University Students' Gynecology Care Experiences in the US and Canada: Implications for Equitable Access to Person-Centered Care

by

Nicole Karen Richards

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Examining Committee Membership

The following served on the examining committee for this thesis. The decision of the Examining Committee is by majority vote.

External Examiner	DR. AUDREY GILES Full Professor, School of Human Kinetics University of Ottawa
Supervisor	DR. SAMANTHA MEYER Associate Professor, School of Public Health Sciences Associate Director, Graduate Studies University of Waterloo
Internal Members	DR. ELLEN MACEACHEN Director; Professor, School of Public Health Sciences University of Waterloo
	DR. ELENA NEITERMAN Continuing Lecturer, School of Public Health Sciences University of Waterloo
Internal/External Member	DR. TONI SERAFINI Associate Professor, Department of Sexuality, Marriage, & Family Studies St. Jerome's University

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

Introduction: The United States (US) and Canada (CA) have differing healthcare systems that play a central role in how reproductive care is accessed and delivered. Yet, their shared patriarchal history and culture contribute to the underdevelopment of medical reproductive knowledge and appropriate healthcare for uterus-having individuals of various intersecting identities. Medical literature lacks uterus-having individuals' lived experiences of navigating reproductive services, and perspectives on how social factors, healthcare structure, and clinical practice can better support equitable access to person-centered reproductive care within both countries. As university students reflect diverse individuals transitioning to autonomous roles and changing reproductive health needs, their voices are critical to uncovering social and structural influences of person-centered access. **The overall goal of this research was to** identify what the US and CA system stakeholders can learn from uterus-having university students to improve reproductive healthcare delivery. I investigated how university students navigate gynecology care within divergent healthcare delivery models to address the following aims.

Aim 1: Identify university students' barriers to accessing gynecology care.

Aim 2: Document factors influencing students' person-centered gynecology care experiences.

Methodology: This study was operationalized from the transformative-intersectional perspective that knowledge is created through individual experiences of reality, power, and oppression. Twenty-two university students who have used reproductive health services (CA: n = 11, US: n = 11) participated in semi-structured interviews and surveys (Nov 2019 – Jan 2021). Five reproductive health experts (CA: n = 3, US: n = 2) were interviewed to further situate students' experiences within existing policy and practice standards. Student data collection tools were guided by intersectionality theory, the equitable access model (EAM), person-centered care frameworks, and American College of Gynecology clinical recommendations.

Qualitative analysis occurred in three coding steps: inductive, identity, and deductive, allowing a broad look at raw data, intersectional identity discovery, and equitable healthcare access framework application. To supplement qualitative clinical-level findings, I analyzed surveys to show descriptive frequencies of students' reported experiences of person-centered care indicators. I used abduction to connect qualitative and descriptive findings to existing concepts (e.g., theories, models, literature), identifying themes within and beyond existing knowledge and standards. To conclude my analysis, I used retroductive reasoning to extend the EAM model as it applies to gynecology care, illustrating social, policy, and practice opportunities to promote accessible person-centered care in both health systems.

Results: Each participant self-reported uniquely intersecting identities (e.g., races, ethnicities, genders, sexualities, socioeconomic statuses, and cultures), which contributed to specific reproductive needs that played a role in their healthcare navigation and clinical experiences. These reports determined the scope of my thematic investigation, establishing a focus on access to and quality of preventive gynecology care and treatment for chronic reproductive issues in CA and US.

Aim 1: University students' gynecology care access was determined by intersecting influences of structural health system nuances and personal cues to accessing reproductive care.

CA's health system provided students in this study with simplified reproductive healthcare navigation, but it limited reproductive health options and prolonged waits to specialist services. The US health system theoretically provided participants with reproductive care choices, but access to these choices was logistically complicated by healthcare fragmentation. Healthcare structure shaped the clinical setting, determining protocols and care provisions that students identified as negatively impacting care options and experiences such as inaccessible preferred contraception methods, short appointment durations, and a narrowed scope of health services. Students reported the importance of providers' health system knowledge and clinical strategies to mitigate negative impacts of their respective health models. Personal influences to seeking care existed at various steps, including identifying when to seek care, knowing how to access care, preparing for clinical interactions, and physically attending appointments. Personal influences of how and when to access care stemmed from participants' life experience and social networks, which they developed over time. Students reported that universities' social and built environments further shaped reproductive health efficacy by providing proximate support, resources, and confidential services.

Aim 2: I noted discrepancies between current reproductive care standards, participants' clinical experiences, and students' perceptions and values of what person-centered care means. Students reported frustration with the wording, intention, and interpretation of some standard clinical screening questions. Most students were not asked questions related to sexuality, mental health, and abuse. With participants' frequent reference to the relationship between mental, sexual, and reproductive wellbeing, failure to ask these questions sometimes limited providers' ability to address students' needs. While most students were offered STI testing and reported STI services as a key reproductive health value, students infrequently reported blood tests, possibly indicating incomplete or insufficient STI testing. Students' discussions about clinical experiences focused on perceived quality of provider interactions. While most survey responses showed satisfaction with providers' shared decision-making approach, interviews revealed nuanced experiences of students feeling unengaged in their care, reporting providers did not offer adequate support to enable them to make informed, autonomous decisions.

Conclusion: Students in both countries expressed the need for reproductive service navigation support within systems that provided timely options to care that centered on their specific intersectional identities and health needs. In addition to policy and practice mitigation opportunities for identified structural barriers within health systems, I found that comprehensive education policy and social support may improve students' access to person-centered reproductive care, allowing for knowledge and skills to identify reproductive needs, navigate health systems, self-advocate, and ultimately make informed decisions. These findings suggest that providers can play a crucial clinical role in mitigating some structural and personal barriers to person-centered care by maintaining and applying proficiencies in reproductive health literature, health policy, and cultural safety as it relates to their patient populations. Overall, this work situates reproductive healthcare access within the EAM, extends this framework to better integrate person-centeredness as a care quality mediator, and connects concepts identified in this study to opportunities for improvement.

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List of Abbreviations

CA – Canada
CHA – Canada Health Act
EAM – Equitable Access Model
GYN – Gynecologist
KI – Key Informant
LARC – Long-Acting Reversable Contraception
LGBTQIA+ – Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, et al.
PCP – Primary Care Provider
SDM – Shared Decision-Making
STI – Sexually Transmitted Infection
US – United States

Chapter 1

Background

Chapter one provides the foundation of this thesis, combining an introduction and literature review to provide a comprehensive context surrounding the need for and design of this study. Section 1.1 summarizes the background of why equitable access to person-centered care is important to investigate. I then begin Section 1.2 by outlining how healthcare access is defined within Westernized cultures and explaining the concept of care quality being intrinsic to access. Subsequently, Section 1.3 summarizes tangible aspects of the US and Canadian health systems, including their evolutionary path to current-day models. Additionally, I examine selected health policies which contribute to the state of reproductive health equity within each country. Further, Section 1.4 elaborates on the concept of person-centeredness as a factor of equitable access to quality reproductive care, providing insight on what we know about university students' person-centered needs. In Section 1.5, I zoom in further on this study's context, specifying the aligned paradigm and theory, and societal considerations during the study period. Altogether, I use this background to justify the scope and aims of this research.

1.1 Problem Statement

Modern human health is in-part formed and altered by health systems. National healthcare models play a central role in their population's health behaviors and medical service utilization.[1] Consequently, government policy that limits healthcare access, utilization, and quality disproportionately impacts marginalized people's ability to attain adequate social and physiological wellbeing.[2–4] Despite movements to achieve gender equality, gynecology health needs remain unmet in current Westernized healthcare systems due to the sociological and biological complexities of fertility over the lifespan.[5,6] In particular, reproductive healthcare services such as family planning and obstetrics care require additional medical attention compared to cisgender men's general and reproductive health concerns. Further, young patients may have a higher need for system supports during their transition to adulthood, as paternalistic forces typically hinder minors' independent navigation and choice.[7] In addition to autonomous healthcare use and health decision-making, young uterus-having individuals often require sexually transmitted infection (STI) and family planning services as they explore sexuality[8] and work toward economic stability before deciding to initiate pregnancy.[9]

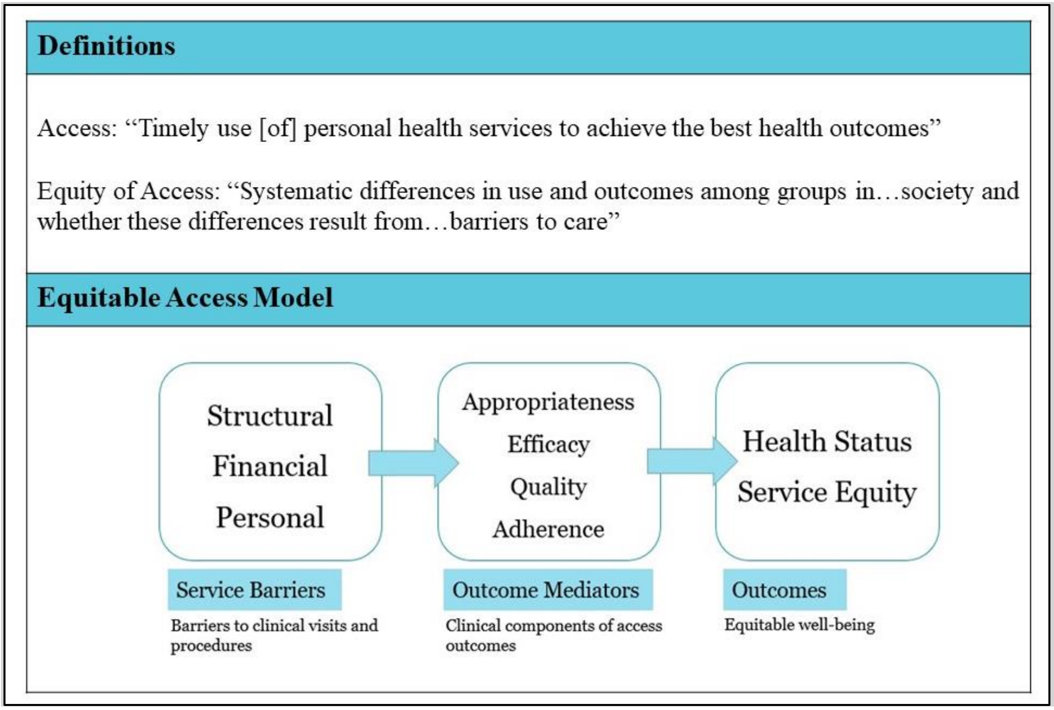
Previous research has discussed healthcare model quality as its ability to reflect the values and needs of its consumers.[10–14] Historically, women and other uterus-having people have not been given adequate agency in their healthcare system needs.[5] Healthcare itself is socially constructed from a cisgender male-dominated worldview. This can be realized through current gender-based medical research funding inequities in both countries, where resources are predominantly allocated toward diseases that disproportionately affect cisgender heterosexual men, while health issues impacting cisgender women and LGBTQIA+ individuals receive less research funding.[15,16] Therefore, in large part, medical institutions and surrounding health policy are paternalistic in perpetuating parameters of how others can use health services through health coverage and stakeholder (e.g. pharmaceutical companies and providers) coercion.[17] Further, health needs and experiences vary among uterus-havers' various intersectional identities.[18] This creates a gap in information between what health systems offer uterus-having individuals and what we know to be important to them in achieving healthful lives. By identifying diverse reproductive health experiences and perceptions of healthcare, we can extend knowledge to create effective health policies and practices that emulate these individuals and improve applications of person-centered care at the system and clinical levels. Applying a person-centered lens to care can better engage patients in autonomous, informed health decisions and improve trust and safety, which may ultimately lead to appropriate care-plans, holistic treatment, and positive health outcomes.[19–25] This research focuses on the health system needs of university students in Canada and United States as they transition to autonomous healthcare navigation roles during young adulthood. Investigating gynecology care navigation in both a universal and public-private hybrid health system is opportune to explore how contrasting health models can improve equitable access to person-centered reproductive healthcare.

1.2 Westernized Healthcare Access Framework

Healthcare access has long been a topic of interest for health systems researchers. Several frameworks have been created to define, measure, and improve access.[11,26,27] The field itself has struggled to employ a uniform definition. Some consider access as the ability to obtain services, while others have a broader view of access that includes the ability to access fit and effective services.[27] The 1990s work of United States' Institute of Medicine (IOM) "Committee on Monitoring Access to Personal Health Care Services" developed a healthcare access framework that encompasses the most comprehensive interpretation of healthcare access. This framework includes a conceptualization of what access means, barriers to access, and consequences of inaccessible health services.[11] This model serves as a base in health access research today and is specifically integral in the organization of the US "Healthy People" initiatives that aim to improve national health outcomes through specific objectives and interventions.[28]

The equitable access model (EAM) includes barriers, types of services, mediators, and health outcomes (Figure 1).[11] It separates access barriers into three levels: structural, financial, and personal/cultural. Moreover, this model considers if these barriers are for general clinical appointments or specific health procedures. The EAM moves forward to account for what happens within the clinical setting and provides care quality mediators that can lead to health outcomes: appropriateness of care, treatment efficacy, provider quality, and patient adherence. Lastly, the model outlines ways in which barriers and mediators manifest in patients' equitable well-being. Thus, there cannot be true access without quality, as quality care is an essential component which affects health outcomes, patient satisfaction, and overall well-being. In sum, healthcare delivery models contain structures that may act as barriers to services and clinical practices that mediate patient health outcomes.

Figure 1. Institute of Medicine's Equitable Access Model (EAM) [11]



Definitions

Access: "Timely use [of] personal health services to achieve the best health outcomes"

Equity of Access: "Systematic differences in use and outcomes among groups in…society and whether these differences result from…barriers to care"

Equitable Access Model

1.3 United States and Canadian Healthcare Systems

National healthcare systems vary in approach, funding, populations served, and health outcomes. The role governments play in healthcare has essentially been publicly dichotomized between philosophies that determine healthcare as a right or a privilege. However, healthcare models exist on a right-privilege spectrum through varying conceptualizations of essential medical services and how the government and free-market interact to provide (or not) equitable access to these services.[29] As many of the leading nations work toward the right to equitable healthcare access from a universal model, some have shown this more achievable than others.[30] As follows, I detail the US and CA healthcare systems, including each system's historical evolution, current structures, and how these systems align with equitable access principles.

1.3.1 United States Healthcare System

The US healthcare system has long evolved from its origin as an unorganized charitable service to an overly-complex consumeristic business.[31] As modern medicine knowledge increased, US healthcare developed into a systematized, consumeristic approach, resulting in numerous stakeholders seeking to capitalize on the economic opportunities of medicalization.[5,32] To address the rising healthcare costs driven by for-profit stakeholders, a managed care approach was put in place during the 1980s, which introduced funding mechanisms to incentivize cost-effective solutions rather than resource overutilization.[31] This capped-fee health insurance approach limits patients to providers within insurance networks and which prescriptions are covered. Researchers have also debated whether lack of provider incentive for treatment may be antagonistic to patients' demand for healthcare quality. That is, providers may be less likely to invest in further diagnostics or treatments if they receive lump-sum reimbursements rather than charge a fee for each service.[33,34] Thus, a struggle to provide low-cost, high-quality healthcare has been at the forefront of healthcare legislation with trial-and-error solutions and rapidly changing policy.

A majority of the US hybrid public-private model is currently funded by federal, state, and insurance-patient cost-shared funds through the Center of Medicare and Medicaid Services (CMS), a regulated health insurance exchange marketplace, and employer-based or military (Tricare) health insurance.[35] These insurance types vary in the ways medical expenses are paid, subsidization of care costs, and which services and providers are covered. Historically, healthcare coverage gaps have existed for millions of healthcare consumers, which have been mitigated by several incrementally added provisions of health legislation, including the previously mentioned insurance exchange marketplace.

The Patient Protection and Affordable Care Act of 2010 (PPACA or "Obamacare") demonstrates the modern grapple between quality and cost. It is the largest enacted healthcare legislation since the 1965 creation of Medicare and Medicaid (CMS), partially publicly funded health insurances for those with disabilities, low-income, and elderly individuals.[36] The PPACA represents the recommitment to providing healthcare as a right while also attempting to preserve individualistic US values. This package of regulations includes over 20,000 pages of a growing entangled system. Part of this entanglement includes delegating coverage organization by state, limiting the ability for US residents to use insurance outside of their home state. Overall, despite PPACA's intention to improve equitable access, it did not fully address fragmentation between states and insurance providers. That is, the US health system is not one true system. Rather, it is fifty states multiplied by the number of state-based health insurance plans plus federal health insurances.

Despite its complicated foundations, the PPACA has achieved several favorable outcomes. Among its most positive impacts are increasing access through expanding health insurance coverage,[37] improving quality through essential insurance benefit requirements,[38] and implementing preventive community-based population health measures.[39] Yet, its complexity has caused stakeholder confusion and misunderstanding,[37,40,41] high overhead costs,[42] and divisive political debate.[43] As a work-in-progress policy, much is needed to fulfill "right to health" promises and ensure stability.[44]

1.3.2 Canadian Health System

The CA health system, referred to as "Medicare", is made up of thirteen provincial and territorial health systems that are supported by the federal government.[45] Based on a quest for health equity, Canada's universal healthcare system seeks to provide tax-based public health insurance to all. Healthcare as a human right has long been integral in the nation's values, beginning in the 1940s with the Dominion-Provincial Conferences and solidified with the monumental Canada Health Act (CHA) of 1984.[46] Starting in 1957, the Hospital Insurance and Diagnostic Services Act permitted 50% federal-provincial and territorial cost-sharing as a means to mitigate individual out-of-pocket hospital and diagnostic care costs. In 1966, the Medical Care Act expanded cost-sharing for provider care beyond hospital-based services. In 1977, a new federal funding precedent was set, implementing federal contributions through block funding and tax points rather than previously established 50% cost-sharing.[47] As such, previously realized cash funding decreased in the form of block grants, and funding was supplemented through lowered federal taxes to permit an increase in provincial and territorial taxes. Finally, in 1984, the CHA constrained public health providers from charging patients more than what provincial and territorial insurance paid (e.g., copayments), and it went further to solidify standards of public administration, comprehensiveness, universality, portability, and accessibility.[48]

Though referred to as one healthcare system, Canada's unique model continues to operate on a provincial/territorial level rather than a centralized basis. That is, provinces and territories are individually responsible for meeting the abovementioned CHA standards through their respective healthcare delivery systems. If provinces and territories fail to uphold CHA, federal financial health system contributions can be withheld or reduced.[48] Further, federal funding in the form of tax points has been shown to be less tangible and more variable than fixed cash, acting as a barrier to provincial and territorial healthcare progress and causing tension between provincial/territorial and federal governments.[47,49]

While each provincial and territorial health model is expected to meet the CHA's baseline requirements, variation of coverage and quality still exists based on provincial and territorial capacity and political decisions.[50] However, patients using these provincial/territorial health systems generally navigate health services as follows: 1. Patients usually have a specific health concern to make an appointment. While provincial and territorial health insurances may cover annual personal appointments for screenings and patient-specific preventive services, comprehensive annual health exams are not covered unless deemed appropriate by the provider.[45,51] 2. Patients, including adults and children, receive primary care from a general practitioner. 3. The general practitioner makes an executive decision for specialist referral.

Canada's approach has proven more equitable and affordable than many other developed models, most notably the US healthcare system.[52] However, this is not without improvements to be made. Despite criticism of little performance progress and low rankings in the Commonwealth Fund's healthcare comparison, positive policy resolutions have been rather stagnant.[50] This may be attributed to absence of citizens' political will and perceptions that Canadian healthcare is "good enough",[46] as well as the fear of risk due to negative views of the US uncertain system changes.[50]

1.3.3 The Role of Health Policy in (In)equitable Reproductive Care Access

Though democracy sets forth a premise of public values in health and healthcare, policies have various consequences within diverse societies. As shown above, health policies often fall short of supporting equitable health. Since policies and resulting services are swayed by those that have privileged voices (i.e., corporate lobbyists, upper-class), health policy is shaped by economic interest[53] and from a standpoint that fails to adequately amplify the needs of the poor or otherwise disadvantaged.[1] These influences are blatantly visible in the US healthcare system,[31] but less so in Canada. However, the existence of corporate healthcare lobbying has been scrutinized as impacting the potential of Canada's health system.[54]

Both Canada and the US have promised quality reproductive healthcare through the lens of autonomy but do not frame policy for the purpose of achieving equality.[55,56] As such, both systems consider reproductive rights, but they fail to support reproductive justice. Without reproductive justice framework, reproductive rights are routed in white feminism and not inclusive of diverse individuals and comprehensive reproductive needs.[57–59] Without a justice lens of health legislation, these systems create a model that treats patients as homogeneous beings. Despite such diverse populations of uterus-having individuals in each country, access and utilization of care may currently be assumed as a uniform experience.

United States

American medicine has been cited as systemically racist by various academic authors detailing the health system's history within the societal context.[12,60,61] Like most societal institutions, the US healthcare system and medical sciences were created by the privileged and still dominate the healthcare field today.[61] For example, most recent data show that white people make up approximately 75% of medical professionals, public health researchers, and policymakers.

