being so awful to myself, and then I just felt resolved that I was like, “Okay, I need to, again, figure something else out [to prevent pregnancy], I need to create better boundaries and find better partners who are going to support me through things like this, ‘cause fuck that guy!” And (chuckles) I was like, “Okay! I really need to get my tubes tied, because this is baloney and I’m not doing this again.”

Given that Quinn was non-monogamous and unable to find a satisfactory method of routine contraception, as discussed in Chapter 6, they were determined to avoid using emergency contraception ever again. Overall, the diversity of participants’ reactions to learning that they were not pregnant highlighted the impact of the personal circumstances surrounding women in larger bodies’ experiences with emergency contraception.

8.4 Summary

In this chapter, I analyzed participants’ experiences accessing and using emergency contraception. Although diverse and context-dependent, the findings revealed that women in larger bodies’ experiences often involved varying degrees of shame, anxiety, and uncertainty. Women’s perceptions of their pharmacy interactions ranged from transactional to stigmatizing. Participants had typically received some information from pharmacists about LNG-EC, albeit this rarely included weight-related efficacy. Finally, while most participants ultimately experienced relief, women were not always confident in their use of emergency contraception and many continued to feel anxious until they learned that they were not pregnant.

Chapter 9: Discussion

This study explored the lived experiences of women in larger bodies who access and use female-oriented contraception in Ontario. The findings revealed significant variation in participants' experiences with routine and emergency contraceptive use and care, including their embodied sense of control when using contraception, feelings of (dis)empowerment throughout contraceptive care, and the role of personal context in shaping these experiences. Disempowerment often pertained to participants' impressions of stigma and unmet contraceptive care needs, whereas empowerment stemmed from perceptions of supportive care. Overall, my analysis demonstrated the unique and diverse nature of the meanings that women in larger bodies assigned to their experiences with contraception.

9.1 Key Findings

One of the key findings from this study was the notion of control, which underpinned women in larger bodies' embodied experiences with contraception. While emergency contraceptive use was often characterized by feelings of anxiety and uncertainty, participants' sense of bodily control when using routine contraception was complex and multidimensional, as women shared stories of seeking, negotiating, achieving, and sometimes, spiralling further out of control. The anticipated control gleaned from routine contraception was merely a convenience for a few participants, whereas others were menaced by the unruliness of their bodies. In this way, participants' embodied experiences with contraceptive use sometimes exemplified the perception that women's bodies are simultaneously uncontrollable and in need of control (151). For instance, many women in larger bodies expressed negativity towards their menses and experienced irregular, painful, or otherwise bothersome menstrual cycles and symptoms. While several participants used contraception for menstrual management, some women were

continuously reminded of their bodies' boundlessness by the pervasiveness of their menstrual irregularities. Furthermore, many participants vividly described the physical and mental effects that accompanied their contraceptive use. These changes revealed the significance of corporeal experiences to the process of contraceptive embodiment and hence, women in larger bodies' embodied sense of control. I situate these findings within a paradoxical discourse proposing that contraception both offers and constrains women's reproductive and bodily autonomy (52–54,152,153).

Research has previously suggested that the notion of control is central to contraceptive decision-making and management (54,57,58,67,68,152,154). However, fewer studies have focused on examining how control (or lack thereof) becomes embodied through contraceptive use (68), and little is known about the lived experiences of women in larger bodies in particular (22). By focusing on embodiment, my study adds to this literature by illuminating the intricacies of the relationship between women in larger bodies' contraceptive use and their embodied sense of control. Some women felt empowered by the control they achieved with their first contraceptive, but many participants became dissatisfied with concerning side effects, the absence of beneficial effects, or method inconvenience. Akin to studies that have articulated how unwanted side effects may threaten women's sense of bodily control (58,67,68), method dissatisfaction was often associated with embodied feelings of disarray, which prompted participants to seek a new contraceptive or discontinue use. Intriguingly, the opposite seemed to be true for emergency contraceptive use, as various participants expected side effects and perceived them to be an indication of efficacy. Nonetheless, in some instances, women chose to tolerate certain aspects of their routine contraceptive use, such as painful IUD insertions, thereby negotiating control over their bodies.

Routine contraceptive use often became normalized over time among long-term users, and as such, some women came to understand their bodies through the lens of their contraceptive use. For instance, some participants became accustomed to the hormonal influx and began to recognize their bodies as “normal” when using contraception, whereas other women’s contraceptive use perpetuated a sense of bodily disorder. The notion of long-term normalization was thus an interesting finding, as participants were able to achieve some semblance of control through the routinization of contraceptive use, even when their bodies continued to feel unruly. While previous research has demonstrated that contraceptive preferences and use may change with age, context, and experience (69,155), to my knowledge, less attention has been paid to the normalization and embodiment of contraceptive use over time, thus representing compelling potential directions for future research.