Though the mid-1960s brought an end to US segregation laws and the creation of government-funded Medicare and Medicaid insurances, the Black population's financial barriers to care persisted due to lack of state and institutional accountability.[62] Medicare is funded by the federal government, while Medicaid is funded by a combination of federal and state governments.[63] The structural differences of Medicare and Medicaid funding has and still continues to perpetuate implicit state-based racism through state decisions involving the level of health insurance support for the poor. Most recently, this is shown in some states' resilience to and rejection of the PPACA's Medicaid coverage expansion. There is evidence that these expansions may be racialized through "state-level racial resentment" (e.g., historically confederate states) and policymakers' significant response to white constituent opinion compared to non-white.[60] Overall, differing insurance plans within and across states create healthcare inequities. These factors determine which providers a patient can see, how much patients pay, and how they gain access to services.[12]

In addition to the state-based Medicaid inequities, health providers within each state can choose to opt-out of accepting Medicaid insurance. Though providers justify their decision to opt-out of providing services for Medicaid patients based on low reimbursement rates, healthcare researchers question if this phenomenon is intersectionally determined by both race and class.[64] For instance, a 2006 study found that providers in poor white or racially integrated neighborhoods were more likely to accept Medicaid than providers in racially segregated areas, indicating that reimbursement rates may not have been the only factor in not accepting Medicaid patients.[64]

Indeed, systematic discrimination does extend beyond the basis of race, resulting in inequities for other marginalized groups. Specific to this study's scope, policies related to reproductive health access disproportionately impact those of marginalized ethnicities, socioeconomic status, and genders. Predominantly illustrated by reproductive health outcomes within these demographic intersections, the US Black pregnancy related mortality (PRM) ratio is consistently significantly higher than white PRM, with Black maternal deaths 2.6 times the rate of white maternal deaths in 2021.[65] Further, not only do PRM disparities persist among all income levels, but experiencing income inequality has been shown to elevate Black PRM risk 20% more than white PRMs, indicating a synergistic risk of being Black and low-income.[66]

In 1970, a federal grant program, Title X, was created to increase young and/or low-income patients' financial access to family planning services providing free or low-cost contraception care.[67] Funding amounts and requirements have fluctuated throughout the last few decades; yet overall, has extended services throughout recent decades to include STI and cancer screenings, reproductive health counseling, and LGBTQIA+ services. Though Title X has never been used for abortion services, there has long been a movement to eliminate funding for clinics that use abortion as a family planning method. From July 2019 to November 2021, this was solidified by a gag rule denying funding to reproductive organizations that not only provide abortion services, but also those that refer patients to abortion services.[68] Therefore, Planned Parenthood and many other clinic recipients withdrew from the Title X program, decreasing at least 17 states' Title X clinical capacity by 50% - 100%.[69] While the health outcome impact is unknown and some state governments secured funding to substitute or mitigate the financial gaps, this was a significant barrier for clinics to provide care to young, uninsured, and underinsured patients. Based on the number of Title X patients served in 2018 and the decrease in clinical funding, it is estimated that the gag rule stripped contraception funding for 1.6 million patients.[70]

While President Biden's administration rolled back Title X changes in 2021, republican party efforts continued to limit healthcare access for uterus-having individuals. In June 2022, the US Supreme Court overturned federal abortion rights, giving power to the states to initiate their own laws surrounding bodily autonomy.[71] This resulted in further fragmented access between states, and continued reproductive healthcare barriers at the state policy level. In fact, global human rights organizations have called on the United Nations to intervene in the United States' international human rights law violations, citing anti-abortion laws as permitting avoidable morbidity and mortality, criminalizing patients and providers, and other mechanisms of oppression.[72] More about the process behind anti-abortion policy related to this study's timeframe context can be found in Section 1.5.

With the success of state anti-abortion laws, the republican party moved forward with an authoritarian platform to include anti-LGBTQIA+ legislation. States have rapidly proposed bills and enacted laws that threaten access to gender-affirming care and the existence of gender non-conforming expression throughout several conservative-led states. During the 2023 legislative session alone, the American Civil Liberties Union identified 426 anti-LGBTQIA+ bills.[73] As of March 20, 2023, five states passed laws prohibiting or limiting access to gender affirming care (AR, MS, SD, TN, UT). Further, two states passed laws criminalizing "adult-oriented performances" using language that targets drag and LGBTQIA+ communities (TN, AR). These policies reinforce social norms of sexual stigma and gender discrimination, and they create state, gender, and sexuality-based physical and psychological health inequities, including access to LGBTQIA+ specific reproductive health services.[73]

Canada

Canada's universal healthcare model mitigates many equity barriers that the US faces. Inequities do exist; however, these inequities are less explicit in the CA healthcare context. Due to the lack of diverse demographic data collection and healthcare surveillance, healthcare access inequities within Canada are not entirely known.[2,74] For example, data, literature, and initiatives pertaining to CA racial healthcare inequalities are heavily focused on Indigenous populations,[75] leaving out considerations for other racially marginalized groups. Below, I discuss some policy barriers that contribute to inequitable experiences. However, the overall absence of solidly organized Canadian reproductive health policy and monitoring results in information gaps about true access to autonomous healthcare.[76]

Healthcare access inequities occur based on the short fallings of the CA healthcare system's provincial and territorial healthcare coverage and quality variation.[50] These major coverage differences include homecare, optometry, dentistry, and mental health support.[49] Lack of covered preventive services leads to inequities among Canadian healthcare users based on their geographic location, hindering the promise of portability especially for Indigenous peoples living in remote communities with limited healthcare resources.[77] Moreover, the option for patients to purchase supplementary insurance causes healthcare access inequites,[78] disproportionately impacting out-of-pocket health expenses for low-income households.[79] Populations with high health risks, such as women and adolescents, are the most disadvantaged in lacking this supplementary health insurance.[78]

Pertaining to Canada's healthcare portability standards, all provinces and territories except Quebec agree to provide reasonable coverage of an amendable list of interprovincial and territorial services.[80] While these lists of covered services are not always easily accessible, some provincial and territorial health ministry resources exclude reproductive health-related services such as sterilization reversal, in-vitro fertilization, gender reassignment services and procedures, genetic screening, and telemedicine.[81–83] Other provinces, such as British Columbia, state explicitly that only emergency services are covered out-of-province.[84] In most cases, out-of-province care costs are billed to the provider's provincial and territorial health insurance and costs are appropriately reallocated between provinces monthly.[80] For example, if an Alberta resident sought care in Ontario, the patient would provide their Alberta health card, the provider would bill the Ontario Health Insurance Plan with the patient's Alberta health card information, and Alberta would reimburse Ontario for services covered. All provinces except Quebec are reported as participating in this process established by Out of Province Reciprocal Billing Agreements.[80] However, due to the decentralized Canadian Health System and the lack of federal oversight, there is no universal obligation for providers to comply with these billing methods.[49,80] Therefore, residents in all provinces and territories may be required to pay out-of-pocket and apply for reimbursement with their health insurance. Services in Quebec or performed by non-participating providers elsewhere will bill the patient, and the patient will fill out a form to be reimbursed by their provincial and territorial health insurance plan.

The Canadian health system also impacts clinical level effectiveness through a strained provider force and its common fee-for-service reimbursement.[85] This sometimes results in a "one issue per visit" clinical policy, which decreases patient-provider communication and holistic health approaches in complex patients.[86] Further, because of the referral system, most Canadians receive reproductive health exams from primary care providers who act as gatekeepers to seeking specialists, including gynecologists.[87] To mitigate these reported issues, health system stakeholders aim to increase interprofessional health teams and care quality,[86,88] and established evidence-based guidelines for primary care.[89] Yet, Ontario women report difficult communication with their provider, citing inadequate time with family doctors and their lack of specialty health knowledge.[90]

Compared to other similar country's drug regulatory agencies (e.g., US, UK), Health Canada has historically demonstrated delayed drug approval times, resulting in lack of pharmaceutical availability compared to other nations.[91,92] Most notably for reproductive health needs, the delay of abortion medication and contraception technologies has far exceeded the average drug review period. Mifepristone was reviewed over a six-year period until approved for normal prescription in 2017,[93,94] fifteen years after the US marketed this abortion medication.[95] Indeed, 2017-2020 population-based data show the positive impact of mifepristone was realized in Ontario's abortion health outcomes, with a decrease in surgical and second trimester abortions, and post-abortion ectopic pregnancies.[94] Similarly, while the US Food and Drug Administration approved the contraceptive etonogestrel implant in 2006, this device was not applied for use in Canada until 2013, when it was rejected due to insufficient data perceived by Health Canada.[96] Fourteen years after approval in the US, Health Canada officially approved the contraception implant in 2020.[97] However, the implementation and uptake of Nexplanon are currently unclear, as providers must be trained and certified before prescribing and inserting these devices. In fact, when I searched the Society of Obstetrics and Gynecology's website in March 2023, it stated that Nexplanon training program funding was at capacity, and they were not providing hands-on training for certification at that time.[98] In addition to delayed approval and availability of contraceptive technologies, deficiencies in prescription coverage creates family planning barriers to the general population and inequities based on ability to pay.[99] For example, some provincial and territorial insurances do not cover medical (medication) abortions due to the technicality of this procedure only requiring pharmaceutical intervention.[100,101]

Other reproductive care access inequities exist between provinces and territories based on geography and legality. Physical access to care is often cited as an issue for residents of remote and rural communities, especially as it relates to reproductive care.[102,103] Geographic barriers to abortion services can be exacerbated by coverage and legal limitations. Since provinces and territories can determine abortion coverage policies, they can shape accessibility through gestational coverage restrictions, with provincial and territorial insurance coverage varying from 12 to 25 weeks' gestation.[103] Moreover, New Brunswick demonstrates the ability to enforce targeted provider restrictions, limiting coverage to surgical abortions performed within a hospital setting.[103]

Relatedly, provinces and territories give hospitals and providers the power to establish their own institutional policies and protocols. For example, while public health insurances allow self-referral for abortion services, some hospitals and providers may require provider referrals.[103] Further, providers have the right to refuse services based on their personal beliefs. This "conscientious objection" is primarily exercised within the reproductive care field, impeding access to critical reproductive health services.[104,105]

1.4 Person-Centered Reproductive Care

Person-centered reproductive care focuses on each individual patient's holistic needs and values, prioritizing clinical services and communication that reflect and engage individuals to make informed and autonomous health decisions.[14,106,107] To increase appropriate clinical experiences, health researchers and advocates have developed person-centered care models and service guidelines. Yet, we lack an understanding of patients' perceptions and experiences of receiving care through these frameworks. As follows, I discuss some person-centered concepts and gynecology care guidelines related to this thesis' study sample, giving background context for tools used in data collection, analysis, and interpretation. Further, I describe healthcare discrimination issues in CA and the US that exemplify the importance of implementing person-centered care approaches. Lastly, I share previous literature on what is known about university students' reproductive health needs to situate an understanding of this study sample's potential person-centered gynecology barriers. Further, I provide a background of university students' reproductive health, and how this group was opportune for exploring adolescent identity development as they experience and are influenced by previous and current institutional constructs.[108]

1.4.1 Person-Centered Care Models and Reproductive Health Service Guidelines

Cultural safety is a term used to describe providers' ability to recognize mechanisms of inequity within the larger society and practice reflexivity to create a safe clinical environment for each patient.[109] Increasing cultural safety can lead to more effective clinical interactions. That is, patients can experience a more person-centered approach to receiving appropriate services and making informed decisions. Positive communication through a cultural competence commitment stems from trust and respect,[19] and contributes to effective shared decision-making.[20] Calls for providers practicing reproductive cultural sensitivity include familiarization with and respect of cultural beliefs, identification of reproductive care barriers, and framing interactions from the patient's cultural identity.[21,110]

Providers can gather a holistic view of patients by familiarizing themselves with their *biopsychosocial* characteristics.[111] Biological aspects pertain to the patient's physical body (e.g., age, genetics, and health conditions). Psychological characteristics include the patient's mental and emotional health, and beliefs. Social facets assess the patient's relationships, social support, and socioeconomic situation. The biopsychosocial combinations relate to a provider's inquiry of the patient's intersectional identities.

In addition to the provider's knowledge of the patient's background, patients benefit from communication that permits informed choices. *Informed choices* are made when the provider communicates the health problem, nature of choice-making, alternative options, and the benefits and risks; assesses for understanding; and asks for the patient's preference.[112] Patients can make informed reproductive health choices through active patient-provider communication using the shared decision-making (SDM) model. *SDM* builds upon informed decision-making by engaging patients through deliberation and respect.[113] Thus, providers empower patients through shifting power differentials and valuing patients' expertise in "self". An evidence-based tool, OPTION, measures clinical shared decision-making approaches through a twelve-item survey.[20] Though these questions are each important for patient-provider communication assessment, they can be categorized in themes of the provider listening to patient concerns, encouraging decision-making, respecting choices, and answering questions.

Canada and the US both have professional reproductive health organizations to support ob-gyn care standards and frameworks: the Society of Obstetricians and Gynaecologists of Canada (SOGC) and American College of Obstetricians and Gynecology (ACOG). SOGC does not have publicly accessible guidelines or recommendations for preventive reproductive care,[114] possibly due to the Canadian health model of accessing specialized care only when there is a health issue. However, ACOG provides recommendations for age-appropriate scope of services to be offered during an annual reproductive health exam, among several other resources for patients and providers.[115,116] ACOG's 2013 recommendation "checklist" for those ages 19 – 39 included various screenings, tests, counseling, and immunizations supporting patient access to comprehensive gynecology care.[115] However, in wake of 2020's social justice discourse, ACOG archived this checklist and created the Women's Preventive Services Initiative (WPSI) to serve as a coalition seeking to improve adaptability and purpose of these guidelines.[117]

Beyond the gender binary, standards of care for transgender individuals have adapted in response to the increasing social visibility of genderqueer populations and consequential healthcare research. The World Professional Association for Transgender Health (WPath) serves as an interdisciplinary group for the establishment of evidence-based care standards, with their latest guidelines published in 2022.[118] Moreover, gynecology-centered organizations, such as The Society of Family Planning and ACOG, have also developed transgender care standards specific to the care they provide.[22,119]

1.4.2 Healthcare Discrimination in the US and Canada

Discrimination is at the forefront of US media, politics, and research.[120] Most notably, there is ever-growing healthcare research and initiatives recognizing discrimination's role in service delivery.[121] Though there is not much information on CA healthcare discrimination from an academic standpoint, social discrimination is known to be prevalent in Canadian culture[122] and multiple groups report experiencing healthcare stigma in the media.[123,124] Mirroring US oppressions, CA experiences discrimination through race, ethnicity, religion, gender, and sexuality.[122] It is not well documented why Canada has failed to consider multiple different racial health and healthcare experiences, but it seems that the omission of this information is intended to approach population statistics with colorblindness to avoid data misuse rather than recognizing and identifying the existing social impacts of racialization.[125,126] For example, the 2004 Joint Canada/United States Survey of Health collected detailed racial data from US and Canadian respondents; yet, the public datafile categorizes Canadian responses as white, other race/multiple race, not applicable, or not stated.[127] However, in recent decades, Canada-based institutions have improved their research focus on Indigenous health and healthcare access disparities, finding complex inequities stemming from colonization, which permeate into the clinical setting through cultural insensitivity and misalignment on what culturally safe means to Indigenous groups.[78,128] In absence of Canada's healthcare discrimination literature pertaining to other groups, the Public Health Agency of Canada uses US information to recognize and inform their possible socially determined healthcare disparities.[75]

Once in the healthcare setting, a patient's social identities may determine their experience. A combination of power differentials and implicit biases can hinder patient-provider communication and decision-making.[23] While acculturation to Westernized society can impact sexual health knowledge, sex-positive beliefs, and safe practices in specific ethnic groups of young people in the US[129] and Canada,[130] a patient's cultural background may also influence reproductive health navigation.[23]

Through unconscious biases, providers may attribute health indicators to causes commonly prescribed to a certain group of people without considering a holistic view of the individual patient.[131–133] For example, provider stigma against patients with mental health conditions can lead to "diagnostic overshadowing", defined as when real physical complaints are ignored or mistreated.[132] Similarly, physicians' pain management decisions among identical cases varies between race[133] and gender.[134] Further, providers may coerce patients into health decisions based on their own agendas. Specific to reproductive health, US providers have a history of using coercive practices to control fertility in oppressed groups via sterilization, and now more recently are questioned with concerns about long-acting reversable contraception coercion.[135] Similar to US coercive fertility practices, Indigenous women in CA have historically experienced and continue to report tubal ligation coercion.[136] Provider stigma and exploitation continue to influence reproductive care seeking hesitancy and provider trust among marginalized people in both countries, including but not limited to Black, Indigenous, and LGBTQIA+ individuals.[137]

1.4.3 Understanding University Students' Gynecology Needs

Most students enroll in university at a young age during the transition from adolescence to adulthood.[138] Within the university setting, these students adjust from diverse cultural and geographic adolescent backgrounds, experience altered social support, and develop complex identities.[7,108] As adolescents transition to the legal age of maturity and exercise personhood, medical and parental paternalism continue to influence young people's reproductive health knowledge, privacy, and choices.[139] Relatedly, one study exploring Black women's sexuality growth identified three phases: starting to understand sexuality, transitioning period of understanding and confusion, and complete autonomy and understanding of self.[140] All phases were reported to be influenced by social norms and empowerment to protect themselves and others, suggesting positive environmental constructs as an ultimate facilitator of reproductive wellbeing.

Female university students may have a higher need for reproductive health services and experience more barriers to care than their male counterparts. For example, one quantitative study showed female students reported that recent sexual intercourse, social approval, and knowledge of services offered influenced their decisions to seek care.[141] Comparatively, male reproductive care seeking was only influenced by knowledge of services offered. Further, female university students face the fear of and more often experience sexual violence and coercion.[142–145] These findings establish the need for further reproductive health focus on young uterus-having university students as it relates to the social construction of sex, gender, sexuality, and shame.

Sources of information, including social networks (e.g., family and friends), internet resources, and formal education can negatively or positively influence young people's reproductive health and autonomy.[146,147] From 1995 to 2013, surveys found a concerning decrease in US adolescents who reported receiving formal family planning education, and illustrated comprehensive sexuality education disparities by state and school district.[148] Given rapid generational and reproductive technology changes, literature encouraging the use of technology in reproductive health information can be effective and adaptive in meeting young people's learning preferences and reproductive health needs, including confidentiality and information accuracy if reputable resources are provided.[149–151] Overall, previous literature indicates that students lack adequate reproductive health knowledge, and cite limitations in their ability to access trustworthy information and tools.[146,150] With the ability of reproductive health issues to impact students' general wellbeing and academic performance,[152] and demands of students' schedule and workload competing with health priorities,[150] the university environment can provide education and health services support to mitigate unintended consequences of sexual behavior common during the transition from adolescence to adulthood.[153]

Overall, this study's focus on university students is opportune to explore social and structural influences of person-centered gynecology care access, providing insight on potential nuances related to adolescent development, institutional roles, sensitive health needs, and reproductive autonomy.

1.5 Theoretical Alignment, Societal Context, and Research Scope

Exemplified above, systemic oppression and related inequities are complexly intertwined within healthcare structure and policy (Section 1.3), clinical care, and the gynecology field (Section 1.4). As a socially constructed mechanism, it is important to investigate equitable access to person-centered gynecology care through philosophical underpinnings that reflect and amplify the lived experiences of those navigating care within the broader societal context during the study period.

This study was developed and operationalized from a transformative worldview: a health justice value of bodily autonomy. It does not seek to reduce complex social injustices to objective tests of a single truth. It is, however, driven by political origins and data rooted from the people's voices to enact change.[154] As follows, I describe the transformative paradigm's corresponding intersectionality theory to bring forth and amplify multiple, intricately related traits that create an individual's truths.[155] Spanning the period prior to and beyond COVID-19's devastating impacts and rise in and recognition of recurring social injustices, this section also illuminates the appropriateness of operationalizing the transformative lens to address reproductive health equity within the current societal context.

1.5.1 Transformative Paradigm and Intersectionality Theory in Reproductive Health Research

Transformative research extends constructivist epistemology by recognizing that knowledge is created through an individual's experiences of reality, power, and oppression.[154,156] Thus, not only is reality co-constructed, but these constructions place groups and individuals at different privileged and marginalized social locations. Transformative investigation focuses on bringing marginalized truths to the forefront and uses this information to develop an informed plan to equitable action.[154] Research through a transformative paradigm places priority on respecting cultural differences while promoting human rights, validates the ontological belief of multiple realities influenced by a multitude of factors, recognizes research itself as a social process perpetuating these influences, and employs a methodology that works to instill trust from and amplify needs of marginalized participants.

Gynecology healthcare access research supports a need for transformative-intersectional research methodology that aligns with the complexities of reproductive health inequities and exploitations. The US and CA's differing healthcare funding,[35,46] clinical practices,[87,157] and reproductive health outcomes[158] provide an opportunity to explore how policy and practice impact health equity among various identities. In addition to the issue of inequitable access in both countries,[2] patients experience health outcome mediators within the clinical setting that are often constructed by the social world, exemplifying the relationship between social powers and a patient's identities.[23,155]

Intersectionality theory operationalizes the transformative paradigm through a matrix understanding of identities within and between individuals, groups, and structures. Rather than seeking to separate variables to identify independent factors contributing to specific outcomes, this matrix-thinking employs research through the rationale of identities being intertwined and impacting one-another.[155] This perspective amplifies how individuals are positioned in society, how they experience life, and the resulting health effects of multiplicative demographics. None of these characteristics can be added together or separated from a person, as they represent a holistic composition. For example, a Black female patient's clinical experience can be determined by the interaction between being both Black *and* female through combined white supremacy *and* patriarchal mechanisms. That is, rather than considering identities as "either/or" and perpetuating a hierarchy of oppressions, they are viewed as "both/and" to support inclusive social justice movements that reject uniformity but promote solidarity,[155] aligning with the values of person-centered care outlined in the previous section.

Intersectionality was first conceptualized by Black women who were born into slavery and led early activist movements in the late 1800s – early 1900s. The literature often points to Anna Julia Cooper, who used scholarship and activism calling for an understanding of the racism-sexism relationship, and how these factors determined social location.[159,160] However, at this time in history, the truths of non-dominant views were discredited and ignored. Thus, the history of intersectionality theory's development is not well-documented. This resulted in waves of feminism that were not inclusive of those with complex oppressive experiences.[159] The 1980s brought forward a movement where these social justice issues could be addressed intersectionally, and academics began to re-employ and add to Cooper's early work. The term "intersectionality" was created by critical race theory contributor Kimberlé Williams Crenshaw, JD.[161] In 1990, Dr. Iris Marion Young developed a model of disseminating an intersectional political lens through the "five faces of oppression", including cultural dominance, lack of power, marginalization, exploitation, and violence.[162] Dr. Young, among other academics, contributed more inclusivity within intersectionality by outlining other oppressive demographics in addition to the intersection of race and gender.

There is a broad use of intersectionality throughout many research disciplines and advocacy platforms. The role of intersectionality in research varies between fields, projects, and researchers. Some use intersectionality as a more abstract, explanatory theory, while others use it to strictly guide methodology.[108] Intersectionality has been used in reproductive health research as it relates to sexual rights at the intersections of identities (e.g., gender, ability, sexuality, race, etc.),[163] the relationship between lived experiences and the intersections of reproductive and mental health,[164] improving participatory policymaking,[165] and many other reproductive topics in effort to promote, achieve, and maintain health justice. I review this study's operationalization of intersectionality in Section 2.1.

1.5.2 Societal Context During the Study Period (January 2020 – June 2023)

The societal context during this study period evolved and influenced each stage of this research from study conceptualization to dissemination of findings. Here, I intend to provide insight on key social events impacting not only the world we live in but, above all, how these social events directly relate to reproductive health equity, and this study's participants and researcher as co-constructors of these research findings.

This research was conceptualized prior to the COVID-19 pandemic. I interviewed thirteen university students in-person before March 2020 isolation measures. COVID-19 caused socioeconomic hardship and healthcare restrictions, which hindered reproductive health access and worsened disparities.[166] The nine participants interviewed online lived in a different social reality than those interviewed prior to COVID-19's multifaceted world impacts.

In May 2020, a Minneapolis police officer, Derek Chauvin, was recorded murdering a Black man, George Floyd. This led to world-wide police brutality protests, a resurgence of civil rights movements, and transdisciplinary efforts to acknowledge and challenge structural racism. While racism, structural violence, and resulting civil protest was not new, the breadth and depth of this global recognition compounded COVID-19 societal trauma and institutional distrust, especially for racialized communities.[167] Recognizing healthcare and university institutions as part of structural racism, reproductive medicine's racially exploitative history, and my representation of these entities as a white person all impacted my communication considerations when interviewing racialized participants.

The United States Supreme Court decision draft to overturn federal abortion rights was leaked to the public in May 2022. Despite civil demonstrations to prevent this decision, federal abortion liberties were officially suspended in June 2022.[168] In response, several states enacted anti-abortion laws that decreased or eliminated abortion access.[169] Participant data were collected and analyzed prior to these changes, and no participants reported living in these states at the time of their interview. However, this new context surrounding reproductive healthcare inaccess altered my data interpretation and the implications of this study's findings.

Indeed, these events reinforced the critical need for this study's transformative lens and implored me to return to the data, auditing and rephrasing interpretations to better encapsulate participant voices, even if they remain ignored by those in power. As a co-constructor of this study's results, I took careful consideration in how my personal feelings surrounding all three of these major societal shifts may influence knowledge translation. The societal events during this study period strengthened my data collection, analysis, and interpretation. From these events, I improved my ability to elicit comfortability and richly candid information from participants, apply participant voices to developing critical threats and opportunities for reproductive health equity, and communicate the importance and urgency of this topic. Yet, conducting this research throughout these events required substantial emotional labor. The following efforts helped mitigate exhaustion and possible undue influence: 1. I kept an adjacent private journal documenting my personal reactions and emotions. 2. I discussed these feelings with my therapist.

3. I received advice and support from committee members. 4. I decreased my workload and extended my degree timeline.

1.5.3 Research Scope

To conclude this chapter, I provide a concise overview of this thesis scope, connecting this chapter's background concepts to the resulting research goals, aims, and methods. The overall goal of this thesis was to uncover what the United States and Canadian health systems can learn from young people to deliver better reproductive care. I investigated how university students navigate gynecology care within differing healthcare delivery models to satisfy the following aims:

Aim 1: Identify university students' barriers to accessing gynecology care.
Aim 2: Document factors influencing students' person-centered gynecology care.

This thesis uses an inclusive definition of gynecology to encompass any care related to the female biological reproductive system (See: List of Definitions). While this is not a comparative analysis of two health systems, this research employed transformative philosophical underpinnings and intersectionality theory principles to gather information from individuals, giving a voice to distinctive needs within large, convoluted systems to inform political change.

This research considered the EAM framework of barriers and mediators as they relate specifically to US and CA gynecology health services. The EAM framework permitted exploration through the lens of structural and social influences of access and clinical experiences. Additionally, person-centeredness was assessed through biopsychosocial, shared decision-making, and ACOG's "well-woman" checklist components. Reproductive health practice and policy experts acted as key informants to contextualize students' healthcare access experiences. Altogether, existing knowledge surrounding the history, structures, policies, frameworks, and research on reproductive healthcare was used to connect university students' reproductive healthcare experiences to a discussion of social environments, policies, and practices that promoted or prevented accessible person-centered care in both health systems.

Chapter 2

Methodology

Chapter two outlines the procedures and methods employed to collect, analyze, and interpret data. This chapter provides valuable insights into the research process, enabling readers to understand the study design intentions and application. Firstly, Section 2.1 situates the research paradigm, setting the transformative-intersectionality framework for subsequent methods and data interpretation. Next, Section 2.2 delves into recruitment methods and a description of student and key informant participants. In Section 2.3, I discuss data collection methods, describing interview and survey tool development and facilitation. Further, in Section 2.4, I describe quantitative and qualitative analyses steps and equitable access model development. Next, Section 2.5 communicates how axiology corresponding to transformative-intersectional values were applied to study methods and data interpretation, including reflexivity and research ethics practices. Overall, this chapter seeks to establish transparency and rigor in the research process, facilitating the interpretation and transferability of thesis findings. I conclude this chapter with an overview of the structure of the subsequent results/discussion chapters (Section 2.6).

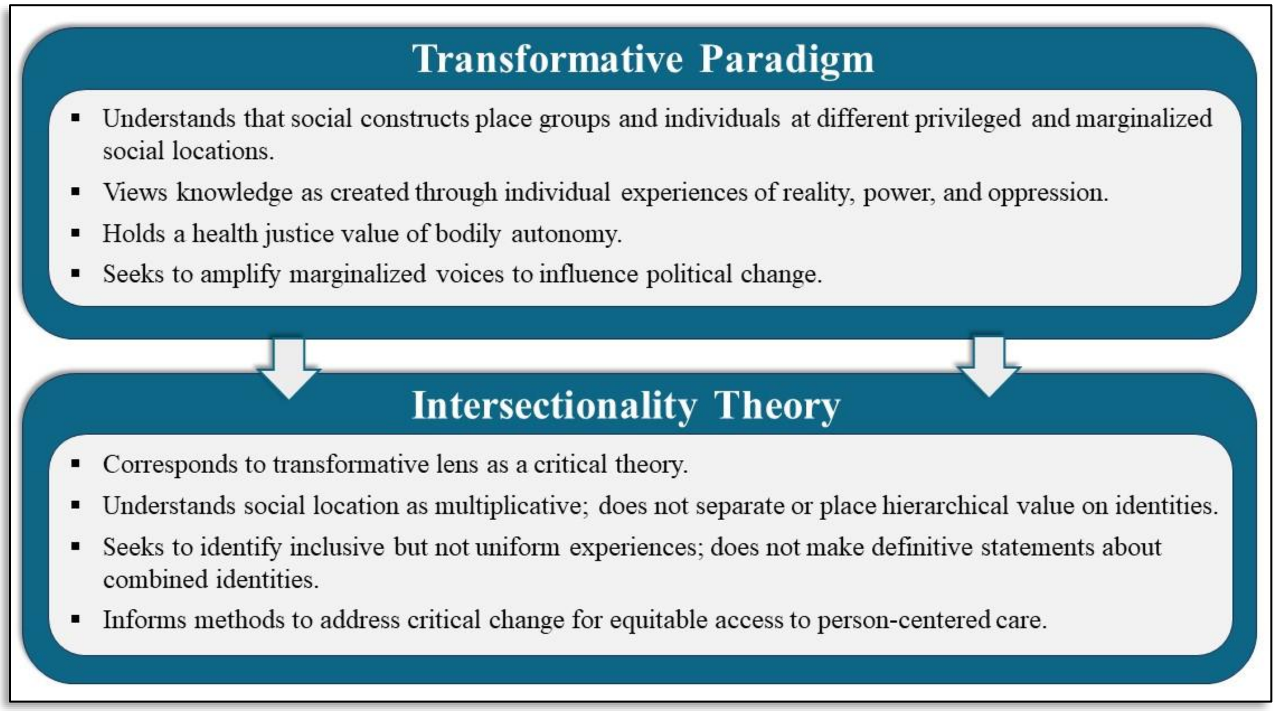
2.1 Situating Research Paradigm

By examining the interplay between systems of power, this research seeks to shed light on the factors that influence university students' access to person-centered gynecology care. Powers of interest within this study included government power, economic power, institutional and provider power, and consumer power. The transformative methodology led to a substantial focus on qualitative inquiry and supplementation of descriptive quantitative survey data. The shared intention of transformative and qualitative approaches is to explore phenomena from stakeholders' lived experiences, providing an in-depth understanding of social context.[154] This intersectionality theory-informed study design further informed an inclusive approach to recruitment, data collection, and investigation of power mechanisms within these data. I used methods such as heterogeneous sampling[170] and theory-driven research questions[108] to identify various systemic oppressions and resulting inequities in accessing person-centered reproductive healthcare. I used intersectional-driven research to acknowledge that social power relations persist during the research process through researcher-participant social interactions, and the history of privilege and oppression.[154]

I operationalized intersectionality to *guide methodology* based on Dr. Susan Jones' intersectional research methodology considerations. Jones et al.'s research includes topics of women's studies, social justice, university student development, multiple identities and intersectionality, and qualitative methodologies.[171–173] These combined topics align with my study exploring university students' individual perceptions and experiences accessing person-centered reproductive health services.

This study's methodology was primarily informed by Duran and Jones' 2019 publication "Using Intersectionality in Qualitative Research on College Student Identity Development: Considerations, Tensions, and Possibilities". This article guides researchers to ensure studies are rigorously considering the role of intersectionality in study design. For example, recruitment methods that resist participant homogenization, interview question development and facilitation that intends to elicit within-group differences, using multiple data collection methods, and framing analysis to find equitable solutions.[108] The insights gained through employing methods informed by intersectionality allowed for a nuanced examination of the unique experiences and needs of individuals at the intersections of multiple social identities, and recognize complex mechanisms of privilege and oppression that may shape access to person-centered gynecology care. Figure 2 summarizes the operationalization of transformative lens and intersectionality theory within this study, illustrating the aligned research values, knowledge, and approach informed by the transformative-intersectionality lens. The following sections answer key questions of how Duran and Jones' framework guided this study's intersectionality-informed participant recruitment, data collection, data analysis, and overall approach. Table 1 consolidates this within Duran and Jones' guide, and shows how I have added methods that align with this applied intersectionality framework.

Figure 2. Study Operationalization of Transformative Paradigm and Intersectionality Theory



Transformative Paradigm

- Understands that social constructs place groups and individuals at different privileged and marginalized social locations.
- Views knowledge as created through individual experiences of reality, power, and oppression.
- Holds a health justice value of bodily autonomy.
- Seeks to amplify marginalized voices to influence political change.

Intersectionality Theory

- Corresponds to transformative lens as a critical theory.
- Understands social location as multiplicative; does not separate or place hierarchical value on identities.
- Seeks to identify inclusive but not uniform experiences; does not make definitive statements about combined identities.
- Informs methods to address critical change for equitable access to person-centered care.

Table 1. Applied Intersectionality Theory Methods Using Duran and Jones' Framework[108]

Designing the Study: Acknowledging intersectional traditions		**Index**
Situating my use of intersectionality:	Intersectionality is situated within transformative philosophical underpinnings as it relates to equitable access to care specific to gynecology, a health field that serves uterus-having individuals of diverse backgrounds and a history of exploiting these individuals.	P. 3, 17-18
Theory tenets & interventions engaged:	I engaged inter and intra-personal identity power dynamics, as well as connecting structural powers which place individuals within a socially constructed reality.	P. 27, 31, 47; Ch 7, App. 7
Alignment with epistemological foundation(s):	Intersectionality was used as a tool to guide transformative research within an equitable access to care framework. This approach intended for insights leading to political change from the voices of study participants.	P. 16 – 19, Ch 3.
Using intersectionality as a theory or methodology:	Intersectionality was deployed as a theoretically informed methodology, meaning that I employed theoretical concepts to employ through conceptualization, recruitment, data collection and analysis, and interpretation throughout this study.	P. 20 - 35
Recruiting and Identifying Participants		
Defining "intersectional being":	An intersectional being is all people, regardless of the number of oppressive/privileged identities that construct each individual.	P. 20 - 24
Resisting homogenization:	I used heterogeneous recruitment method of "variation" sampling to include diverse individuals with multiple identities.	P. 20 - 22
Data Collection		
Illuminating within-group differences:	I adapted recruitment strategies and materials to address identified missing identities within existing participants.	P. 20 – 23, App. 1 - 2
Asking questions that are intersectional:	Interview and survey tools were developed based on intersectionality theory, equitable access model, and person-centered approaches to clinical care.	P. 24 – 26; App. 4 - 6
Allowing participants to describe their identities:	I used surveys to contextualize students' interview data. I also connected participant experiences to scientific knowledge, policies, and expert reports to better situate students' experiences.	P. 29 – 31, Ch. 3, Ch. 7, Fig. 11
Analysis and Using Findings		
Employing trustworthiness:	I demonstrated reflexivity in this written thesis and throughout the research process through journaling and engaging a research assistant from overlapping and different identities/backgrounds.	P. 32 – 35, 120 – 121
How does this study lead to equitable futures?	I highlighted similar mechanisms that influenced those of differing identities, leading to multiple instances of the same mechanism influencing individuals' care. I call for policymakers to consider improvements and providers' roles in improving care.	Ch. 7
Throughout the Study		
How do my identities/positions affect my approach?	See section 2.5.1 for details on my power and identities. I developed this research with the intention of decentering waves of white feminism and focusing on multiplicative identities/backgrounds to identify mechanisms of power.	P. 32 – 35

2.2 Recruitment Methods and Sample Description

Participant recruitment included developing inclusion criteria and recruitment approaches for university students and key informants. Recruitment approaches and inclusion criteria were amended as appropriate to include more diverse voices resulting in the determination of data adequacy.

2.2.1 University Student Recruitment

Participant inclusion criteria consisted of uterus-having university students that have used reproductive healthcare in their respective country. Inclusion criteria were based on literature pertaining to intersectionality theory as it relates to healthcare access and reproductive health. This research sought to uncover barriers to accessing informed health options, focusing on identities that impact health coverage, availability of services, and cultural safety.[174] Social determinants of healthcare access such as race/ethnicity, socioeconomic status, cultural/national origin, sexuality, and residential location[2,175,176] were key identities and lived experiences sought when recruiting both countries' university students.

Recruitment approaches were aligned with targeted population location and language. I used variation purposive sampling to emphasize disparate experiences in reproductive healthcare. In contrast to other heterogeneous sampling methods,[177,178] this study did not seek independently opposite cases or in-depth inquiry into any specific single-axis identity. Instead, this strategy followed intersectionality's tenets that each individual and groups of individuals have multiple oppressive and privileged identities.[155] I use the term "variation" rather than "maximum variation" because this study does not actively look for extreme cases representing intersectional oppressions but does pursue a "spectrum of positions and perspectives".[170,178] The spectrum-variation method was operationalized by recruiting those exhibiting *more* or *less* of multitudinous, interwoven privileges.[18] Recruitment approaches, material language, and inclusion criteria evolved over time to overcome COVID-19 related limitations and recruit a more diverse sample. This sampling approach is further explained in stages 1 – 3 below.

Stage 1: Inclusion criteria included those ages 20 - 24 who identified as women who have used gynecology services in their respective countries (CA and US). The initial age range was limited to 20 – 24 to allow initial focus on common age of university students and alignment with reproductive health research stratification showing this age group as having the highest rates of Canada's STIs[179] and United States' unintended pregnancies.[180] I recruited nine participants via university departmental announcements and flyers on and nearby Syracuse University (US) and University of Waterloo (CA) campuses.

Stage 2: After discussions with the research assistant (AM) about stage one participant homogeneity concerns, I extended recruitment beyond these two universities and eliminated age criteria to expand on the sample's diversity.

AM and I identified stage one participants as mostly cisgender white women and discussed recruitment methods and materials that may reach other potential participants. I revised recruitment and study material, receiving ethics approval to use "womxn" instead of "women" and continue recruitment via Instagram, a popular social media platform for the university student population. Instagram was used in two ways: 1) Via targeted advertisements for those that fit inclusion criteria; and 2) through clubs, organizations, and schools that shared the recruitment flyer on their pages. These pages represent groups that provide services to diverse students (e.g., University of Waterloo AHS, Upstate Health Justice, New York Public Interest Research Group, and cultural university clubs).

Stage two resulted in the recruitment of five participants. Retrospectively, I found this stage yielded more variation in age, race, ethnicity, location, and sexuality. Further, Instagram proved to be an effective way to reach students as they transitioned to remote learning during the COVID-19 pandemic.

Stage Three: Remaining participants were selected by comparing their characteristics with initial participant identities[108] to improve identity inclusivity and decrease intersectional uniformity.[155] I used participant identity analyses and summarized participant narratives to identify potential key missing social demographics, finding that this study was lacking Black, Indigenous, Hispanic, transmasculine, genderqueer, and those who have experienced a pregnancy (See Section 2.3, Step 3 for details related to identity analyses).

Stage three recruitment material specified the abovementioned identities still needed for this study. Those interested were directed to an online screening survey and were selected to increase a heterogeneous sample. The screening survey (Appendix 1) was developed from previous participants' identity inventory and consulting the intersectionality wheel, a tool developed by Simpson in collaboration with the Canadian Institute for the Advancement of Women to illustrate examples of intersectional identities, discrimination, and structures.[181] Recruitment materials were also revised to change wording from "womxn" to "students with uteruses" to indicate to potential participants that this study was gender inclusive. "Students with uteruses" was derived from accounts of transgender and genderqueer communities and academic literature. See Appendix 2 for the terminology rationale approved by a University of Waterloo research ethics board.

Stage three yielded 66 screening surveys and 35 of these respondents were invited to participate in the study, ultimately recruiting eight university students who further diversified the sample with variations of intersecting race, gender, sexuality, socioeconomic status, and lived experiences. I invited students based on their eligibility criteria and considered heterogeneity based on the existing sample. Those who were no longer university students or had never used gynecology services were excluded from this study. Further, I prioritized those holding more marginalized intersectional identities or differing identities than the existing participants. For example, because the first 14 participants were mostly white or Asian, heterosexual, and cisgender, I prioritized screening surveys from those who identified as LGBTQIA+, Black, Hispanic, and/or Indigenous. To mitigate loss of interest in participating, I reviewed screening surveys iteratively and invited students to participate within one week of screening survey completion. Of the 35 invited students, 25 did not respond and two scheduled an interview but did not attend.