In exploring how women in larger bodies navigated contraceptive care, I found that participants were disempowered by stigmatizing experiences. Perhaps unsurprisingly, participants most often experienced stigma surrounding their contraceptive use (e.g., sexual activity, sexual and reproductive health) and weight. Participants who described internalized negative attitudes fostered a sense of discomfort that manifested throughout their experiences with contraceptive care. Additionally, previous stigmatizing health care experiences sometimes incited distrust or avoidance of health care providers. Several women also shared experiences where they observed stigmatizing behaviour from prescribing or dispensing health care providers during contraceptive care, leading to feelings of shame or judgement. For example, some participants described instances where their weight was unwantedly or inappropriately discussed. My study thus adds to an established body of literature documenting weight stigma in

reproductive health care (7,9–14) and reinforces previous research inferring that women in larger bodies' contraceptive use and care may be hindered by stigma (117,128,131).

In particular, my findings provide evidence that women in larger bodies may face intersecting stigmas throughout their experiences with routine and emergency contraceptive care. A recent study by Holland et al. (156) suggested that multiple internalized stigmas towards one's body, including body shape, menses, and genitalia, may contribute to discomfort when speaking with health care providers and avoidance of sexual health care. My study further suggests that women in larger bodies' engagement with contraceptive care may be influenced by overlapping forms of internalized and perceived stigmas not exclusively limited to their bodies, but also to their assumed and actual sexual behaviours. Lastly, I found that stigmatization was further shaped by participants' various social identities or practices, such as ethnic, cultural, or religious background, non-monogamy, and sexuality. This finding complements recent research investigating how body size interacts with other axes of marginalization in reproductive health care (9,13).

In accordance with research on how health care utilization is shaped by weight bias (93) and the findings from Holland et al. (156), participants who experienced stigma did not always fully engage with their contraceptive care. These participants sometimes described avoidant behaviours, such as concealment of information surrounding their contraceptive use, an unwillingness or inability to discuss all their contraceptive needs or concerns, and at times, complete avoidance of contraceptive care. What is more, experiencing stigma in multiple ways had a compounding effect on how certain women in larger bodies interacted with contraceptive care. While the findings from this study call for research on women in larger bodies' experiences with various forms of stigma and marginalization in contraceptive care, they also emphasize the

need for inclusive care approaches that are non-judgemental and trauma-informed. Tailored anti-stigma and weight neutrality training (e.g., Health At Every Size® (157)) may be appropriate first avenues that could be explored to better equip health care providers to offer unbiased, shame-free, patient-centred contraceptive counselling and care to women in larger bodies.

To exemplify the impact of multiple stigmas, learning about LNG-EC's weight-related efficacy sometimes reinforced the notion that larger bodies are devalued in society (87). Given that women typically experienced some degree of embarrassment or shame surrounding their use of emergency contraception, a sentiment that is well-documented in the literature (45,71,72,74), participants who learned about the weight warning when seeking LNG-EC often described experiencing enhanced feelings of stigmatization or anxiety. A few participants consequently questioned whether their bodies were unworthy of care. Of notable importance, negative perceptions sometimes led to subsequent non-use of emergency contraception when participants believed that LNG-EC would be ineffective or wished to avoid potentially stigmatizing conversations about their weight. Unfortunately, several participants were unaware of other options, which is commensurate with a study where Ontario pharmacists indicated that most women specifically request Plan B® rather than “emergency contraception” or a Cu-IUD (49). As women in larger bodies may consider weight-related efficacy when selecting a method of emergency contraception (121), my findings accent the need to improve the provision of emergency contraceptive information and counselling. Public health and clinical efforts are necessary to increase awareness of all emergency contraceptive options, including UPA-EC and Cu-IUDs, and ensure that accurate information about weight-related considerations is delivered in a respectful, sensitive manner such that women in larger bodies do not feel discouraged from using emergency contraception.

Researchers have also articulated how weight bias and stigma may impair the quality of care offered to individuals in larger bodies (94,95). In a similar manner, health care providers may restrict women's contraceptive agency through the care they provide – or rather do not provide (154,158). Consistent with a recent scoping review proposing that women in larger bodies may receive inadequate contraceptive counselling and care (22), many participants implied that their contraceptive care needs were not always met.