2.2.2 Key Informant Recruitment

After preliminary analysis of university student interviews (Section 2.4), I recruited reproductive rights and policy experts from CA and the US. Key informant criteria included those who were 1) Involved in reproductive health advocacy; and 2) familiar with federal and provincial and territorial/state level reproductive health policies. Identified stakeholders included policymakers, nonprofit leaders, lobbyists, reproductive health providers, and academics. Key informants contributed to validity of preliminary findings by adding their professional perspectives, contextualizing participants' reported experiences.[175]

Potential key informants (KIs) were identified via professional networks, Google searches, Twitter, and LinkedIn throughout the study period. I identified relevant experts based on preliminary themes reported by students surrounding family planning, health coverage and availability, and patient knowledge and rights. I contacted potential KIs by email, through website information forms, and via phone. I used professional networks to identify and connect with reproductive health access stakeholders. I attended two virtual conferences (North American Primary Care Research Group (NAPCRG) and Society of Family Planning (SFP)) and emailed reproductive health presenters after attending their sessions. Google searches included a variation of combined terms such as "reproductive healthcare", "gynecology services", "contraception", "menstrual pain" AND "young adults", "adolescents", "university/college students" AND "equitable access", "intersectional identities", "clinical practice", "policy barriers", "reproductive rights". I scanned Google results and identified suitable experts within organization and personal websites. Twitter queries were conducted through my account's personal feed and hashtags. From my personal Twitter, I skimmed through prominent reproductive healthcare experts' feeds and identified other key reproductive health stakeholders interacting with their profile. I explored hashtags using ATLAS.ti (v. 9), importing 100 recent and most popular tweets with relevant hashtags (e.g., #MedTwitter, #HealthCareAccess, #ReproHealth, #HealthPolicy) and performed text searches to identify reputable reproductive health organizations and experts.

Overall, 65 experts were invited to participate via email, organization website contact forms, and LinkedIn and Twitter direct messages. Further, mentors and colleagues shared information letters within their networks inviting potential KIs to interview. Of the 65 interview invitations sent to potential key informants, only six responded. While it is unclear why the response rate was low, one expert who responded but rescinded their participation indicated political influence on willingness to participate. This expert was a state-level US politician who initially agreed to schedule an interview. However, upon follow-up during the period of US Supreme Court's Roe v. Wade decision, this politician withdrew their interview agreement. Further, without any other responses denying interview requests, it is not known how many of these requests were received. Follow up emails did not impact participant response. Phone calls to the few publicly available contact numbers did not result in contacting potential key informants, perhaps in part due to COVID-19's influence on remote work rather than in-office. Lastly, 12 invitations were sent via website contact forms due to lack of available email addresses for appropriate stakeholders.

2.2.3 Determining Participant Sample Adequacy

Though interviews and surveys elicited adequate information about participants' gynecology healthcare access and clinical experiences within the recruited sample, I was unable to recruit participants with key identities and experiences such as Indigenous peoples and those who have given birth. Moreover, while each participant reported a unique experience accessing and using reproductive healthcare, all topics were repeated by participants in both countries, while others were repeated within the CA or US samples.

Since this study included heterogeneous participants with differing gynecology needs, detailed saturation was not an appropriate classification of data adequacy. Data adequacy was instead determined by repeated reported phenomena and no new themes relating to access or clinical care arising in later transcripts.[182] For example, a repeated phenomenon of provider insensitivity was reported by both a transmasculine participant and an immigrant participant specific to their respective identities. These specific instances did not require repetition in later transcripts, but more reports of provider insensitivity proved this phenomenon to persist in unique ways. Further, later analysis contextualized information through retroductive connections to various sources of evidence-based literature, policy, and previous research findings.[182,183] In sum, data adequacy was determined by intrinsic study themes and connected to adjacent existing knowledge.[182]

2.2.4 University Student Sample Description

Twenty-two university students were recruited in total, including 11 CA and 11 US university students. Each participant self-reported uniquely intersecting identities (e.g., races, ethnicities, genders, sexualities, income levels, and cultural upbringings) contributing to specific reproductive health needs that played a role in their healthcare navigation and clinical experiences. Though most participants attended university in Ontario or New York, some students reported receiving reproductive care in other provinces (BC, QC) and states (CA, FL, IL, MD, MI, UT).

A diverse group was represented within each country subset. However, I was unable to recruit participants I feel are necessary to include, such as students that have experienced birthing, Indigenous students, and students with a physical disability. Moreover, this sample lacks the Canadian voices of transgender individuals and students who attended university outside of their home province. My recruitment barriers and implications of these missing perspectives on reproductive healthcare are detailed in section 7.2.

2.2.5 Key Informant Sample Description

I recruited five KIs for interviews focused on concepts that emerged from university student participants such as LQBTQIA+ reproductive health, patient efficacy, and family planning. Canadian KIs represented a reproductive justice organization leader, an international sexual and reproductive health policy analyst and abortion doula, and a lawyer representing efforts to establish abortion laws. United States KIs represented a champion of applied reproductive healthcare access initiatives and an Ob-gyn Medical Doctor.

Though this study included a small number of formal key informant interviews, publicly available information from many invited experts informed some findings that mapped students' experiences to existing structural and social influences of person-centered care access (e.g., academic articles, blogs, media statements). Moreover, my community-based participatory reproductive healthcare access research experiences were useful in connecting this study's data with key issue topics previously discussed in collaboration with stakeholders such as non-profit community and professional health organization representatives, ob-gyn providers, and academic researchers.

2.3 Data Collection: Interview and Survey Tool Development and Facilitation

This study used interview and survey data to uncover factors facilitating or preventing university students from accessing person-centered gynecology services. All 22 recruited university students completed interviews and surveys (CA: n = 11, US: n = 11). Five key informants responded and participated in interviews (CA: n = 3, US: n = 2). The information letter provided prior to data collection informed participants of a background of healthcare's influences on reproductive wellbeing, the study procedure, potential risks and discomforts, benefits, voluntary participation and alternatives, remuneration, confidentiality, and contact information (Appendix 3). No participants exercised their right to discontinue participation or omit answering interview or survey questions.

All data collection tools were based on the IOM equitable access framework (EAM) (Section 1.2), person-centered care literature (Section 1.4), and intersectionality theory principles (Section 1.5). The student interview guide was developed to elicit information related to both aims: gynecology access barriers and factors influencing person-centered care. The student survey intended to quantify clinical-level experiences and document potential influences such as healthcare insurance and race/ethnicity. The key informant interview guide was created using preliminary findings from university student interviews. Appendices 4-6 illustrate literature, framework, and theory components employed within each data collection tool (student interview guide, student survey, key informant interview guide).

The university student interview guide inquired about policy's role in structural, financial, and personal/cultural barriers[11,174] as they relate to student's reproductive healthcare access and continued to explore clinical-level experiences (Appendix 4). First, the interview guide assessed students' understanding of their reproductive rights and how they have or would exercise these rights. Then, it invited participants to discuss how their healthcare system impacts their wellbeing as it relates to reproductive health, prompting on subjects such as making an appointment and identifying any services that they had trouble receiving. Other interview questions sought to uncover other service barriers. The latter half of the interview guide addressed students' experiences and perceptions of their providers' accounts for *biopsychosocial* characteristics as appropriate for gynecology care.[111] To co-create this concept and related experiences of person-centered care, the interview questions asked participants to explain their typical clinical experience and talk about their relationship with their provider. The last question gave students the open-ended opportunity to advocate for their reproductive health improvement needs.

The survey (Appendix 5) first invited participants to report their race/ethnicity, type of provider(s) they have accessed, and their insurance type(s). This intended to capture some factors which may influence clinical experiences, including patient-provider communication, provider quality, and health options.[13,133,184] Then, the survey assessed biopsychosocial approaches appropriate for young adult patients through the *American College of Obstetrics and Gynecology's well-woman exam guidelines*.[115] Responses determined participant recollection whether their provider offered biological tests (e.g., STI, Pap Smear), and asked questions about psychological (e.g., mental health, drug use) and social (e.g., sexuality, abuse) well-being. The survey also assessed patient involvement via elements of informed reproductive health choices through *shared decision-making* (SDM).[20] Specifically, the survey asked if the provider listened to patient concerns, encouraged decision-making, respected choices, and answered questions (yes, somewhat, no).

The key informant interview guide began by inviting key informants to describe their role in reproductive health. Subsequent interview question topics surrounded reproductive health policy, patient healthcare navigation, access to specific reproductive services, clinical provision variation, and patient demographic differences (Appendix 6). Self-disclosed expertise and experience informed focus points within these topics. For example, one key informant discussed their work in educating young people about their patient rights, which led the interview conversation to a focus on young people's healthcare literacy that aligned with students' reported difficulties navigating care.

Each university student participant verbally consented before engaging in the research. University student data collection included an interview and short survey. In-person interviews were held in a private room on or nearby the student's campus. Online interviews were held in password protected Zoom meetings to preserve the participant's confidentiality and comfort. Interviews ranged from 25 – 48 minutes, depending on the amount of detail the participant chose to share. The survey was administered after the interview to prevent influence on the participant's interview responses. I read aloud survey questions with participants as we both referred to the written survey document on paper (in-person) or shared on-screen (online). I answered any clarifying questions participants had about the survey content. Administering the survey through visual, auditory, and feedback communication intended to improve survey comprehension and data accuracy. KIs were provided with an adapted version of the information letter and consent form appropriate to their role in the study. KIs verbally consented prior to interview participation. Recorded interviews were held via the informants' preferred video conference medium (i.e., Zoom, WebEx, BlueJeans) and ranged in length from 28 to 55 minutes.

2.4 Data Analysis

This section details how interview and survey data were managed and analyzed to amplify student themes, co-contextualize quantitative and qualitative reports, and understand university student experiences within healthcare structures, policies, practices, and existing literature to apply and extend current equitable access and person-centered care frameworks.

I documented each participant interaction via field notes. These notes included setting, demographics, non-verbal behavior, and a critical journal reflection.[185] In addition to my thoughts about the interview process, the critical journal reflection included a summary of the participant's interview focus, including their "life-story narrative", which formed an initial conceptualization of how they describe where they come from, who they are, and what they value.[186] Field notes collated individual interview topics, and they were used as supplementary data that contributed to identity analyses contextualizing participants' reproductive health experiences (Section 2.4).

Intersectionality theory guided analysis through three concepts: The exploration of oppression and privilege between individuals, multiple levels at which power-differentials occur, and ways in which power constructs individuals' social location.[175] This theory-guided analysis identified participants' multiple identities represented within and between individuals. Power differentials were identified based on healthcare access and clinical experiences. To achieve comprehensive findings, social theory analysis occurred in six steps: inductive, identity narrative, deductive, survey frequency, abductive, and retroductive analyses. This method is adapted from Meyer and Ward's insights on integrating abstract social theory concepts within healthcare analysis.[187] Inductive coding allowed a broad look at raw interview data. Identity analysis supplemented Meyer and Ward's framework to address intersectionality's core concept of identifying individual and between-participant interwoven identities within interview and survey data. Then, deductive analysis of interviews narrowed coding to the original research aims of person-centered care access. Further, after all student data were collected, I analyzed surveys to show reported frequencies of clinical experiences. Next, I used abductive reasoning to connect information learned from this study's student interviews and surveys to key informant interview data and previous knowledge and concepts (e.g., literature, policies). Thus, informing a retroductive illustration which models logical mechanisms that produce inequities.

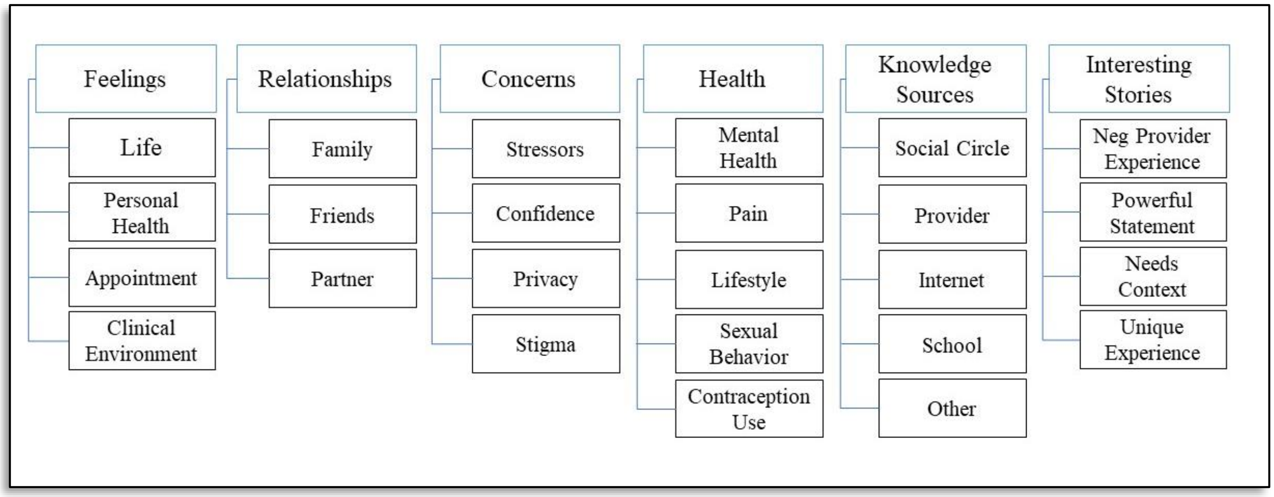
Step One: Inductive Coding

What is Happening? "Pre-coding" in the inductive analysis stage allowed me to step back from power-identity relationships within healthcare access and quality to work directly with the data.[187] Therefore, I used initial inductive codes to illuminate the voices and "common sense" of the participants.[188] I used emergent codes to ensure that important healthcare experiences outside of the equitable access scope were documented in the analysis. Rather, inductive codes assessed general navigation; getting to the clinical setting and what happens once the participant is at their provider's office.

After twelve interviews were completed and transcribed, I chose three transcripts (participants 1, 7, and 10) for initial inductive coding and codebook development based on field note review, considering potential variance between experiences to promote the resulting codebook's ability to capture subsequent transcript content.[108,189] Details about these three selected participants can be found in participant narrative summaries (Appendix 7). To align with intersectionality guided methods, the research assistant and I individually coded these transcripts to separately become familiar with the data and open-code, then refine codes through research team agreement.[108,187] These three transcripts were coded using highlighter/pen and paper to promote closeness to the data and preliminary understandings.[189,190] I met with the research assistant to review and discuss our individual codebooks, comparing code definitions and subsuming similar codes for a more concise inductive codebook. These codes were transferred to NVivo (v.12), where I coded transcripts #1 – 13, leaving an open mind for additional codes to emerge. The remaining transcripts were coded using the inductive codebook as these data were collected.

Figure 3 shows a map of the final list of inductive codes, reorganized in higher level themes for readability. Generally, inductive codes included participant perceptions and feelings, interpersonal relationships, concerns, health and wellbeing, and knowledge sources. "Interesting stories" was added as part of the inductive codebook to collate particularly interesting participant reports for future reference. Interesting stories overlapped with coding for participants' reflections on negative experiences with their provider and powerful statements about their reproductive needs. This code also captured unexpected unique experiences and identified topics to investigate for further meaning.

Figure 3. Inductive Codebook Map



Step Two: Identity Coding

What are the participants' identities? Coding specifically for sociodemographic factors identified participants' intersectional identities and aligned with the person-centered lens of this study. This stage occurred after inductive coding to prevent unintended influence of identities on emergent codes, and it continued iteratively during recruitment stages two and three. That is, the identity codebook was created and applied after inductive coding was completed for transcripts #1 – 13, and inductive coding for remaining participants occurred prior to identity coding. This coding approach allowed for identity coding to inform heterogeneous recruitment and contextualize results as they related to subsequent analysis steps.

I highlighted participants' identities within the transcripts, surveys, and field notes. Each interview transcript was then coded with their respective identities. Table 2 below shows the codebook developed to capture participants' identities and lived experiences. I used NVivo's "Project Maps" function to visualize identities for each participant and shared identities between participants. Seeking to address calls for more applied use of intersectionality theory,[108,155] I first used identity frequency estimations to display single axis; then, I exhibited how project maps can improve the visualization of intersectionality's matrix-thinking principle within and between participants (See Chapter 3).

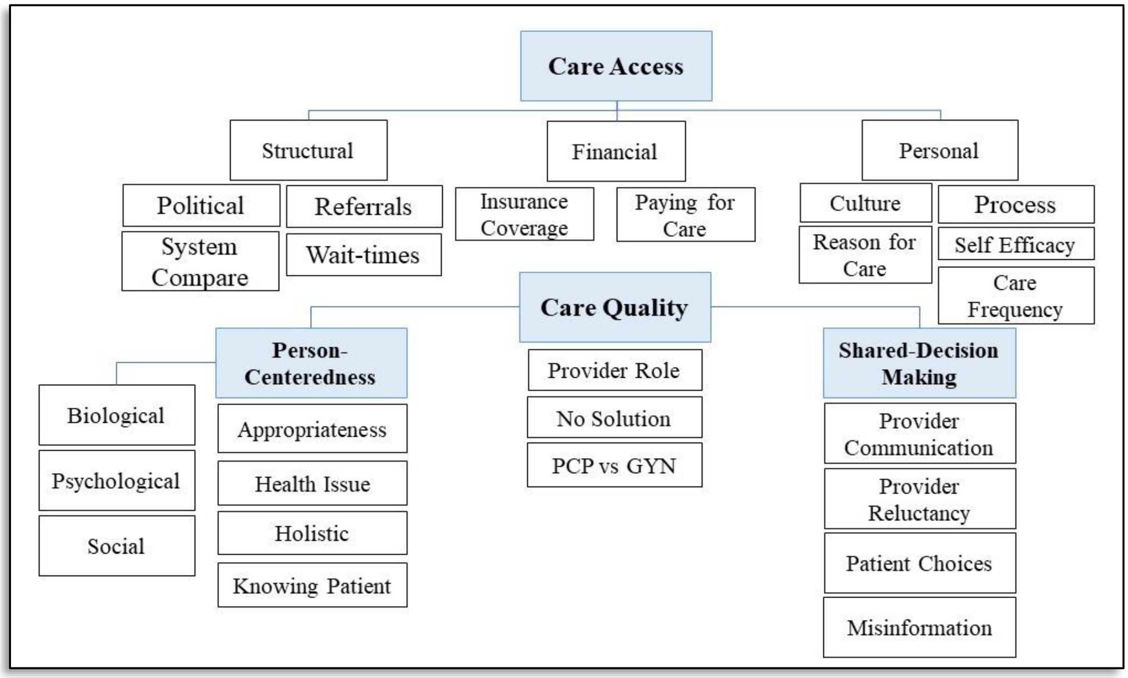
Table 2. Identity Codes by Category

Identity Category	Identity Codes
Race/Ethnicity	Black, White, Hispanic, East Asian, South Asian
Income/Health Insurance	No Insurance, Medicaid, Supplemental (CA), Parental-Based (US), University-Based, Low-Income, Middle/High-Income
Reproductive Health	Chronic Reproductive Issue, Preventive Care Only
Gender/Sexuality	Cisgender, Transgender and Genderqueer, LGBPQ
Location/Residency	US, CA, Immigrant, Out-of-State, Rural, Urban/Suburban, State/Province
Culture/Social	Religious background, Family Support, Peer Network
Other	Disability, Trauma Experience

Step Three: Deductive Coding

What impacts participants' ability to access person-centered reproductive care (i.e., access barriers and quality mediators)? Deductive analysis identified codes related to study aims, uncovering the relationship between data and existing theory.[187] This inquiry moved healthcare access and person-centered care to the forefront of code development. I used the EAM[11] as a framework to organize participants' access barriers and facilitators. Clinical guidelines, biopsychosocial components, and SDM indicators assessed experiences of person-centered reproductive healthcare interactions. Figure 4 below maps out the deductive codebook, including codes relating to structural, financial, and personal access barriers (Aim one), as well as codes related to care quality mediators through a person-centered and shared decision-making lens (Aim two). I used this codebook to code all transcripts and wrote memos on my personal reflections. To ensure this work fulfilled thesis authorship requirements but mitigated undue influence of my privileged lens,[108] the research assistant also performed deductive coding and memos on transcripts 1 – 12, becoming familiar with the data to contribute intersectional insights and feedback.

Figure 4. Deductive Codebook Map



Step Four: Abductive Reasoning

How do structural and social factors determine access experiences? Abductive analysis combines inductive and deductive findings to conceptualize these empirical data within and beyond existing theoretical understandings.[183,187] I used abductive reasoning to connect "logical" or "descriptive" individual and between-participant observations with "scientific" or "known" concepts to identify and make critical inferences about phenomena that may be related to EAM but does not necessarily fit within its obvious scope.[183] Moreover, since intersectionality theory is relatively abstract and remains in the development stage of concrete theory,[108,155,175] abductive inquiry was key in informing more inclusive frameworks of health care access and quality.

I first integrated field notes with inductive, identity, and deductive codes and memos to develop preliminary interpretive themes for the first twelve participants. For example, I noted the relationship between family and knowledge sources (inductive), how these codes may interact with culture and race/ethnicity (identity), and the potential influence on personal processes of accessing and participating in care (deductive) to develop the theme "transitioning to autonomous roles". Interpretive phenomena summaries were written in a Microsoft Word document with selected interview excerpts that supported these inferences. These themes were contextualized and strengthened in four steps: Research team feedback, survey data triangulation, key informant data matching, and literature review.

1. Research team feedback: The research assistant and I reviewed my phenomena summaries for the first twelve participants (Appendix 7), comparing my developed themes to her memos to agree on some preliminary abductive concepts. After remaining data were collected, I completed this process and revised qualitative themes to include new concepts.