Women described paternalistic contraceptive care encounters where they felt dismissed by health care providers who rushed their appointments or did not truly listen to their concerns. For instance, some participants felt pressured to (not) use a certain method, referred to contraception as a “band-aid solution” whereby little effort was made to investigate their issues further, or felt frustrated when their health care providers failed to consider their expressed needs and experiences with contraceptive use. When participants felt dismissed, they sometimes conceded to their health care providers' authority or learned to self-advocate and take control of their contraceptive care. Moreover, several women wished they had received more contraceptive information and resources from their health care providers. Participants reported experiences where they were not fully informed about the complete range of contraceptive options and received minimal explanation of the methods they were prescribed, which often prompted women to seek information elsewhere. Health care providers also rarely discussed weight considerations when women in larger bodies sought LNG-EC, representing a significant gap in care that warrants further research. Congruent with some of these findings, Gomez and Wapman's (158) study with young Black and Latina women proposed that an authoritarian approach to contraceptive counselling and care may disempower women and ultimately impact

how they engage with contraception. As such, my findings underscore the importance of improving the quality of contraceptive care offered to women in larger bodies.

Nonetheless, it was encouraging to learn that many women felt supported in some capacity. Several participants reported at least one positive experience where they felt empowered through patient-centred contraceptive care. Specifically, women in larger bodies valued non-judgmental health care providers who offered comprehensive information and approached contraceptive care in a collaborative manner, wherein participants played an active role in discussions and decision-making. These findings echo some of the contraceptive counselling preferences previously reported by women in Western countries (62) and the SOGC's clinical practice recommendations (111).

Overall, the provision of high-quality, non-judgemental, equitable contraceptive and reproductive health care for women in larger bodies is critical for achieving reproductive justice. This study offers valuable insight into some of the challenges that women in larger bodies may face during routine and emergency contraceptive care and use, while also celebrating the compassionate, inclusive, and empowering care that some participants received from their health care providers. My findings highlight the value of and need for non-stigmatizing, patient-centred approaches to support women in larger bodies to make informed contraceptive decisions. In addition to facilitating open discussions with patients about their contraceptive care needs and preferences, I suggest that health care providers explain the full range of contraceptive methods and include emergency contraception in routine contraceptive counselling. In keeping with Canadian clinical guidelines, the use of LNG-EC should not be discouraged based on body size; however, women in larger bodies should be adequately informed about weight-related efficacy considerations and when possible, a Cu-IUD or UPA-EC can be recommended as first-line

options (111). I further propose that women in larger bodies may benefit from being offered an advanced prescription of UPA-EC and information about access to prompt or same-day Cu-IUD insertions. This suggestion would encourage timely access to highly effective methods of emergency contraception when needed, if desired. By taking a sensitive and holistic approach to contraceptive counselling and care, health care providers can help improve the experiences of women in larger bodies.

9.2 Limitations

Although this study offers novelty by using a qualitative approach to explore women in larger bodies' lived experiences with contraception, it is not without limitations. IPA lends itself to relatively small, homogeneous study samples (146), and thus the large sample size and vast range of experiences documented in this study posed some analytic limitations. I attempted to capture diversity, but it was challenging to convey all the complexities and nuances of the lived experiences of 19 participants within this thesis. To further illustrate the mosaic of experiences and their respective meanings, future research could independently examine women in larger bodies' use of individual methods of female-oriented contraception to provide a comprehensive account of each of these embodied experiences. A narrower focus could also help to understand women in larger bodies' experiences using various short-acting barrier methods of contraception that were not captured in this sample of participants (e.g., diaphragm, internal condom).

Despite the significant diversity in participants' lived experiences, it is important to consider the social privileges represented within the study sample. Participants were highly educated; predominantly urban-dwelling, white, and heterosexual; and most participants stated that they had insurance to fully or partially cover the cost of routine contraception at some point throughout their experiences. Some participants acknowledged their respective privileges and

noted that other women (e.g., women whose bodies were larger than theirs, women of colour, uninsured or rural women) might face greater challenges when accessing contraception. Individuals in larger bodies with multiple marginalized identities may also experience more profound weight stigma (159), and hence it is crucial that future research further examines the experiences of women in larger bodies who have various intersecting identities and characterizes the unique challenges that they face. To gain a better understanding of how overlapping marginalized identities shape women in larger bodies' lived experiences with contraception, succeeding studies would benefit from an intersectional approach and analysis, as conceptualized by Crenshaw (160), which would be better suited to tease out the intricacies and nuances of multiple forms of oppression. Recently, scholars have drawn attention to the value of approaching intersectionality through a reproductive justice lens when examining reproductive health experiences, including those pertaining to contraception (153,154) and women in larger bodies (9,13). This lesser-used framework considers how various dimensions of social power and inequality are ingrained within issues related to sexual and reproductive experiences (153) and should thus be prioritized when designing future studies.

The exclusive focus on individuals who identify as women and use female-oriented contraception is a notable limitation of this study. One participant explained that while the term “woman” resonated with them in some ways, they described their gender as “femme” and used they/them pronouns. Indeed, contraception is used across the gender spectrum and thus, the use of gendered language (i.e., “women,” “female”) in the eligibility criteria and recruitment materials excluded some transgender and gender diverse individuals from participating in this study. This focus was chosen in consideration of the research design, the relatively homogenous samples used in IPA studies (146), as well as the previously noted gendered nature of

contraception and larger bodies (54,143). Also, studies suggest that transgender and non-binary individuals may have unique contraceptive needs, considerations, and experiences (161,162). In line with the previous recommendation for intersectional inquiry, more inclusive study designs are needed and future research should seek to explore the experiences of transgender and gender diverse individuals in larger bodies who use contraception.

Finally, by the nature of conducting qualitative research, it is important to acknowledge that the findings from this study are not meant to be generalized to the greater population of women in larger bodies (134). It is further worth recognizing my role in making interpretations through the “double hermeneutic” (146), in which case I may have misinterpreted, overaccentuated, or underemphasized some aspects of women in larger bodies’ experiences as I examined and reconstructed their stories. As the researcher, I have presented the features of participants’ experiences that I found to be the most meaningful or impactful based on my analysis of the interview data, and thus this thesis represents my interpretation of participants’ lived experiences.

Chapter 10: Conclusion

Women in larger bodies are an important population of contraceptive users, yet they remain underrepresented in contraceptive research. This study aimed to understand the lived experiences of women in larger bodies who access and use female-oriented contraception in Ontario. My findings begin to fill a significant gap in the academic literature and the Canadian context by offering the first detailed account of women in larger bodies' lived experiences with routine and emergency contraceptive use and care, highlighting the complexity and diversity of these experiences. Building on the SOGC's call for comprehensive contraceptive counselling on a variety of contraceptive options and timely access to emergency contraception for all women (111), the recommendations derived from this study suggest how to better support women in larger bodies who access and use contraception. With the support of the current literature and any future studies that may follow, the findings from this research may be used to help develop clinical practice guidelines or inform health policy to bolster the expansion of information and access to highly effective methods of contraception for women in larger bodies in Ontario and across Canada. In this way, contraceptive care can be improved for women in larger bodies with the hope of one day achieving reproductive justice for all.

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Appendix A – Recruitment Poster



CALLING FOR RESEARCH VOLUNTEERS:

Women in larger bodies who have
accessed and used
FEMALE CONTRACEPTION
in Ontario in the last 5 years



Photo adapted from: Unplash and You+Life

WE WOULD LIKE TO
HEAR ABOUT YOUR
EXPERIENCES!

*We also have a special interest in
speaking with women in larger
bodies who have used
emergency contraception*

IF INTERESTED, PLEASE VISIT:

<https://contraceptionstudy.wixsite.com/info>

Or contact **Tierney Boyce:**
tierney.boyce@uwaterloo.ca

This study has received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #42481). Participation in this study is completely voluntary. As a participant, you will be asked to take part in an open-ended, in-depth interview that will last approximately 60 minutes. The questions will focus on your experiences accessing and using contraception, how you feel about contraception and the care you have received, and what these experiences mean to you.



Appendix B – Study Website

[Home](#) [Purpose](#) [Female Contraception](#) [Participation](#) [Contact Me](#)

CONTRACEPTION STUDY

Do you identify as a woman in a larger body? Have you accessed and used female contraception in Ontario in the last five years?

As part of a Master's thesis at the University of Waterloo School of Public Health and Health Systems, we are looking to interview you about your experiences!

This study has received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #42481)



Photo by Reproductive Health Supplies Coalition on Unsplash

WHY ARE WE CONDUCTING THIS STUDY?

Women are often the users of contraception, whether that be for birth control or for other reasons. There are many options available, and women may look to find the best fit for them. In Canada, we have many women living in larger bodies. However, there is little known about the experiences of women in larger bodies who access and use contraception. **By speaking with women about their own lived experiences with contraception, we hope to identify ways to improve contraceptive care for women in larger bodies.**

[Get in Touch](#)

WHAT IS CONSIDERED FEMALE CONTRACEPTION?