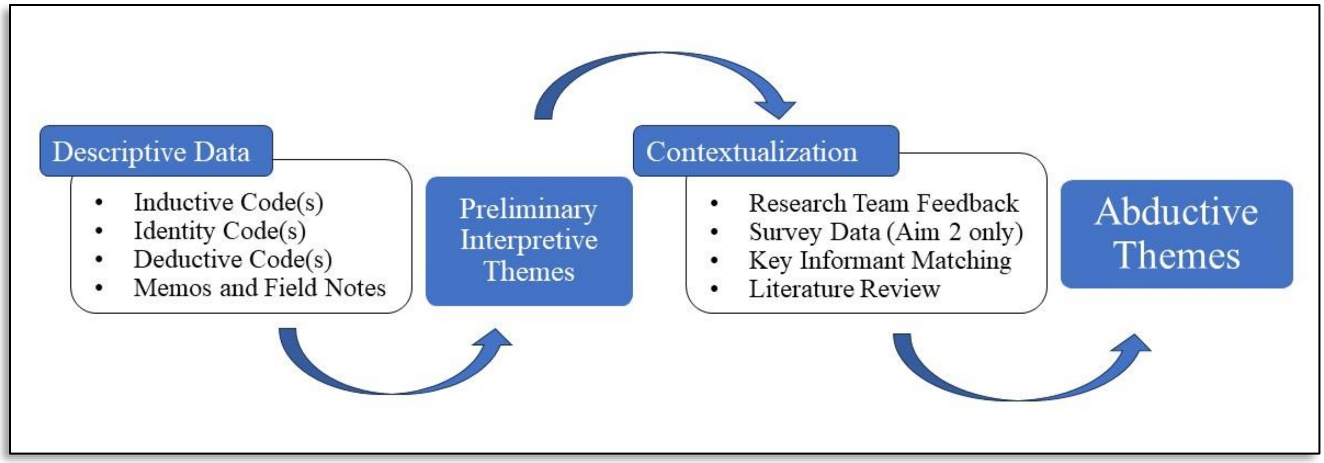
2. Survey data triangulation: To supplement qualitative aim two, clinical-level person-centered care findings, I analyzed surveys to show descriptive frequencies of students' reported experiences of person-centered care indicators. The Microsoft Excel dataset was imported to SPSS (v. 24) to develop a frequency table showing the counts (n) and proportions (%) of participants who answered "yes" to experiencing specific clinical person-centered services by country. This table was used to illuminate clinical elements and communication components experienced or not experienced by patients and reported differences by country. These data lent toward qualitative themes of patients' clinical perceptions, knowledge, and self-efficacy.

3. Key informant data matching: I matched key informant interview data relating to preliminary themes to contextualize within expert knowledge of structural and social factors influencing access to person-centered care. For example, KI excerpts related to patient rights and self-efficacy, privacy policies, and the university setting's role in healthcare access were matched with the theme "transitioning to autonomous roles".

4. Literature review: I noted questions surrounding emerging themes and reviewed literature to confirm, provide more information, or identify gaps in connections made in previous abductive reasoning steps. For example, academic literature and government or nonprofit organization resources provided more information on policies and structures in place that may influence students in "transitioning to autonomous roles".

Altogether, abductive reasoning was used to outline how participant reports aligned within and extended the EAM, including access of care within and beyond existing structural, financial, and personal barriers, and person-centered care within and beyond ACOG's well-woman exam recommendations and shared decision-making guidelines. The abductive reasoning approach described above is visualized in Figure 5 below.

Figure 5. Illustrating the Abductive Reasoning Process



Step Five: Retroductive Model Development

What conditions can we improve to promote equitable access to person-centered care?

Retroduction is driven by a critical realist standpoint, which coincides with intersectionality's quest to uncover mechanisms that influence participants' experiences,[155,183] and the use of a "both/and" approach in identifying social issues.[191] Retroduction "moves from a description of some phenomenon to a description of something which produces it or is a condition for it".[192] Retroductive analysis connected concepts from abductive themes to conditions that permit phenomena.[183] This comprehensive investigation linked participants' access and person-centered care experiences to a range of conditions that shaped pathways of person-centered reproductive healthcare access among people of various social locations. For example, after observing differences in participants' reproductive health literacy and patient self-efficacy, I asked, "What are the mechanisms that contribute to these concepts?" and connected these phenomena to complex interactions between identities and experiences related to specific social and institutional conditions.

These findings are illustrated through an extended equitable access model integrating influencers of person-centered care. This model outlines the process of reproductive healthcare navigation by distinguishing factors of person-centered reproductive care access. It shows students' experience with factors over time, relationships between these factors, and how sociocultural factors dually impact patients getting to the clinical setting and their ability to experience person-centered care. Thus, retroductive reasoning allowed for this thesis to conclude with an exploration of potential solutions to improve university students' reproductive healthcare access.

2.5 Applied Axiology: Reflexivity and Ethics

Axiology shows how this study aligns with philosophical values and worth, including practices of what constitutes ethical outcomes and how we assign meaning and importance to methods.[193,194] Axiology aligning with transformative-intersectional lens was considered and operationalized from my reflexive standpoints and research design decisions. Research ethics were iteratively considered in ways to protect the safety and confidentiality of participants, as well as mitigate any power dynamic influences and show appreciation for participants' time and emotional labor.[108]

2.5.1 Reflexivity in the Researcher Roles

Intersectionality was a tool used to support the transformative lens ethical value of human rights and cultural safety. As a white self-identifying feminist, it was primarily important that my research interpretation did not only reflect white feminist values. Rather, I sought to deconstruct narrow ideas of white feminism. I documented reflexive accounts of my positionality throughout this study's conceptualization, implementation, and analysis.[108,156,181,186,195] These journal entries noted how my background, experiences, identities, and beliefs could play a role in participant interaction, data collection, and interpretation. By recognizing my positionality and emotional responses to the participants' reports, I remained cognizant of how my own perceptions influence data collection and interpretation.

In addition to my self-reflexive efforts, I hired, trained, and mentored an undergraduate research assistant (AM) who played an active role in preliminary qualitative analysis. I worked with AM on codebook development, pre-coding, and memo writing for the first 13 participants. AM and I had continuous conversations that defined our positionality in relation to the research topic and participants. Further analyses were influenced by this collaborative process, including my refined coding structure and memo reflections as they related to the remaining participants. Though we remained conscious of how our experiences could impact findings, other unidentified influences may exist in data interpretations.

As the lead researcher throughout this study's duration, I held identities of a mid-twenties, white cisgender, pansexual, middle-class, American woman who has used reproductive health services in the United States and Canada. I have taken part in gender equity advocacy and other social justice activism. I am a trained mixed-methods researcher and a Public Health Sciences PhD candidate. Moreover, my skills as a principal qualitative researcher were strengthened with each stage of this research through grant writing and study design, administrative and ethical research duties, and refining my qualitative expertise through research application, training a research assistant, and developing curriculum for and instructing a graduate-level Advanced Qualitative Methods course. My research intention was to use these attributes to critically assess current practices in both health systems and advocate for change in practice and policy.

The research assistant (AM) identified as a cisgendered, queer, woman of color who was born in Pakistan and moved to Canada when she was young. She acculturated within a Western education system that has informed language, thinking, culture, and educational background. In addition to intensive social justice learning and application within her Health Studies undergraduate curriculum, AM served in social equity leadership roles throughout campus organizations during her four years at University of Waterloo. AM reviewed and approved all information shared within this thesis about her identities and research roles.

Reflexive journaling assisted in questioning biased assumptions held before, during, and after the interview process. For example, I learned to ask for pronouns, studied reproductive health issues specific to participant identities (e.g., transmasculine), and overtly invite participants into a safe space to share information within their comfort levels. During analysis, I recognized some of my reproductive health perceptions started to change. For example, I documented innate biases favoring reproductive medicalization such as contraception use and Western medical approaches. In response, I dug deeper into why I felt this way, reassessed my beliefs, and conceptualized a new personal understanding of reproductive health's meaning.

Positionality discussions between researchers influenced the study design and data interpretation. AM challenged the use of white persons' intersectionality interpretation, which led to my further investigation of the theory's history, review of and increased reference of Black literature, and critical self-inquiry of the unintended consequences relating to using intersectionality as a white researcher. AM contributed to interpretations of immigrant and first-generation born (CA/US) participant reports, and I contextualized the structural inequities in the US healthcare system. We worked together to ensure our backgrounds provided support for participant voices and mitigated one another's uninformed or overreaching interpretations. After preliminary analysis of the first 13 participants, I continued these reflexive practices within self-dialogue.

Transformative lens and intersectionality are interwoven within this research design and application beyond axiology. However, in an effort to avoid redundancy throughout this thesis, I omit in-depth discussion related to the transformative-intersectionality influences and instead provide citations related to these concepts for more detailed reference. Further, chapter three serves as a use-case, exemplifying intersectionality theory's applied role in this study's findings of equitable access to person-centered reproductive care.

2.5.2 Ethical Considerations

Overall, the ethical considerations for this study encompassed critical self-reflection, mitigating power dynamics, amplifying participant voices, and protecting comfort and privacy. All participants were given the abovementioned information letter detailing the purpose of this study and their research participant rights. Each verbally consented to participate. Due to the sensitive nature of interviews, identifying information was maintained between myself and the participant. Though participants did not review their interview transcripts, they were provided with an email to request preliminary research findings. Interview recordings were transcribed via an online

Microsoft Word application, and manually reviewed and revised for accuracy and deidentification. Survey responses were manually keyed into a Microsoft Excel file. All recordings, transcriptions, and survey data were stored on a password-protected computer and backed up via a private OneDrive folder.

Some ethical considerations specific to the research scope and participant group were the researchers' potential preexisting relationships with participants, privacy of in-person and online interviews, and the sensitivity of socially stigmatized reproductive health conditions. To mitigate preexisting relationship ethical issues, the research assistant only had access to deidentified transcripts since she was an undergraduate student attending the same university and/or program as some participants. Prior to this research, I had existing relationships with two students, one of a professional and one of a personal nature. Both students volunteered for this study with knowledge that I was the interviewer, and they were informed verbally and in written form of my promised confidentiality protocols. Upon reviewing audio recordings, transcripts, and field notes, I did not feel these preexisting relationships hindered data collection.

Other methods for maintaining confidentiality relied on interview location. For in-person interviews, I booked a private room within academic buildings easily accessible to participants. For online interviews, I asked participants to be in a comfortable, private space prior to the interview. However, it must be noted that many students returned to their parents' home during the COVID-19 university closures and may have struggled to find complete privacy.

Sensitivity to sexual and reproductive health stigma was mitigated by building rapport prior to interviews. Many students were recruited through my Instagram page, giving insight to who I am personally and professionally, my values and openness to destigmatizing stigmatized topics. In addition to genuine conversational approaches, I ensured a safe space through validating and thanking interviewees for speaking their truths when they apologized for disclosing "too much information".

University students received $20 CAD or $15 USD for their time, either in the form of cash, e-transfer, or Venmo.[196] Privacy was of special consideration for Venmo transfers, and they were set to private so neither the researcher's nor participants' Venmo 'friends' could see the transaction. Taking time and emotional labor into consideration, I felt this amount was appropriate to galvanize interest of the university student population while still maintaining ethical duties to sustain a non-coercive interview environment. Further, providing cash remuneration rather than other forms (e.g., gift card) aligned with this study's goal of supporting autonomy, permitting choices in how students received and used their remuneration.[196,197] KIs did not receive participant remuneration, promoting the ethical goals of this research to amplify voices of university participants[154] rather than providing financial incentives, which could represent inequities in this research. That is, I made an inference that this study required university students' personal emotional labor and may have a higher socioeconomic need compared to KIs who approach reproductive health from a professional standpoint.

In sum, this thesis methodology operationalized transformative underpinnings and intersectionality theoretical principles to seek a critical understanding of participants' person-centered reproductive care access experiences. Recruitment approaches, data collection tools and facilitation, and the adaptation of social theory analysis intentionally sought to connect students' experiences to the mechanisms of power (e.g., policy, practice, environment) that allow these experiences to occur.

2.6 Organization of Thesis Findings

Thesis findings are structured to promote readability through clear and concise concepts. Chapter three explicitly exemplifies intersectionality theory integration to enhance understanding of theory application and interpretation, while subsequent chapters implicitly embed intersectionality to succinctly address aims one and two. The structure of findings integrates study data and interpretation rather than separating results and discussion to improve clarity of contextual connections, showing the value of abductive reasoning in extending analysis of this study's immediate findings. Each findings chapter (chapters 3-6) begins with an "introduction" section to further inform the reader of subsequent section topics and concludes with an interpretive summary of chapter content.

Chapter 3 details identity analysis findings to set the stage for the important role of participants and key informants cocreating the scope of person-centered reproductive healthcare access results, exemplifying how the application of intersectionality methods can provide tangible findings. This chapter goes beyond students' single-axis identity descriptions to delve into matrices influencing reproductive health needs and values. It introduces the relationship between students and expert stakeholders, uncovering how key informants' reproductive healthcare roles and philosophical underpinnings align with university students' reproductive health needs and values.

Chapters four and five address aim one by exploring university students' experiences accessing gynecology health services. I organize access barriers and facilitators through the dynamic between health systems and students' reproductive care-seeking behaviors, illuminating first-hand accounts of accessing person-centered reproductive care within the sociopolitical context. These chapters focus on different levels and mechanisms influencing reproductive healthcare access, including structural healthcare's nuanced influence on university students' general reproductive healthcare access and navigation (Chapter 4), and students' personal cues to care-seeking (Chapter 5).

Chapter 6 delves into students' clinical reproductive care experiences, contextualizing their voices through mechanisms that influence these clinical experiences. This chapter addresses aim two by identifying how students define factors of person-centered clinical care, including clinical care standards, patient-provider communication, and clinical environment and protocol appropriateness.

Chapter 3

Setting the Stage: Participants' Intersectional Identities, Reproductive Health Needs, and Values

Chapter three acts as a bridge between methodology and results, illustrating the applied role of intersectionality theory in this study sample's experiences and needs for accessing person-centered reproductive care. The use of the term "intersectionality" in social research commonly misappropriates intersectionality, falling short of applied methods and interpretations that truly engage intersectionality's meaning and objectives.[193] That is, "intersectionality" research often lacks methods that identify synergistic phenomena occurring between two or more factors, and fails to critically interpret findings within the broader political context in which phenomena are constructed.[198] Therefore, this chapter serves as a use-case to narrow current gaps in intersectionality research use. It intends to substantiate an ethical and tangible application of intersectionality theory, showing how intersectionality can be meaningfully applied to strengthen and contextualize findings corresponding to intersectionality's critical focus.

Through identity analyses, this chapter goes beyond single-axis demographic descriptions to show the matrices that make up intersectional identities within and between participants. Here, I share the iterative identity analysis process and findings that occurred throughout data collection and analysis stages to illustrate how this analysis led to this study's sample and relational context for subsequent results. I provide a matrix explanation of university students' self-described identities and reproductive health needs to establish the specific scope represented in the sample. This aims to give the reader insight on this study's missing voices, individual participant identities, and inter-participant variance. These interpretations delve deeper to elucidate ways participant identities led to key informant selection through thematic investigation. I describe the relationship between selected key informants' (KIs) background expertise and students' identities, reproductive healthcare needs, and values.

This chapter concludes summarizing how identity analysis results served as a foundation of this study, shaping findings related to accessing reproductive healthcare and experiences of person-centered care. It provides a high-level framework introducing the relationship between intersectional identities, health needs, reproductive care access, and person-centered care.

3.1 Student Identities

With intentional heterogeneous recruitment strategies, each student held intersecting identities, backgrounds, and healthcare interactions. Many participant identity components overlapped with one another, yet, each individual's identities were uniquely intersected, creating a holistic picture of their distinct lived experience (Appendix 7). In addition to the interwoven student experiences before, during, and after reproductive care interactions, these narratives contextualized patients as people outside of the clinical setting, shedding light on personal pathways to personhood. Table three and figure six below summarize selected key participant identities. Table 3 demonstrates the traditional single-axis approach to displaying participant characteristics.[154,155,193,199] The design of Figure 6 illuminates the complexities of intersectionality, going further to illustrate each participant's individual identities and identities shared between participants. Participants are mapped by country to allow a visualization of similarities and differences between CA and US participants. Identities are grouped and listed in an order that permits an organized figure to promote reader understandability.

Collecting demographic information through qualitative and quantitative methods allowed identification of power relations that participants may not have considered as impacting their healthcare experience.[155,200] Firstly, two interview questions prompted participants to consider intersectionality.[108] Surveys were used to collect proximate characteristics related to this study's background and research questions of access to healthcare and health information: provider type, health insurance types, race/ethnicity, and country. I use the term "prompted identities" to describe identity categories reported by all 22 participants.

Students' prompted identities included an even split between CA and US students. Participants reported white, Black, South Asian, East Asian, and Hispanic racial and ethnic backgrounds. Two participants chose more than one race/ethnicity, with one identifying as Hispanic and white and the another identifying as Black and East Asian. Most identified as cisgender women, but three reported variations of transgender and non-binary or gender fluid identities. Participants either only used gynecology care for preventative health measures or used additional gynecology services for chronic reproductive health issues. Chronic reproductive health issues included physical, mental, and emotional conditions related to sexual and reproductive health.

Further, without prompts from the researcher, participants naturally explained their cultural and geographic origin, sexuality, and other identity influences. The term "unprompted identities" is used to describe self-reported identities participants offered *without* prompts from interview or survey questions. Therefore, unprompted identity categories were not given for all students and cannot be compared between participants. However, those who did disclose these identities provided further insight into how students defined themselves and communicated their reproductive health and healthcare experiences. The emergent nature of students disclosing these identities indicates an importance to their individual identities. Furthermore, the frequency at which unprompted identity categories were reported between participants indicates a collective importance of identity categories.

Unprompted identities reported by participants included individual identity categories such as sexuality, university's state/provincial residency status, immigration and citizenship status, income level, and geographic upbringing. Twenty participants discussed their sexuality, with fifteen reporting heterosexuality and five identifying as lesbian, gay, bisexual, pansexual, and/or queer (LGBPQ). Most mentioned their status as an out-of-state student or disclosed their in-state/province hometown (n = 17). Only three mentioned their citizenship status to their respective countries, with all self-identifying as immigrants or first generation born in North America. Some participants related their lived experience to their family's socioeconomic status as being either low (n = 5) or middle-higher (n = 8) income. Further, students discussed their home communities as either rural (n = 5) or suburban-urban (n = 6).

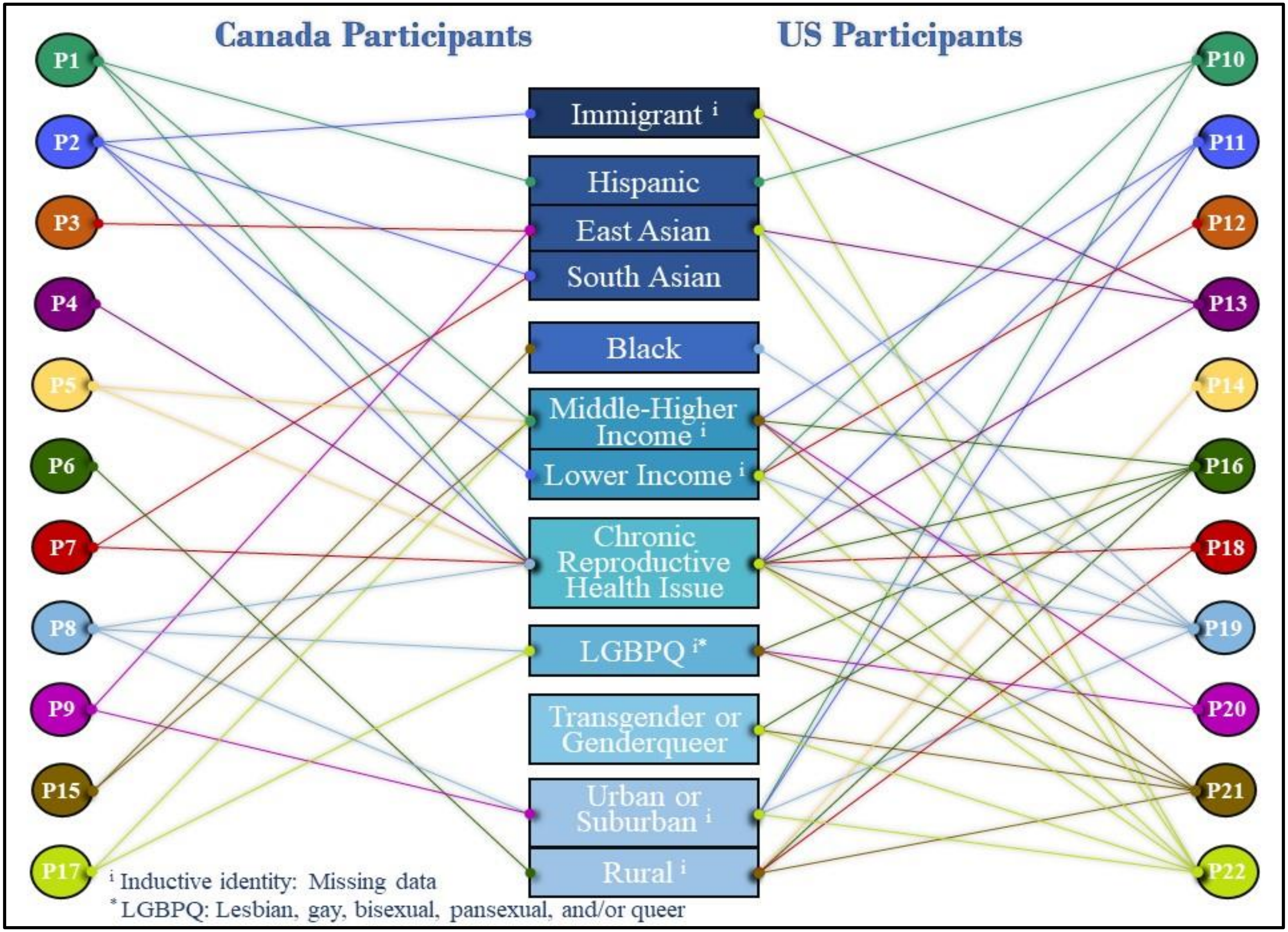
I noted differing identities between CA and US students that may impact the way they encounter accessing person-centered reproductive care within their respective health systems. I observed both prompted and unprompted identity distinctions between the two countries. Prompted identities such as race, ethnicity, and reproductive health status were well-matched between countries. However, US recruitment yielded gender diversity, while CA students all reported being cisgender. The difference between CA and US participants' unprompted identity disclosure may indicate self-identity importance as it relates to each country's culture and health system navigation. For example, eight US participants disclosed family income level compared to five CA students, with more US students reporting coming from a low-income home (US: n = 4, CA: n = 1).