You are eligible for this study if you have accessed and used at least one of the following birth control methods in the last five years:

- Oral contraception (birth control pills)
- Intrauterine devices or systems. This includes copper IUDs or hormonal IUSs, such as, Mirena®
- Contraceptive patch
- Contraceptive injection ('the shot', for example, Depo-Provera®)
- Contraceptive implant (Nexplanon®)
- Vaginal ring
- Female condoms
- Diaphragm
- Cervical cap
- Contraceptive sponge
- Emergency contraception pills ('morning after pills', for example, Plan B® or ella®)

ABOUT PARTICIPATION

Exploring the lived experiences of women in larger bodies who access and use contraception in Ontario



ONE-ON-ONE INTERVIEWS

The interview will last about 60 minutes
(online or telephone)

TOPICS COVERED

The interview will focus on your experiences
accessing and using contraception, how you
feel about contraception and the care you
have received, and what these experiences
mean to you

PARTICULAR INTEREST IN EMERGENCY CONTRACEPTION

We have a special interest in speaking with
women in larger bodies who have used
emergency contraception!

Participation in this study is completely voluntary and your participation will remain confidential. You have the right to withdraw from this study at any time.

CONTACT ME

Thank you for your interest in this research! If you have any questions about the study or would like to volunteer to participate, please contact Tierney at

tierney.boyce@uwaterloo.ca

E-mail me

Appendix C – Information-Consent Form

Letter of Information and Consent

Title of the study: Exploring the lived experiences of women in larger bodies who access and use contraception in Ontario

Faculty Supervisor: Elena Neiterman, PhD, School of Public Health and Health Systems, University of Waterloo. Phone: (519) 888-4567 ext. 38221, Email: eneiterman@uwaterloo.ca

Student Investigator: Tierney Boyce, MSc Student, School of Public Health and Health Systems, University of Waterloo. Email: tierney.boyce@uwaterloo.ca

Dear Potential Participant,

To help you make an informed decision regarding your participation, this letter will explain what the study is about, your rights as a research participant, and the possible risks and benefits associated with participating in this research. If you do not understand something in the letter, please ask Tierney Boyce prior to consenting to the study. You will be provided with a copy of the information and consent form if you choose to participate in the study.

What is the study about?

You are invited to participate in a study conducted by Tierney Boyce, as part of her Master's thesis research at the University of Waterloo. The purpose of this study is to learn about the experiences of women in larger bodies who access and use contraception in Ontario. Women are often the users of contraception, whether that be for birth control or for other reasons. There are many options available, and women may look to find the best fit for them. In Canada, we have many women living in larger bodies. However, there is little known about the experiences of women in larger bodies who access and use contraception. This study will examine the lived experiences of accessing contraception or receiving contraceptive care, explore the use of female methods of routine or emergency contraception, and learn about how women feel during and about these experiences. The ultimate goal of this study is to suggest how contraceptive care can be improved for women in larger bodies.

I. Your responsibilities as a participant

If you decide to volunteer, you will be asked to take part in an individual interview that will take approximately 60 minutes. The interview will be scheduled at a date and time that is convenient for you and will take place online (e.g., Skype, WhatsApp, MS Teams) or via telephone. Privacy cannot be guaranteed when information is transmitted over the Internet. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). University of Waterloo researchers will not collect or use internet protocol (IP) addresses or other information which could link your participation to your computer or electronic device without first informing you. If you prefer not to participate using this online method, please let the researcher know so you can participate using an alternative method such a telephone call.

At the beginning of the interview, you will be asked to introduce yourself and answer some demographic questions, including your age, your ethnicity, whether you live in a rural or urban setting, your level of education, and your sexual orientation. You will then be asked open-ended questions that will focus on your experiences accessing and using contraception, such as receiving contraceptive counselling and how your body feels when using contraception. In general, you will be asked to share your experiences and feelings about the contraception you have used, the contraceptive care you have received, and what these experiences mean to you.

The interview will be audio recorded to ensure an accurate transcript. With your permission, anonymous quotations may be used in publications and/or presentations.

Who may participate in this study?