Table 3. Selected Student Identities: Single-Axis Approach

Student Identity	**Total (n)**	**Canada (n)**	**US (n)**
Prompted Identities			
Ethnicity and Race	24*	12	12
Hispanic	2	1	1
East Asian	5	2	3
South Asian	2	2	0
Black	2	1	1
White	13	6	8
Reproductive Health Status	22	11	11
Chronic Reproductive Issue	13	6	7
Preventive GYN Care Only	9	5	4
Gender	22	11	11
Transgender or Genderqueer	3	0	3
Cisgender	19	11	8
Unprompted Identities			
Immigration Status	3	1	2
Immigrant/First Generation	3	1	2
Income Level	13	5	8
Middle-Higher Income	8	4	4
Lower Income	5	1	4
Sexuality	20	10	10
LGBPQ	5	2	3
Heterosexual	15	8	7
Geographic Location	11	3	8
Rural	5	1	4
Suburban/Urban	6	2	4

**n=24: Two participants reported both race and ethnicity*

Figure 6. Selected Intersectional Participant Identities



3.2 Identifying Student Health Conditions and Service Needs

Student identities influenced reproductive healthcare needs, including access, clinical services, and personal requirements for patient-provider communication. In addition to participants' shared identity of being assigned female at birth, other identities such as gender, sexuality, and culture often served as a reason for a specific reproductive care need. Thus, identifying participants' intersecting identities was crucial in understanding the context of and reason for reproductive health needs to truly address aims of exploring barriers and mediator mechanisms which prevent or permit person-centered reproductive care access.

As mentioned, recruited students either only sought preventive gynecology care or self-identified chronic reproductive issues requiring healthcare attention. Preventive care visits included contraception, wellness exams, and STI testing. Most chronic health issues surrounded conditions such as polycystic ovary syndrome (PCOS), premenstrual dysphoric disorder (PMDD), endometriosis, undiagnosed dysmenorrhea, abnormal uterine bleeding, or recurring UTIs. Less common were students who needed a surgical abortion, testosterone therapy, or services for chronic STI, uterus abnormalities, and/or vestibulodynia. Table 4 provides counts and definitions of chronic conditions and service needs reported by students.

Table 4. Participant chronic reproductive-related conditions and Health Service Needs[199,200]

Conditions	**Definition**	**(n)**
Polycystic Ovary Syndrome	Hormonal cause of infrequent or prolonged menstruation	3
Premenstrual Dysphoric Disorder	Hypothesized to be caused by hormonal imbalance	1
Endometriosis	Abnormal endometrial gland growth	1
Undiagnosed Dysmenorrhea	Painful menstruation without known etiology	4
Abnormal Uterine Bleeding	Bleeding due to anatomical or functional etiologies	1
Recurrent Urinary Tract Infection	Frequent bacterial reinfection of the urinary tract.	3
Chronic STI	A sexually transmitted virus with no specific "cure"	2
Uterine abnormalities	Congenital abnormality in uterus shape	2
Vestibulodynia	Vaginal pain with touch or insertion	1
Services	**Definition**	**(n)**
Contraception	Any contraception method	20
LARC Procedure	IUD & implant insertion/removal	11
STI Testing	Any STI Testing	16
Surgical Abortion	Medical procedure to remove fetal tissue from a patient	1
Testosterone Therapy	Prescribed testosterone to induce masculine traits	1

3.2.1 Reproductive Health Medication: Students' Contraception Needs

Reproductive health-related medication was a major health need for participants. Identities influenced students' best fit methods, and sometimes contributed to their sense of self. Almost all students reported a history of or current contraception use including oral, injectable, implant, and IUD methods. Students of different genders and sexualities shared various uses for contraception beyond pregnancy prevention. Interview conversations surrounding contraception focused on contraception's multiple other health uses with pregnancy prevention as an additional benefit. Among those who reported contraception use without being heterosexually active, one student described factors influencing her contraception method decision,

> *"I decided to get an IUD before I was even sexually active. I was in high school, and I just needed to stop my periods. I had the worst of the worst symptoms physically…It will be seven [years] before mine's even run out."*

Gender and sexually queer students reported using contraception to regulate hormone imbalances, menstruation issues, gender concerns, and skin conditions. One genderqueer participant shared their experience failing to find a method that would help relieve menstruation symptoms and not cause other hormone-related health issues,

> *"Birth control is not something I'm interested in taking to control whether or not I get pregnant, but I've struggled with access to manage my period cramps. I tried hormonal birth control, and it made me sick, so I didn't keep doing that…I have a bicornuate uterus…So, I couldn't ever use an IUD…I've struggled to get access to birth control."*

The student above is referring to their negative experience with combination birth control pills, which have a different hormonal mechanism than a hormonal IUD would have. However, it should be noted that other forms of contraception have similar hormonal mechanisms to the hormonal IUD that may be more suitable for someone with a condition like this individual, those with vaginismus, or for transgender patients with gender dysphoria concerns.[118]

Participants also reported using contraception to take control of their bodies. While most expressed empowerment as an abstract idea, two students discussed their personal context surrounding their critical need to control fertility as a response to or prevention of trauma. The first student said she used contraception to take back control after growing up in a conservative religious culture that dismissed her when she was raped. The second participant used contraception as added protection, sharing a raw fear of sexual assault in the university setting,

> *"As a woman, there's a fear that somebody is going to impregnate you if you don't want them to. It's scary to be a woman in college…Nexplanon [contraceptive implant] has been really great…You never know when some horrible person is going to do something horrible and if you take care of it ahead of time, at least you won't get pregnant from that...It's traumatic, but it's a line of defense for myself."*

Despite contraception's role in perceived wellbeing, participants also drew attention to the added burdens uterus-having people undergo compared to penis-having partners. Seeking best-fit and using different birth control methods proved to be a grueling process for many. One outlined her experience of trial-and-error contraception prescribing, including frequent clinic visits, invasive procedures, contraception side effects, and prescription prices. In addition to pregnancy prevention responsibilities, another participant shared frustration with the added burden of UTIs after having sexual intercourse,

> *"It sucks for a woman… I always feel like I'm the one having problems. The guy just doesn't have to deal with anything…I have to be the one who makes appointments and see the doctors. That takes up time in my day…to also go get and take medication…pay for it. But I'm not the person who caused the problem. It's the two of us."*

Indeed, uterus-having individuals face an inordinate burden relating to reproductive health, including healthcare needs such as medication. This study demonstrates a need for contraception for more reasons than preventing pregnancy, including regulating hormones and a sense of safety from sexual violence. Yet, together, university students exemplified some situations where males contributed to their biological and social medication need (e.g., pregnancy prevention, UTI antibiotics), which added to the labor of seeking and paying for care. While family planning literature commonly focuses on contraception side effects as a source of health stress,[201–203] this study shows a more comprehensive understanding of disproportionate medical burden for those using contraception beyond side effects including time, finances, and medical stress compared to their cisgender male counterparts. Each student's identities and lived experience led to their specific reasons for reproductive medication need, which later informed person-centered ways to improve reproductive care access and quality.

3.2.2 Reproductive Health's Intersection with Other Health Needs

Other identity-related health needs intersected and sometimes counteracted reproductive health goals. Primarily, students reported considerations of how other health conditions and treatments would interact with contraception medications. While some noted temporarily prescribed medications such as antibiotics and acne medication, others discussed more long-term prescriptions that interacted with contraception. Students who required long-term interactive medications reported various impairments, chronic physical illness, or mental health conditions. For example, one participant discovered that her oral contraception was causing discomfort when wearing contact lenses. Others mentioned that psychotropic medications can reduce contraceptive effectiveness. In addition to concerns about medication interactions, many students discussed other ways their mental health conditions interacted with reproductive health needs. Mental health issues impacted reproductive health, vice versa, and were sometimes inseparable.

Mental health influenced students' reproductive health status and priorities. While students sometimes mentioned their mental health conditions (i.e., anxiety and depression) as influencing reproductive health, participants primarily talked about the role of mental stressors as antagonists to reproductive wellness. Educational and job workload stressors were commonly mentioned as a possible source of menstrual irregularities, with some participants attributing stressful schedules to behaviors that may impact their cycle such as poor food quantity or quality and lack of sleep. An international Chinese graduate student in the US encompassed multifaceted stress sources impacting menstruation,

> *"This year, it [irregular menstruation] happened again. It's mostly like my period come[s] once a month. Until now, it's delayed for a month or more. I asked the doctor and she said I was too stressed because… I'm looking for a job, going through some certifications, my graduation, and a long course that is not really easy to go through."*

This student continued to list additional international student-related stressors such as applying for permanent residency after graduation, and concern for her family in China as the COVID-19 pandemic had recently begun during the time of our February 2020 interview.

Reproductive health influenced mental health status in both positive and negative ways. While contraception was sometimes used to regulate hormone-associated mental health conditions, some students also reported contraception as negatively impacting their mental health. One student described how menstruation triggered gender dysphoria, and how reproductive care could address this trigger through testosterone therapy. He described his psychological need for amenorrhea as the ultimate reason they began testosterone therapy,

> *"I had dysphoria related to menstruation, which is a sort of tangential issue, but it's ultimately more mental than physical and something that only accessing testosterone was going to fix."*

Further, supplementing their testosterone medication with mental health counseling played a crucial role in navigating his general physical and emotional changes.

Another student highlighted the intertwined relationship between reproductive and mental health as she spoke about having a menstrual phase-related form of perpetual physical and emotional symptoms, which severely limited her quality of life. This student felt relief when she was diagnosed with PMDD, a disorder that explained both symptoms, stating,

> *"It reduced a lot of my anxiety about thinking 'Is this going to be the rest of my life or what's affecting what? Like what came first?'"*

Uncovering students' reported relationship between mental and reproductive health lends to ways reproductive healthcare access and options can be improved for university students with psychological barriers to existing reproductive needs. These findings are of equitable importance as those with psychological disorders are at a higher reproductive health risk. In fact, one literature review identified studies indicating that those diagnosed with severe psychological disorders have lower rates of contraception use, and they are more likely to have a greater number of sexual partners, unintended pregnancies, and sexually transmitted infections (STIs).[204] Similar mental and reproductive health risks are seen with those who have chronic disabilities,[205] LGBTQIA+ persons,[206] and university students.[207] Moreover, research finds the relationship between some characteristics and health status to be bidirectional. For example, reproductive pain can impact students' general wellbeing and academic performance.[152] Thus, the intersections between mental health disorders and other identities contributed to this thesis analysis and interpretation. That is, this study considers how the biopsychosocial pressures on holistic identities may amplify the complex relationship between mental and reproductive health, including person-centered needs, healthcare seeking (Chapters 4 – 5), and clinical experiences (Chapter 6).

Overall, participants from both countries expressed a need for proactive reproductive health solutions. Contraception went beyond heteronormative purposes and was also used by those who were not engaging in penile-vaginal intercourse. As a crucial reproductive health component, contraception methods meant much more than pregnancy prevention, assisting those with hormonal imbalances, irregular and painful menstruation, and provided a sense of safety. Many advocated for alternative and more effective solutions best fit to their biological needs and social lifestyles. Further, students needed a multitude of reproductive health solutions that involved holistic health considerations. Urology, psychological services, primary care, dermatology, and optometry all overlapped with participants' gynecology needs.

3.3 Identifying Key Informants Based on Student Identities, Reproductive Needs, and Values

To explore the intersections between social powers and students' identities,[153] key informants (KIs) were recruited to provide expert policy and clinical insights on students' reported characteristics and experiences. Thus, I purposefully engaged KIs with backgrounds and reproductive healthcare advocacy roles that intersected with university students' identities and health needs. I selected KIs to include a variety of perspectives on student participants' heterogeneous lived experiences. KIs' perspective variation included expertise on multiple social power levels (e.g., global, national, clinical) with differing reproductive influence intentions (e.g., pro-choice, anti-abortion) and roles (e.g., providers, analysts, policy advocates, community actors). Inclusivity of students' heterogeneity led to KIs with expertise on issues such as family planning, chronic reproductive conditions, LGBTQIA+ patients, and cultural safety. Further, KIs held personal heterogeneous and intersecting identities with students and one another (e.g., gender, sexuality, religion, race). KIs provided insight into their personal and professional backgrounds. KI biography summaries can be found in Appendix 1, and KI reproductive health roles are summarized below (Table 5)

Table 5. Key Informant Reproductive Health Roles and Focus Areas

KI#	Reproductive Health Role	Reproductive Health Focus Areas	Country
1	Patient Rights Advocate	Family planning access, cultural safety, transgender care	CA, US
2	Policy Analyst	Abortion doula, sexuality education, patient rights	CA
3	Anti-Abortion Lawyer	Abortion laws, holistic care, sexuality education	CA
4	Abortion Fund Leader	Community-based support, person-centered care	US
5	Ob-gyn Physician	Family planning, LGBTQIA+ health, patient advocacy	US

3.3.1 Identifying Values to Ensure Participant Voice Amplification

As a key component of the transformative-intersectionality paradigm, I sought a closer understanding of participants' values to ensure participant voice amplification.[108,154,155] Before subsuming codes into interpreted themes, I coded for participant statements surrounding reproductive health beliefs. I then identified between-participant values, noting shared and differing reproductive health values. Lastly, I uncovered how participant values fit within the intersections of existing feminist theories to align participant data interpretation within the broader social context.

Overall, KIs' demonstrated values can be contextualized on a spectrum of bodily autonomy and relational feminism lenses. Bodily autonomy is the right to have control over one's own body without interference from other entities (e.g., government, individuals, etc.).[58] On the other hand, relational feminism emphasizes the importance of relationships and interdependence in addressing gender and equity issues.[6] Exemplifying bodily autonomy, four of the five KIs established themselves as reproductive rights advocates during their interviews. These four experts (US: n = 2, CA: n = 2) played different roles supporting those with uteruses make informed individual bodily choices. As KI4 stated,

> *"I want to make sure that all people – no matter where they come from, what they've gone through, how they've lived – have the access to whatever they need…the legislators don't actually determine our destinies, we do. It's up to us to figure out what we need to do to make sure we can amplify our voices…against various levels of reproductive oppression that is not allowing us to live sustainable lives where we can thrive."*

The remaining key informant, KI3, reported holding a relational feminist lens with an interpretation that connected her reproductive values with femininity that focuses on making decisions for the purpose of upholding and protecting relationships. She sees uterus-having people's relationships as an extension of oneself, permitting both a collective stake in a person's reproductive health decisions and issues, and accountability for aiding an individual with the consequences. KI3 contributed to advocacy for policies where decisions about one's body must involve social and legal input. She shared personal beliefs supporting this reproductive care approach,

> *"When it comes to women's health and wellbeing, I never want to think about her just as an individual. I want to think about who she is as a relational component of a broader intertwining web of relationships…including that very serious mother-child relationship that starts from the moment of their existence, which is fertilization."*

When exemplified by the two quotes above, bodily autonomy and relational feminism seem to be mutually exclusive. Yet, some scholars argue that bodily autonomy can be understood as a relational concept since the ability to exercise autonomy is shaped by social relationships and structures.[25,208] This suggests that providers can be mindful of approaching care through both bodily autonomy and relational feminism considerations to contextualize individual experiences within broader contexts. As it pertains to reproductive healthcare access and quality, I propose here that person-centered clinical care and shared decision-making (SDM) utilize these two concepts to maintain ethical, culturally safe practices. For example, SDM guides patients in making best-fit, informed decisions without provider coercion or choice limitation.[209] Further, considering patients' individual preferences on a spectrum of needing full agency or needing others' involvement their health decisions honors intersectionality tenets of how multiplicative identities influence an intersectional being's values and encompasses mechanisms of social influence between individuals.[156,165,166] In other words, providers' mindfulness of bodily autonomy and relational feminism can give patients the power to choose various levels of social network influence or involvement in their reproductive care.

University students' echoed beliefs representing how relational feminism and bodily autonomy should be operationalized. Yet, all students held values that conflicted with KI3's interpretation of how a relational feminism lens should be used as a reproductive health decision-making and policy framework. Students unanimously reported their need for political and social environments (relational feminism) that permit individual health decisions (bodily autonomy). For example, one student said,

> *"[I'm able to] make my own decisions of when I want to get pregnant, getting STD testing, and Pap smears…That should be accessible to everyone else, period. In this country, in the world. Shouldn't be forcing anyone to either carry out pregnancies that they don't want, or not giving them the resources to prevent it in the first place."*

Other students provided examples of reproductive health autonomy that extended beyond abortion rights, including general healthcare access, choosing one's own health behaviors, pregnancy prevention, STI testing, and gender affirming care. In addition to students expressing disapproval of policies limiting autonomy, one student elaborated on how policymakers' gender exacerbated inequitable policy. They felt that male-dominated political and legal powers construct policy intending to maintain control over women, explaining,

> *"All our policymakers are male for the most part. So, the problem is that, 'think about what you want for your daughter'. But you're still putting it in their control what happens to women's bodies…I don't know how to get through to people that don't want to let women be responsible for themselves. I just think it's a deeper issue."*

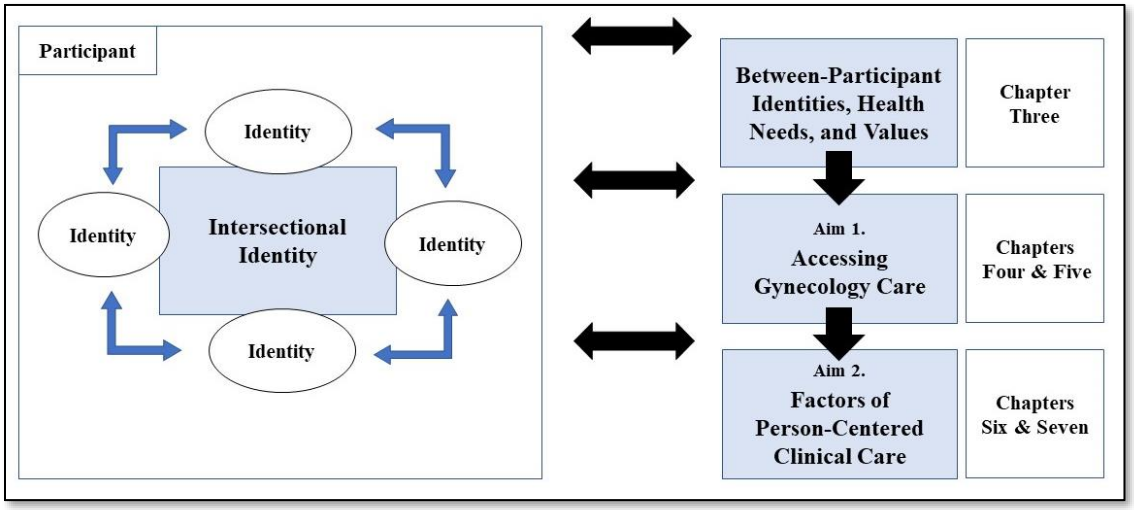
While the above student's sentiment toward male-dominated policy aligns with long-standing feminist scholarship and activism,[6,162] participant perspectives like this contributed to data analysis and interpretation that represented students' voices. Specifically, this student's overt expression led to exploring inter-participant patriarchy concerns and how sexism manifested in students' reproductive healthcare access and quality (Chapters 4 - 6). Further, literature connecting patriarchy, policy, and reproductive care was used to inform my investigation of the intersections between reproductive policy, practice, and participants' individual lived experiences. For example, two studies in the US and UK found that hostile sexism is associated with a belief that men have the right to constrain women's reproductive choices, concluding that reproductive health educators and providers should recognize these factors to help affirm reproductive autonomy.[210] Altogether, participant values led this study's intersectional lens at the juncture of bodily autonomy, relational feminism, and patriarchy within reproductive healthcare.