To participate, you must be a woman (i.e., aged 18+) who speaks and understands English. Additionally, you must meet the following criteria to be eligible to participate in this study:

- 1) You must identify as living in a larger body
- 2) You must have accessed and used a female method of contraception* (or emergency contraception) in Ontario within the last five years
- 3) You must have Internet or telephone access

***What is considered female contraception?** Female birth control refers to any methods that are used by women and their bodies. We are looking for women who have used at least one of the following methods:

- Oral contraception (birth control pills)
- Intrauterine devices or systems (copper or hormonal IUD/IUS for example, Mirena®)
- Contraceptive patch
- Contraceptive injections (‘the shot’, for example, Depo-Provera®)
- Contraceptive implant (for example, Nexplanon®)
- Vaginal ring (for example, NuvaRing®)
- Female condoms
- Diaphragm
- Cervical cap
- Contraceptive sponge
- Emergency contraception pills (‘morning after pills’, for example, Plan B® or ella®)

If you have any questions about eligibility for this study, please contact Tierney Boyce at tierney.boyce@uwaterloo.ca.

II. Your Rights as a Participant

Is this study voluntary?

Your participation in this study is completely voluntary. You may decide to leave the study at any time prior to or during the interview by communicating your request to the researcher. During the interview, you may decline to answer any question(s) you prefer not to answer by requesting to skip a question. Following the interview session, you may completely withdraw from the study by contacting the researchers, Tierney Boyce or Elena Neiterman.

Will I receive anything for participating in this study?

You will not receive payment for your participation in this study.

What are the possible benefits of this study?

Participation in this study may not provide any personal benefit to you, but the findings from this study will enhance our understanding of women in larger bodies' contraceptive experiences and needs, and may be used to inform future research. The knowledge gained from this study may one day be used to contribute to the development of clinical practice guidelines, policy, or make recommendations on how to improve contraceptive care in Ontario.

Are there any risks to participating?

The risks of participating in this study are considered minimal, but you may feel mild discomfort talking about your personal experiences with contraception and contraceptive care. We have attempted to minimize this risk by asking broad, open-ended questions that will allow you to share your experiences at your own pace and on your own terms. You may decline to answer any of the interview questions, and the interview can be paused or discontinued at any point. Sexual health, health advice, and mental health resources will be available, if wanted, to support you after your participation.

Will my personal information remain confidential? Will I be identifiable?

Your confidentiality is a priority throughout this research.

Your verbal consent will be stored as a separate audio file and will be encrypted and stored on the researcher's password-protected laptop. With your permission, we will gather some of your demographic information, such as your age, ethnicity, geographic setting (i.e., rural or urban), education level, and your sexual orientation. To ensure the confidentiality of your data, you will be identified by a participant pseudonym, which you may choose.

With your permission, the interview will be audio-recorded to facilitate the accurate collection of information, and later transcribed for analysis. Within this audio-recording, your name will not be used, but your voice may be heard. The audio recording collected during this study will be destroyed immediately upon transcription (within two weeks of the interview) and only the anonymized transcript from the interview will be retained. All information that could identify you will be deleted from the interview transcript. Only the research team will know which data is from your participation, and any identifying information will be kept separate from the data. Only researchers associated with this study will have access to any study records. Your interview transcript will be stored separately under an anonymous participant code, encrypted and stored on a password-protected laptop, which is only available to the researcher. Encryption of electronic files will be conducted according to University of Waterloo IST policy. Any paper data (i.e., researcher notes) will be stored in a secure location. We will keep your data for a minimum period of seven years following the date of the interview, after which it will be destroyed according to University of Waterloo policy.

III. Questions, Comments, Concerns

How is this study funded?

This study has not received any funding and there are no conflicts of interest to declare.

Has the study received ethics clearance?

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #42481). If you have any questions for the Committee, please contact the Office of Research Ethics at (519) 888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

Who should I contact if I have questions about my participation in the study?

For all other questions regarding this study, or if you would like additional information to assist you in reaching a decision about participating, please contact me by e-mail at tierney.boyce@uwaterloo.ca. You can also contact my supervisor, Dr. Elena Neiterman, at (519) 888-4567 ext. 38221 or email eneiterman@uwaterloo.ca

Yours sincerely,
Tierney Boyce

School of Public Health and Health Systems
University of Waterloo
tierney.boyce@uwaterloo.ca



CONSENT FORM

I have read the information presented in the information letter about a study being conducted by Tierney Boyce, under the supervision of Dr. Elena Neiterman. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details that I wanted.

I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that the excerpts from the interview may be included in the findings of this study with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time by advising the researchers.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #42481). I was informed that if I have any questions, I may contact the Office of Research Ethics, at (519) 888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

YES NO

I agree to have my interview audio recorded.

YES NO

I agree to the use of anonymous quotations in future research projects/publications developed from this project.