Summary: Intersectional Identities, Reproductive Health Needs, and Values

Overall, this chapter extends tangible, ethical applications of intersectionality theory by connecting abstract concepts to corresponding methods, literature, and existing tools through retroductive principals.[211] In addition to intersectional applications recommended in literature (e.g., heterogeneous sampling),[108,155] I demonstrated more detailed intersectionality-informed data collection and analysis approaches as it relates to this thesis' aims. Consistent reflexivity and continuous return to intersectionality theory's tenets informed research decisions. That is, I intentionally chose each feasible research approach that aligned with amplifying participant voices, critically contextualized political equity, and explored intersections between individual identities, inter-participant identities, and levels of power.[155] I used existing tools and concepts within the healthcare field that aligned with intersectionality (e.g., equitable access framework, person-centered care, SDM) to operationalize intersectionality theory throughout study development, data collection, analysis, and interpretation. Without a complete existing intersectionality research methodology framework, I demonstrated examples of these methodological processes within this thesis to promote transparency, replicability of these methods, and provide a reference for future development of intersectionality's use in research.

In addition to intersectionality's methodology extension, I exhibited critical ways intersectional analysis served as a building block to addressing research aims. Knowledge of intersectional individual and inter-participant identities intersected with students' health needs and values, which led to uncovering intersections and mechanisms between reproductive healthcare access and person-centered care identified in subsequent chapters. Figure 7 below shows the relationship between intersectionality's foundational research influence. Arrows exemplify intersections and direction of influence. For example, study findings show health needs and values outlined in this chapter contributed directly to students' experiences accessing reproductive care. In contrast, a bidirectional relationship was constructed between individual identities and accessing person-centered reproductive care.

Figure 7. Intersectionality's Role in Study Analysis and Findings



Chapter 4

Health Systems' Influence on Gynecology Care Access

Chapter four contextualizes students' reproductive care access experiences within healthcare systems, identifying system level factors that determine students care pathways and access to quality care. Section 4.1 shows how the US and CA healthcare structures influenced general pathways to reproductive health services. Section 4.2 explores healthcare structure's influence on clinical level provisions, including ways patient care is impacted by clinical constraints. Section 4.3 delves deeper into barriers to person-centered services. Here, I detail students' obstacles to accessing specific reproductive services and the provider's role in mitigating structural barriers within the clinical setting. Overall, this chapter describes structural factors that influenced how students accessed reproductive healthcare. I use healthcare navigation factors identified by participants and connect reported experiences to what is known about existing healthcare structure, broader societal concepts, and healthcare access barriers.

4.1 Structural Health System Navigation

Generally, students' health system navigation experiences centered around finding a provider and determining healthcare coverage parameters. Participants used various health provider types for reproductive health needs, including general or specialized clinicians. Students sought generalist care at community clinics, university health services, or family providers/primary care physicians. Students who sought specialized care used services from gynecology practices, family planning clinics, midwives, and one dermatologist who diagnosed an STI. University students used provincial (CA), university, parental-based, or Medicaid (US) health insurance. Interestingly, many participants knew little about their insurance plan and coverage details. Moreover, fifteen interviews illuminated a spectrum of participants' self-described reproductive healthcare literacy and patient competence. This spectrum ranged from participants having high levels of confidence in reproductive health service utilization to participants who did not feel they had the skills or information to adequately seek care for their reproductive health needs.

Though both US and CA students reported having health insurance permitting access to different provider types, each health system's structural processes and policies influenced pathways to care, determining provider options, service coverage, and influencing students' care navigation competence. Below, I exemplify how each country's healthcare structure interacted with students' pathways to care and ability to access reproductive services, providing insight on structural inequities based on participants' statements connecting social locations to care access.

4.1.1 Understanding and Navigating Health Systems in the US and Canada

US students described being tasked with the responsibility of identifying providers who accepted their health insurance and clinical options for reproductive care without having the adequate knowledge or resources to do so. As one US participant stated, *"At least in my experience, there's no systemic support for knowing [how to access care]"*. As follows, US students showed how lack of healthcare navigation support manifested as laborious and prolonged time to reproductive care.

Some US participants were unaware that preventive reproductive health services were covered by law.[212] They did not know the ACA required insurances to provide full coverage for preventive care, or that they had the option to access these services through a primary care provider or an in-network gynecologist without a referral. For instance, one student reported visiting their primary care provider for a gynecology referral like they have with other specialist needs. In addition to the labor and time for this student to receive specialist care, this primary care provider appointment resulted in an unnecessary copayment cost.

Other US participants reported a trial-and-error process of using reproductive healthcare: making mistakes and applying learned information to future healthcare seeking. Like the student above, this trial-and-error process was exhaustive and created hurdles to accessing appropriate providers. For example, one student accidentally made an appointment with an out-of-network provider and was turned away when she arrived. She learned that her overarching insurance provider had other insurance plans in-network with this provider, but her specific plan was not. As this student explained,

> *"I tried to look for provider based on my healthcare, and then the provider that I went to was like, 'Well, your insurance does not cover here.' So, I had to look for a different [provider in] my insurance [network] for that specific topic, for that specific area."*

In contrast to US students' healthcare navigation confusion, CA students felt that their universal healthcare streamlined service access. Even with little knowledge of the health system's innerworkings, CA students reported less patient burden in navigating services. As one Canadian student said,

> *"I think because it's public…because you have your health card, you get a lot of services available to you…Everything has been really smooth and easy to navigate the system… the whole process is pretty easy and straightforward…I didn't realize it was that easy."*

Other CA students discussed similar experiences, all using their provincial health card to access a pre-established primary care provider who then led the student to general reproductive health options or specialist referrals. One student explained how the Ontario health system's referral process helped organize her care pathway,

> *"[Providers] just help streamline the whole process…and refer you to whoever you need to go to next…So for me, it's just part of the whole healthcare system and how everything works. It makes me feel like it's more organized…it's efficient."*

4.1.2 Health Systems' Impact on Equitable Access

In addition to each health system's structure impacting standards for how all participants accessed clinical reproductive health services, students recognized how health systems differently impacted access based on an individual's social identities and lived experiences. For example, one student in each country described how coming from an immigrant family contributed to limited knowledge about their health systems. Yet, the structural differences between the US and CA health systems determined their ability to navigate care. The US student exemplified how her struggle to navigate an already confusing health system was compounded by her childhood experience with low-income, immigrant parents. She stated,

> *"[My parents] were born outside of the US. So, they weren't sure how to use the government stuff, and it doesn't help when no one explained it…So I just didn't get to do a lot of those things…Growing up low-income, that wasn't a luxury or privilege I had."*

In contrast, the CA participant from an immigrant family reported how Canada's healthcare structure alleviated some of the need to learn about the health system to receive care. She favored her experience as a permanent resident using the Canadian health system due to simplicity, cost, and convenience. She compared her experience to seeking care in another country, stating,

> *"I have a health card that makes everything a lot easier for me. I think the whole process…[is]straightforward. When I was in another country and dealing with their health care system…the fees were really expensive, and it was a lot more inconvenient. So, convenience would be the biggest factor."*

Participants identified other ways healthcare structure and reproductive related policies impact access to reproductive care based on social locations. Many students discussed inequitable access based on race, gender, and sexuality. Yet, due to Canada's universal care model, only US students mentioned socioeconomic status as a barrier to care. One US participant connected lack of universal healthcare coverage to inequitable access through an intersectional picture of the barriers a person with multiple oppressed identities faces in the US,

> *"Universal healthcare would be beneficial to everyone…Because how many people – poor people, both of color and trans people – don't go to them because they can't afford it or because the doctor doesn't know anything about their body? So, I think [provider] education and universal health care. Like, why aren't we doing these things?"*

While Canada's universal coverage and comparatively simplified model mitigated barriers to care, students in both countries recognized geographic healthcare access disparities. For example, after spending summers working in northern Canada, one participant recognized her healthcare access privilege based on her geographic location. She compared her sense of access in the north to when she is home in Toronto,

> *"Coming from a bigger city…it's a very accessible place…I'm grateful that there is that option. But if you're from a smaller area – Let's say you're from somewhere north in Canada, you have to travel…to a bigger city to get healthcare... If I had a health concern there, I don't know what I would do…So, I think that's a big difference."*

Though we know similar physical healthcare access disparities exist in the US,[213] US-based participants focused on geographic disparities based on lack of insurance portability. They showed how the inability to use health insurance across state lines uniquely impacts students attending out-of-state universities. Many US universities require students to have health insurance, offering university-based insurance for an additional fee, or students can opt out by providing proof of other health insurance.[214] However, proof of insurance is not proof of adequate coverage. Specific to students attending university out-of-state, health insurance companies are only required to provide emergency coverage outside of the state or network in which consumers are insured.[215] This policy impacted out-of-state students who were faced with a difficult decision to purchase university-based health insurance in addition to their home-state insurance or remain underinsured while at university.

Only three out of five out-of-state students opted for university-based insurance. Their decisions to opt in included the financial ability to afford the extra university billing costs or requiring frequent care for chronic health conditions, illustrating the compounding impact at the intersections of being a low-income, out-of-state student with complex healthcare needs. Despite reporting frequent illness, one student from a single-parent household already felt the financial burden of paying out-of-state private university tuition and did not purchase university insurance, stating,

> *"I waived the university health insurance fee because it's a couple thousand dollars. So, I don't have insurance out here except for emergency coverage."*

Further, this student described the ways she managed her health, proactively taking vitamins and supplements to prevent illness while keeping medications such as antibiotics for self-treatment. When experiencing a health issue, she first called a nurse hotline for medical guidance. Then, if her ailment became unbearable, she would seek care at the emergency department where her home state insurance was required to cover costs.

Since no CA participants reported being out-of-province students, we do not know Canada's out-of-province students' first-hand experiences of using health services while at university. Though the Canada Health Act includes insurance portability for medically necessary services, provinces determine definitions of "medically necessary" services and parameters of out-of-province coverage.[45] Few provincial and territorial health insurance websites specifically indicate accommodations for students attending out-of-province accredited educational institutions,[82,216,217] indicating an identified need to address inter-provincial and territorial portability issues for students. More investigation is needed to uncover potential out-of-province student issues, such as misunderstanding aspects of health coverage portability or needing to purchase additional health insurance plans within their university's province.

4.2 Health Systems' Influence on Clinical Care-Seeking and Service Delivery

Canadian and US healthcare structures and social values influenced university students' reproductive care navigation engagement, experiences, and expectations. As detailed above, the US health system includes complex insurance networks leading to narrowed provider access based on a person's health insurance network while Canada's universal health system abates uneven patient distribution by assigning patients to a primary care provider who may refer patients to specialists. However, students from both countries perceived that these respective healthcare approaches inadequately addressed short appointment durations and time-to-care delays.

4.2.1 Appointment Duration's Influence on Care-Seeking Behaviors

CA students described how Canada's universal healthcare delivery approach influenced their initial decisions to seek care. Some CA participants reported being restricted to one specific health issue per appointment, and sometimes found it difficult to identify one prominent issue relating to complex reproductive concerns. The "one issue per visit" approach triggered one student to question if it was appropriate to seek care for her broad reproductive health concerns. They explained, *"I was thinking like, 'Is this something that I need to be going in for?...is this necessary?'"*

Further, CA students reported that short appointment durations inhibited their ability to communicate their needs. As one participant explained,

> **"***I want to be able to feel comfortable talking with them and letting them know what my concerns are fully and completely without feeling like 'I have 15 minutes with this person and what is the most important thing that I can tell them?' And then having to condense it all and then try to get all my concerns out…"*

The 15-minute appointment timeframe this student referenced was frequently mentioned by other CA participants. Limiting appointment times and requiring one health issue per visit are common clinical practices to ensure efficiency based on the way providers are paid for their services.[86,218] Fee-for-service models (FFS) pay for specific services performed, incentivizing providers to take on more appointments. While this intends to safeguard healthcare access, it can be counteractive to care quality by limiting time and resources needed for patient-provider communication, holistic care, and provider accountability for patient outcomes.[219]

Combined with the above appointment limitations' influence on care-seeking behavior, CA students showed a more collective, empathetic lens when seeking healthcare such as recognizing patient capacity limits for specialist services and feeling other patients may have more urgent health needs than themselves. One student shared how this lens impacted her decision to not only seek care, but how she approached conversations with her provider during her appointment,

> *"[Before my appointment, I'm] trying to think about how I can describe it the best way while still staying within that timeline and being mindful of the fact that they are very busy people, and they see plenty of people every day coming in for appointments. So, I don't want to overload them with information."*

Despite appointment time constraints, some students acknowledged their providers' commitment to communication, allowing for more comfortable and effective clinical interactions. One student reflected on her clinical reproductive health experiences where the provider has prioritized communication over appointment time limits,

> *"If the doctor takes the time to be like, 'How are [sic] you feel about this treatment or do you have any questions about this medicine?' Then it's more like, 'Oh, look, they're listening to me. I can ask them my questions.' You feel a bit more comfortable."*

US students also valued time spent with providers to engage in effective conversations during their appointments. However, no US students reported that their health system placed a clinical burden on time spent with their provider. Perhaps those in the US did not experience short appointment times due to the multifaceted financing system offsetting FFS time constraints?[86,220] Another possibility is that US students often referred to clinical interactions with a nurse in addition to their provider, indicating a shared nurse-physician responsibility for patient care which is shown to mitigate provider burden and healthcare costs.[221] For example, one US student recounted their nurse's and doctor's shared roles in contraception care,

> *"[The nurse] set me up for everything. She was just very easy [to talk to], definitely one of those people who puts people at ease…when the doctor explained things, like, 'Okay, we're going to do this and then it's going to happen here'."*

In contrast, CA students did not cite their nurses as a clinical source of patient counseling. In fact, one CA participant said,

> *"I don't think the nurse plays much of a [role] during visits…With a nurse, [they are] just giving a quick description, saying what has to be said…But with my actual [concerns], I usually keep to the doctor."*

4.2.2 Student Experiences and Perceptions of Specialist Referrals and Time-to-Care

In addition to CA participants' primary care-seeking hesitancy, some students explained that the health system's gynecology specialist referral requirement itself instigated apprehension about if and when they needed to receive gynecology care from a specialist. The nature of Canada's system referrals indicated that needing a gynecologist appointment was a rarity, and negatively impacted students' perceptions around specialized services. Two students explained that being referred to a gynecologist meant there was something critically wrong with their health, both comparing gynecology care experiences to how they may feel intimidated when receiving hospital-based or other specialty care. As one stated,

> *"I see a family doctor being more accepted…because it's easier and more mainstream. But when it comes to a special doctor, it's much more rare and like you're diseased."*

Another student recounted how the wait-time to her referred appointment exacerbated worry about her genital skin abnormalities,

> *"I got the kind of like, 'oh, it's a red flag. You need to go to a specialist.' And that moment, it's kind of scary…the time from the family doctor to the actual specialist appointment is two months apart…It's a long time to be worried…"*

Once accessing care, family providers acted as gatekeepers to reproductive health information and services. CA participants reported troubles with restricted reproductive care avenues, including difficulty changing their family provider, family provider reluctance to give gynecology referrals, and time from initial primary care appointment to specialist care. One CA participant experienced all three challenges when she sought help for pain after an IUD insertion, and reported that her doctor told her to find a new provider,

> *"I'd tell her [family provider] that I'm in pain. And she'd be like, 'alright, so your pain's better'…Then she just at one point said to me, 'you should just get a new family doctor'…I can't. It's hard to get a family doctor."*

Not only were CA students reporting lack of power within their narrow reproductive healthcare seeking pathway, but two Canadian KIs also voiced concerns around the Canadian healthcare model permitting gatekeeping and limiting patient autonomy. While some reproductive services may be within a family provider's scope of practice, KI2 spoke to the very issue experienced by the above participant saying,

> "*Even if people bring these [reproductive health issues] up to their doctors, they might not be addressed or given the proper referral pathways to have it explored to see what's actually wrong…That's a really big issue."*

KI1 expanded on the consequences of Canada's referral requirements when providers are simultaneously permitted to deny certain services based on their beliefs,

> *"Doctors and other registered medical professionals are self-regulated professions and have a lot of discretion on how they treat patients and what kinds of treatments they give. So, you end up in situations where you have anti-choice doctors and nurses and midwives and pharmacists…They have the codes of ethics to treat patients respectfully and give them all the information they need…[but] the Canadian Medical Association recognizes this so-called 'right to conscientious objection'… [the providers] are supposed to make sure that they give implicational information and refer, hopefully. But actually, most of the provinces don't require referral, except for Ontario requires an effective referral to another practitioner. Though, this opens the door for a lot of abuse."*

Though US students less-often mentioned prolonged waiting periods as a barrier to quality care, they expressed a more critical perception of their current clinical access barriers from their country's more individualistic healthcare delivery approach. One US student established care at a new in-network health clinic where they were put on a waiting list. Since this clinic was located nearby campus, this student chose not to seek care from a different in-network provider with sooner appointment availability. However, they expressed frustration as they waited for their appointment,

> *"It's like a waiting list…they only have a gynecologist that comes to the clinic once a week. So, I had to wait for them to have an appointment ready for a month. So, they gave me a pack [of oral contraceptives] while I waited for that appointment…I just wanted to talk about getting something different than pills. I was like, it'd be great if this is one less worry I had to worry about."*

Another US student explained how the US insurance structure contributed to her struggle with identifying and making an appointment with a provider who works with her specific insurance. Not only was finding a provider burdensome, but it also extended her anticipated wait for care. Interestingly, she advocated for the US to adopt a more collective, equitable healthcare approach to address provider wait-times caused by in-network provider disparities,

> *"… a lot of things that had to be done, when it just could've been simple where every health insurance is covered here...So, it doesn't matter where you go, because everybody will have open spots."*

After making calls to several providers, this student identified one in-network reproductive health location where the provider made a special effort to book an appointment outside of clinic hours, sympathizing with this student's inability to find an in-network reproductive health provider who was accepting new patients. While this student felt uncomfortable with attending outside of hours, she was able to receive services before leaving for university and acknowledged the patient-load burden of in-network gynecologists,

> *"Appointments were backed up until October and I was like, 'Well, I have to leave for college in August'. Then, they had to make some weird appointment…I don't know, it wasn't super shady like how I'm describing it, but it was just – they had to squeeze me in before any appointment."*

No CA students mentioned experiences where their provider has played a role in decreasing these wait times. Yet, similar workarounds at the clinical level likely exist in Canada. KI2 discussed Canadian access barriers and areas where providers may be able to mitigate system issues,

> *"[Some] family doctors don't have the training or comfort…[to insert IUDs]. So, you really have to work your way through the system to find access to these services…you're sort of being pushed around doctor to doctor…There's such simple barriers such as access to transportation to get to these appointments or follow up when you don't hear from that doctor. The waiting lists, et cetera, they're just very straightforward barriers."*

4.3 Healthcare Systems' Impact on Need-Specific Service Availability/Coverage

University students cited a narrowed scope of available health services fit for their specific needs as antagonistic to reproductive health solutions. Participants in both countries gave examples of situations where their provider went beyond clinician expectations to patch need-specific access issues that trickled down from healthcare structure. Others mentioned situations where providers may have had these patient advocacy opportunities but did not have the resources, tools, or knowledge to mitigate healthcare policy barriers in the clinical setting. Overall, students unveiled the importance of providers' health system knowledge and ways clinical care was delivered within respective care models. To overcome reproductive healthcare hurdles, clinical-level stakeholders (i.e., providers and other health workers) needed to know healthcare policy intricacies, and they sometimes took on a role of mitigating financial costs and other structural barriers.

While contraception availability and coverage were discussed in both countries, CA students more often reported policies, and lack of policies, preventing timely access to their preferred method. However, coverage policy sometimes positively impacted students' clinical contraception access, allowing students to secure short-acting methods for longer periods of time (Section 4.3.1). Though only one participant reported using abortion services, many students and all key informants reported abortion access as a major concern with nuances preventing quality abortion services that do not exist for other reproductive health needs (Section 4.3.2). Further, students and key informants discussed ways the US and CA health systems limited the scope of transgender care, and what needs to be changed to permit person-centered access to gender services as it relates to gynecology (Section 4.3.3).