YES NO

I give Tierney Boyce permission to retain the transcript from my interview for a minimum period of seven years and use it for research purposes as long as it has no identifiable information that ties it to me.

YES NO

By agreeing to participate in this study, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.



Appendix D – Verbal Consent Form

Hello! My name is Tierney Boyce and I am a student in the Master of Science in Public Health and Health Systems program at the University of Waterloo. For my thesis research, I am conducting semi-structured, in-depth interviews with women in larger bodies who have accessed and used female methods of birth control or emergency contraception in Ontario in the last five years. I will be asking you to share your experiences with contraception and contraceptive care, and your feelings during and about these experiences.

You were identified through [insert wording such as name of: *social media website; website; suggestion by previous participant/mutual contact*].

What will happen during this study?

I am inviting you to do a one-on-one interview [through an online platform of the participant's choice, such as Skype, WhatsApp, Microsoft Teams, or over the phone] that will take about one hour. The interview will begin by asking you a broad question to introduce yourself. I will then ask some brief demographic questions, including your age, ethnicity, whether you live in a rural or urban setting, your level of education, and your sexual orientation. Throughout the rest of the interview, I will ask you questions about your experiences accessing and using female contraception, and your feelings about these experiences, such as “Could you describe your experiences with contraception?”, “Can you walk me through your experiences of receiving contraceptive counselling and the process of accessing contraception?”, and “Could you describe what contraception means to you?”. With your permission, I will take brief hand-written notes and I will use audio recorder to make sure to capture everything you say. We will set up a time and place that works best for you.

Are there any risks to participating in this study?

The risks involved in participating in this study are minimal. You should be aware that some participants may feel uncomfortable discussing their private sexual and reproductive health experiences. During the interview, you may decline to answer any of the interview questions and/or share your personal information with me. If you ever feel distressed, please let me know and we can pause or end the interview. I am trained on how to navigate these situations and will provide you with support resources that can be shared with you if you are interested. Finally, you may withdraw from this study at any time. If you decide to withdraw, I can also erase the interview transcript and any notes that I may have taken during the interview process.

Your identity will remain confidential. Your name or any other personally identifying information will not appear in my thesis, any presentations, or publications resulting from this study. To protect your identity, you will be assigned a pseudonym, which you may choose, and I will erase the audio-recording of your interview right after I transcribe it. The transcription will be identified by your pseudonym.

Are there any benefits to participating in this study?

It is unlikely that there will be direct benefits to you; however, I hope that the data collected from these interviews will help us to understand women in larger bodies' experiences with contraception in Ontario, and may be used to inform future research. The knowledge gained from this study may one day be used to contribute to the development of clinical practice guidelines, policy, or make recommendations on how to improve contraceptive care in Ontario.

Voluntary participation

- Your participation in this study is completely voluntary.
- You can decide to stop at any time, even part-way through the interview for whatever reason.
- If you decide to stop participating, there will be no consequences to you.
- If you decide to stop, we will ask you how you would like us to handle the data collected up to that point.
- This could include returning it to you, destroying it or using the data collected up to that point.
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- If you have any questions about this study or would like more information, please refer to the full information letter, you may e-mail me at tierney.boyce@uwaterloo.ca or you can call or email Dr. Elena Neiterman at (519) 888-4567 ext. 38221 or eneiterman@uwaterloo.ca

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# 42481). If you have questions for the Committee, contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

Consent questions:

- Do you have any questions or would like any additional details? [*Answer questions.*]
- Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you? [If yes, move to next question/ If no, thank the participant for her time.]
- Do you consent to having your interview audio recorded?
- Do you agree to the use of anonymous quotations for future research or publications developed from this thesis?
- Do you give me, Tierney Boyce, permission to retain a copy of the interview transcript for a minimum period of seven years and use it for research purposes as long as it has no identifiable information that ties it to you?

Appendix E – Interview Guide

1. How would you describe yourself to someone who has never met you before?

➤ Demographic Questionnaire:

- What is your age? _____
- What is your ethnicity? _____
- Do you live in an urban or rural location? _____
- What is your level of education? _____
- What is your sexual orientation? _____

2. Could you describe your experiences with contraception?

- What are your preferred methods? Why?
- How does your body respond to contraception?

3. Can you walk me through your experiences of receiving contraceptive counselling (**if you have received it**) and the process of accessing contraception?

- Could you describe your interactions with health care providers?
- How did you feel during the counselling [or when accessing contraception] (i.e., interactions with health care providers)?
- What did you think about the counselling that you received (i.e., quality, options presented) [or care received when accessing contraception]?

4. How confident are you about preventing pregnancy when you use contraception (**if applicable**)?

- Has there ever been a time where you felt your contraception may have failed?
- What signals (if any) did your body give you? What did you do?
- Have you ever considered using emergency contraception? If so, could you tell me about how you felt about emergency contraception? (e.g., attitudes, knowledge)

5. **If applicable:** Can you tell me about a situation where you used emergency contraception?

- Could you describe the timeline between sex and using emergency contraception?
- How did you decide which method of emergency contraception to use?
- Could you describe how you (and your body) felt throughout this process?

6. In your own words, could you describe what contraception means to you?

- How do you (and your body) feel when using contraception?

7. Overall, what have you found to be helpful when accessing and using contraception? What have you found unhelpful?

- What can you tell me about the information, counselling, or care you received?
- What did you value about the care you received?
- What, if anything, would you change or improve?

8. Reflecting on this experience and other experiences with health care services, how would you compare contraceptive care?

- Was it easier or more challenging? How so?
- Did you feel well-supported?

9. Is there anything else you would like to add?

Appendix F – Feedback Letter

Exploring the lived experiences of women in larger bodies who access and use contraception in Ontario

[date]

Dear [name],

I would like to thank you for your participation in this study entitled *Exploring the lived experiences of women in larger bodies who access and use contraception in Ontario*. As a reminder, the purpose of this study was to learn about women's experiences and suggest how contraceptive care can be improved for women in larger bodies.

The data collection from your interview will contribute to a better understanding of the experiences of women in larger bodies who access and use routine female contraception or emergency contraception, how contraceptive care is navigated and experienced, and how women in larger bodies feel during and about these experiences.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #42481). If you have any questions for the Committee, please contact the Office of Research Ethics at (519) 888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions, please contact, Tierney Boyce (tierney.boyce@uwaterloo.ca) or Dr. Elena Neiterman (eneiterman@uwaterloo.ca).

Please remember that any data pertaining to you as an individual participant will be kept confidential. The findings from this study may be shared through conferences, presentations, and journal articles. However, the experiences you share will not be attributed to you and your identity will not be revealed. If you would like to receive the report from this study, please contact Tierney Boyce at the contact information above. The study will be complete in August 2021.

Yours sincerely,

Tierney Boyce

University of Waterloo
School of Public Health and Health Systems

tierney.boyce@uwaterloo.ca



Appendix G – Participant Resources

Sexual health services and information (birth control, sexually transmitted infection testing)

Sexual Health Infoline Ontario (SHILO) – anonymous toll-free 1-800-668-2437
OR e-chat <https://www.toronto.ca/community-people/health-wellness-care/sexual-health-infoline-ontario/>

Sexual Health Ontario – <https://www.sexualhealthontario.ca/>

Action Canada for Sexual Health & Rights – <https://www.actioncanadashr.org/>

Sex & U – <https://www.sexandu.ca/>

It's a plan – <https://www.itsaplan.ca/>

Mental Health Support

Mental Health Helpline – 1-866-531-2600

ConnexOntario – 1-866-531-2600 OR <https://www.connexontario.ca/>

Health advice and information

Telehealth Ontario – 1-866-797-0000

***If you are in a mental health crisis, call Telehealth Ontario
or go to your nearest emergency department***



Appendix H – Participant History of Female-Oriented Contraceptive Use

Pseudonym	Routine contraception	Emergency contraception
Alice	OCPs, LNG-IUD	LNG-EC
Antara	OCPs	LNG-EC
Barbara	OCPs	LNG-EC
Beyoncé	OCPs, Vaginal ring, Spermicidal film*	LNG-EC
Gia Grace	OCPs	LNG-EC
Gwen	OCPs	
Ivy	OCPs	LNG-EC
Kendra	OCPs	LNG-EC
Lilieae	Contraceptive injection, LNG-IUD	
Luna	OCPs	
Marie		LNG-EC
Mavis	OCPs	
Quinn	OCPs, Vaginal ring, Cu-IUD, Tubal ligation*	LNG-EC, two prescribed oral medications
Roxanne	OCPs, Contraceptive injection, Vaginal ring, LNG-IUD	
Sapphire	OCPs, LNG-IUD	LNG-EC
Sloane	OCPs, Vaginal ring, LNG-IUD	
Steph	OCPs	
Sultana	OCPs, LNG-IUD	LNG-EC
Tuck	OCPs	

*Methods that were not specified in the inclusion criteria or recruitment materials but were incidentally discussed in the interviews.