4.3.1 Securing Students' Preferred Contraception Methods

When students attended their reproductive health appointments, healthcare policies determined differences between US and CA university students' preferred contraception technology access. For example, at the time of participant interviews, some CA students reported that their preferred method, the contraceptive implant, was not approved by Health Canada. One participant shared her plans of paying out-of-pocket in a different country to secure a pregnancy prevention method she felt was best fit for her,

> *"I'm going to Colombia in December. I'm going to visit a gynecologist there [to] pay out of pocket…you can get it removed in Ontario for free."*

Soon after the time of this interview, Health Canada approved contraceptive implants in May 2020, and these contraception devices were marketed on August 17th, 2020.[222] In the United States, the Food and Drug Administration (FDA) approval and availability of comprehensive contraception technologies proved to safeguard contraception access even when students did not have access to clinical care. While the fragmentation of US healthcare coverage hindered out-of-state students' healthcare access, the contraceptive implant served as a strategy to mitigate being uninsured while at university. Both uninsured out-of-state students chose to insert the contraceptive implant in their home state prior to leaving for university. They reported choosing the implant due to its long-acting, no maintenance characteristics that would not require accessing healthcare or prescriptions in their university's state. As one explained,

> *"I have to get my Nexplanon replaced every three years, and I line it up with winter break because I can't get it done here [at university]…I wanted something that*

> *was…stable and not really dependent on my memory, and I wanted something that was really effective."*

Though an IUD could provide similar benefits, one out-of-state student shared her fears about uterine perforation. While she acknowledged that perforation was unlikely, she felt peace of mind with her implant choice, stating,

> *"I went [to the provider], and I was like, 'I want an IUD'…And she's like, 'this is an arm implant, it's kind of the same. Why don't you try this instead? You can take it out whenever you want…' So, thank God for her because otherwise I would have just gotten an IUD and I could have a hole in my uterus right now."*

In addition to contraception method availability, students stated that contraception coverage policies narrowed participants' method and brand options. While CA participants had prescription coverage through supplementary insurance or provincial prescription programs for young people, pharmaceutical insurance sometimes still required copayments or limited coverage for specific contraception brands. One provincial program, OHIP+, was often mentioned as a factor in preferred contraception method access. This Ontario program provides full coverage of over 5,000 prescriptions to those under age 25 who do not have supplementary private insurance.[223] Two participants were worried about oral contraception costs when they aged out of this coverage. Therefore, one student chose a long-acting reversable contraception (LARC) method,

> *"I was going to be 25 so I was going to lose my OHIP+ – I didn't want to have to pay for birth control – that's when I talked to her [provider] about getting an IUD."*

Three other students reported that OHIP+ coverage limited their contraception method brand options. The first student who reported OHIP+ contraception coverage issues was satisfied with the oral contraception brand that she switched to after experiencing negative symptoms with a generic brand. While the name brand was previously covered by her university's prescription insurance plan, the implementation of OHIP+ recently limited coverage to the generic brand. She shared a detailed explanation of how these policy coverage changes impacted her,

> *"I started birth control before [OHIP+ coverage] came out and the student coverage would cover the entire prescription price...Once that new legislation came out, [student health insurance] stopped covering a lot of prescriptions because they said OHIP is going to cover it. But the thing with OHIP is that they don't cover brand names…It would have covered my generic brand, but that one gave me a lot of symptoms."*

This student continued to discuss how her provider's familiarity with insurance coverage and clinical resources helped her obtain the preferred brand. The on-campus provider informed the student that her new insurance would not cover her oral contraception brand and gave her free samples prior to upcoming insurance coverage changes. Further, he continued support in securing this medication after these changes were in place,

> *"He [the provider] gave me all these samples so that I didn't have to buy them for a while…And he's like, 'If they're still not covered [when you run out of samples], come back and talk to me.' And then I did, and he said, 'Well, here's some more samples.' So, I'm…making an appointment with him before I'm done school [to get more samples]"*

Another student recalled lacking OHIP+ coverage for her contraception brand in 2018 and used her father's supplementary insurance to cover costs. She stated,

> *"I had to use my dad's health insurance to cover the rest…So, it's more of integrating or using different coverages to make sure that it's actually free for you."*

In response to my inquiry regarding students' ability to supplement OHIP+ insurance with private coverage, KI2 explained changes made by the new provincial government on June 30th, 2018 that prevented young people from being covered by both private insurance and OHIP+,[224]

> *"When the Conservatives came in, OHIP+ was amended…If you had private insurance through parents or school, for example, that would take precedence over OHIP+."*

Another participant impacted by OHIP+ limitations exemplified that not all providers are aware of contraception coverage variation. This student told her story of being prescribed an IUD not covered by her insurance, which resulted in additional patient labor and prolonged time to IUD insertion of a brand she did not initially feel was best-fit. This student was limited to only one hormonal IUD brand (Mirena) but was originally counseled on and prescribed a different brand (Kyleena). She chose Kyleena after her provider recommended it as best-fit, informing her it was a smaller IUD appropriate for nulliparous individuals. Yet, she discovered Kyleena was not covered only after she arrived at the pharmacy to pick up her device. The student described the burden of this mistake and additional steps needed for insertion,

> *"I ended up getting the five year one [from the pharmacy] and having it for like three months…I was a woman who hadn't given birth yet, so [the prescribing provider] wasn't comfortable inserting it for me, so she was sending me to someone else."*

Overall, this provider's lack of prescription coverage knowledge led to contraception counseling insufficient in providing comprehensive information necessary for informed decision-making, created additional patient hurdles, and prolonged the student's time to device insertion and pregnancy prevention.

Similarly, in the US, despite federal law requiring complete insurance coverage for FDA approved methods, insurance providers can select which brands of each method they will cover.[225] At the time of their interviews, all US students had health insurance required to cover a comprehensive list of contraception methods. However, some US participants reported that their providers discussed out-of-pocket costs of contraception during counseling. One student chose a specific IUD brand after her provider counseled her on all IUD brand options. When asked how her provider helped her make this decision, she recalled,

> *"She [provider] said this [IUD brand] is the one that will probably last longest. It just keeps getting approved for longer and longer…so she was like, 'I don't want you to have to pay. And when you get your next one, it will be free.'"*

Within the context of the law's contraception brand coverage limitations, it seems here that other IUD brands were not covered by this student's insurance. The above quote indicated that this student considered long-acting reversible contraception due to its long-term effectiveness but was limited in her choice of IUD brand.

Other students recounted contraception barriers during times when they did not have health insurance. One student discussed paying out-of-pocket for contraception injections (Depo-Provera) during a period when she did not have access to confidential insurance coverage,

> *"They [provider] said that if my household income falls within a certain level that I would qualify for Medicaid…but since my dad was still putting me down as a dependent on his tax returns, my household still was above that line. So, I couldn't get on the Medicaid…They just billed me $20 when I would go and get the next round of shots."*

While the provider interaction described above did not lead to a complete contraception coverage solution, it showed the importance of health worker's understanding of health systems and healthcare coverage. The provider assessed this student's ability to enroll in public health insurance for low-income individuals and worked to find an alternative solution. Based on Depo-Provera's average retail drug price of 65 dollars[226] and the added service cost of performing injections, it seems this gynecologist office worked behind the scenes to provide a discounted price. The 20-dollar payment could have been subsidized by Title X or another family planning grant program ensuring confidential family planning access for uninsured or minors.[68]

US students discussed other ways providers worked to mitigate healthcare structure limitations of insurance network and interstate fragmentation. For example, two US students stated that their providers worked with insurances to cover up to three months of oral contraception prescriptions at a time. This prescribing method lessened the burden of students' monthly coordination to access prescriptions and alleviated geographic or state-based barriers to consistent contraception use. As one participant who moved from Michigan to Florida for graduate school said,

> *"I got like 3 months' worth of pills I had just refilled before we left [for university]. I had enough to get me through the first semester of grad school while I waited for that appointment [with a new provider]"*

Though it is possible for providers in any state to work with their patients' insurance companies to cover dispenses of three or more months of oral contraception at a time, only twenty states and the District of Columbia require insurance companies to cover extended supplies.[225]

Some CA students also reported receiving three-month oral contraception supplies and valued the convenience of not needing to make monthly pharmacy visits. Like the United States, Canada's coverage of extended oral contraception supply is pharmaceutical insurance dependent.

In the case of CA students using OHIP+, oral contraception three-month supplies are covered after a patient requests extended supplies from their pharmacy.[227] An additional benefit of extended contraception supplies for Canada's healthcare users with medication co-payments includes less frequent and lower fees over time.

Overall, both health systems held policies that promoted and limited contraception access. CA students' contraception options were limited by Health Canada's lack of contraceptive method approval and provincial health insurance's scope of contraception coverage. Conversely, most insured US students were able to access their preferred existing contraception method due to the availability of various methods and full insurance coverage of these methods. Both countries lack true comprehensive coverage of students' preferred contraception brands. In addition to each nation's tangible healthcare policies surrounding contraception coverage, provider familiarity with contraception policies played a role in how, when, or if a student received their preferred contraception method.

4.3.2 Protecting Access to Abortion Services

By proxy, individuals do not have equitable access to quality abortion care without abortion rights. The June 2022 Dobbs decision that unrecognized abortion as an American right resulted in more state control of abortion laws, and various levels of abortion bans throughout US states. According to Guttmacher Institute, in December 2022 sixteen states had enacted near-total bans and several states implemented stricter gestation laws. Conversely, seven states increased abortion support through legislation and funding.[71]

All student interviews were held a year prior to the Dobbs decision. Yet, students in both countries expressed uneasiness about current and future abortion access. Abortion access concerns were reported more often in the United States, with nine US students and two CA students specifically worried about abortion legality and patient rights, physical and financial access, and policies that impact clinical protocols.

Though Canada is not directly impacted by the US Supreme Court abortion decision, Canadian KIs pointed toward Canada's similar legal precedent, noting that the only guarantee of federal abortion rights is through the current legal interpretation that abortion provides the constitutional right to "life, liberty and security of person".[228]

Further, KI1 and K13 shared insights on Canadian abortion politics, discussing anti-choice measures and bill proposals from their two different perspectives. Table 6 shows these initiatives and key informants' interpretations of potential outcomes if passed.

Table 6. Abortion Policy Proposals in Canada: Pro and Anti-Choice Perspectives

KI1: "Pro-Choice"	**KI3: "Anti-Choice"**
Policy Description: **General abortion-related policy proposals.**	
"Many bills are dressed up as 'we're trying to protect their health as well as safety'...but that's just a cloaking mechanism...It's really about trying to ban abortion."	*"We are looking for an abortion law. Canada has no abortion law. Abortion is legal all nine months of pregnancy and no matter what reason..."*
Policy Description: **Form a committee to develop a definition of when life begins. Criminalize fetal harm.**	
"[Anti-abortion lobbyists are] trying to create a degree of fetal personhood...opens the door to other laws that would elevate fetuses to the level of people."	*"We try and move our abortion policy to a point where we start to recognize that these are human beings."*
Policy Description: **Require counseling prior to making abortion decisions. Strengthen provider's conscientious objection rights.**	
"The only enforcement mechanism a patient has is to complain. That's the only way you ever find out if a doctor is doing something wrong, and most patients wouldn't complain."	*"[If a patient seeks abortion] because of... countless situations, the abortion doesn't fix those...we need to come alongside women."*
Policy Description: **Ban abortions based on fetal sex or anomaly.**	
"In Canada [patients] don't have to say the reason for an abortion, so it's really a foot in the door for more restrictions on abortion. Plus, it kind of invites racial profiling"	*"It gives tools for the doctors...to do what's ethically right in that situation...Gender discrimination or disability discrimination."*

Most KIs discussed their roles as advocating for abortion protection policy and against anti-abortion legislation like the proposals above. However, they went beyond to include how their own policy advocacy is supplemented with ways to mitigate policy impact, such as informing people of their rights and resources, and connecting individuals with financial and transportation support. Further, as an Ob-gyn provider, KI5 demonstrated how providers can advocate beyond the clinical setting. While her primary intention was to positively impact reproductive health policy and beliefs, KI5 felt that her community advocacy contributed directly to patient perceptions of safety when under her care. She explained,

> *"[I'm] involved in as many pots as I can - the local, the institutional, community, city, the state…and just trying to be present wherever the conversations are happening…Doing local stuff…rallies and demonstrations. Seeking that out and being very vocal about my interest…allowed people [patients] to be like, 'Hey, this is going on'."*

Key informant four (KI4) echoed the importance of scaffolding advocacy efforts. As an abortion fund leader in the US she stated,

> *"[I'm a] bridge or middle person between what we know happens and how the community can make sure that they actually benefit from advancements or movements."*

Students reinforced the concept that patient resources and knowledge can mitigate structural abortion barriers. US students often discussed state-variance in physical abortion clinic accessibility, and how state policies added to the burden and resources required to travel for abortion services. Sometimes, students were unaware of their state's abortion laws and noted that lacking this information would leave them unprepared if or when they require abortion services. As one student mentioned,

> *"I know we're [Florida] primarily a red state, and so I'm just like…I have no idea. It would be lots of Googling. Hopefully it wouldn't come down to that…"*

Physical access to abortion clinics was also mentioned as a concern from one CA student. In addition to Canada's vast geographic area and low population density contributing to geographic abortion access disparities, this participant referred to a recent reproductive health clinic closure in the nation's capital,

> *"They just closed in Ottawa…and they had not given any warning to people…and a lot of them [patients] were kind of left in the dark with…nowhere to turn…it's not things that people can put off and leave for later. It's stuff that needs to be addressed quickly."*

While it is important to note that other clinics in Ottawa remained open when this clinic closed, this student's statement highlights how perceptions of abortion access can be a barrier to care. Further, despite other clinic locations, it is unclear how previously established patients at this closed clinic transferred their care elsewhere, including potential personal hurdles and structural re-distribution of patients.

Related to physical abortion access, providers were mentioned as having a role in abortion service availability. Providers' commitments to supporting and providing abortion services could mitigate geographic disparities. In both countries, providers have the right to deny abortion care based on "conscientious objection". Providers' ability to deny reproductive services based on personal beliefs has been cited as contradictory to medical ethics oaths and linked to overburdened providers and poor reproductive health outcomes.[104] Most KIs agreed it was important for providers to share an ethical duty to provide comprehensive reproductive health services. KI5 demonstrated that providers' specialized training and continued ethical commitment instilled elements of patient access, support, and safety. As an Ob-gyn physician trained and practicing in the United States, KI5 exhibited the value of additional training surrounding abortion provision in a rural area with limited healthcare options,

> *"There's something specific called a Ryan Program…it is not guaranteed in every Ob-gyn residency, but in a select few…It's designed to give residents advanced abortion and reproductive choice training…We've had a lot of closures of local hospitals. So, we're really the only show in town…we're taking care of women in that sense and so now, it's just kind of taking all my training and putting it into action."*

KI1 discussed ways to ensure providers share pro-choice values through medical training, setting ethical standards, and incentivizing abortion providers. KI1 continued to explain,

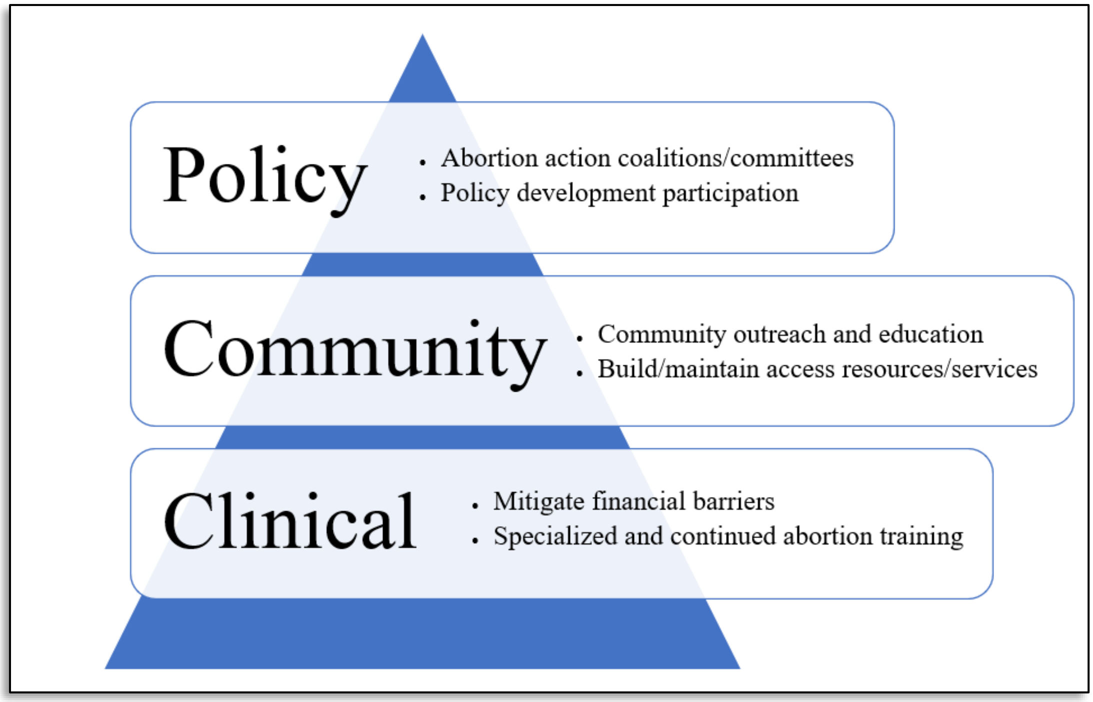
> *"Some objectors, I think, are objecting maybe not because they're anti-abortion exactly, but it could be because of abortion stigma or other reasons. So, there's a lot you can do to move existing objectors towards abortion provision."*

In addition to the provider's roles in advocating outside of the clinical setting, and sharing and specializing in family planning service values, one US student reflected on her provider's role in mitigating abortion costs. She explained the provider's efforts to minimize the cost of an out-of-pocket surgical abortion and IUD insertion. For a decreased rate, this provider gave her options to opt out of anesthesia and have a resident physician insert an IUD. Due to these combined cost savings, this patient was able to afford IUD insertion after her abortion,

> *"I could go under anesthesia…but it would cost about $350 extra so I said we weren't going to do that. My husband had saved $500…that was how much money we were able to spend [on an abortion]. We asked them to place an IUD at the same time as they were performing the termination…it would be an additional $600…But they gave us the option of having a resident [physician] place it and then it would only be $100."*

As demonstrated by KIs, maintaining and progressing toward equitable abortion access required individual stakeholders to continuously operate at policy, community, and clinical levels (Figure 8). Policy advocacy for these KIs looked like abortion action coalitions, professional committee involvement, and participation in developing healthcare standards and policy. Indeed, policy advocacy was at the forefront of students' and key informants' concerns, but KIs revealed meaningful actions within communities and in the clinical setting. Community roles included an actionable presence within communities through demonstrations, education, and informational resources. Further, connecting people with transportation, financial, and autonomy affirming support was seen as an effective way to mitigate structural abortion barriers at the clinical level.

Figure 8. Reproductive Healthcare Provider and Stakeholder Abortion Access Roles



4.3.3 Improving Access to Gender Affirming Care

Though only one participant reported using transgender services (i.e., testosterone therapy), others explicitly included transgender health in their definitions of reproductive rights. Students recognized that health systems showed evident exclusion of services outside cisgender social and biological assumptions. Gender non-conforming participants and others within the LGBTQIA+ community discussed instances in which they felt excluded from the health system.

Students expressed the feeling that reproductive care for uterus-having individuals was underdeveloped. Two students stated that healthcare was created and maintained to fit cisgender males, neglecting to provide adequate medical solutions and environments for both cisgender women and transmasculine individuals. After not finding a solution for chronic reproductive pain, one non-binary participant conveyed frustration with lack of medical reproductive knowledge, connecting shortcomings of reproductive healthcare to structural sexism,

> *"Our institutions are set up in a way…The lack of knowledge about people who have uteruses and the origins of gynecology – it's not set up to be comfortable for people who are assigned female at birth…the norm that cisgender men, their bodies are normal and natural and everyone else is, you know, aberrant."*

Further, a transmasculine US student (He/They) encompassed their health system's failure to provide the structures necessary for transmasculine needs. He stated,

> *"But really, it's just that the medical system is not prepared for my existence."*

Throughout his interview, they pointed toward inadequacies of established and available services, and insufficient coverage policy standards and provider competencies to provide existing services. Despite US healthcare law against sex discrimination, health insurance coverage of transgender services varies, with some insurance companies explicitly excluding all services related to transgender needs.[229]

This participant also shared that access to transgender services was not financially feasible without insurance coverage. Compared to health needs primarily intended for cisgendered and heteronormative reproductive uses such as contraception coverage, specific gender-nonconforming needs were difficult to establish medical necessity for insurance coverage. For example, this student's insurance required them to access other services before covering testosterone therapy. They needed to first be diagnosed with gender dysphoria and was then required to maintain psychological counseling services in combination with their medication treatment. He discussed his personal struggle accessing trans-appropriate care and the long-time self-advocacy it took to secure testosterone therapy coverage,

> *"It's a lot of fighting with insurance companies, particularly to access trans care. I've been on testosterone for 2 1/2 years now and I spent a good two or three years fighting to get it before I could even start."*

The World Professional Association for Transgender Health's (WPATH) standards of care carefully distinguish between those who are non-conforming and those who experience gender dysphoria.[118] Gender dysphoria medicalizes a person's struggle of "marked incongruence between experienced or expressed gender and the gender assigned at birth".[230] While the WPATH standards acknowledge issues with pathologizing transness, it states that diagnosis can "facilitate access to medically necessary health care and guide further research into effective treatments".[118] In other words, powerful structures (e.g., health insurance companies and research funders) define and uphold a diagnosis that influences individuals' treatment access and the direction of transgender care's development.

This student also mentioned provider access barriers prior to and throughout their testosterone therapy. First, he had to identify a provider who works with transgender patients and ensure the provider was within his insurance network. Then, he needed to establish care with a transgender-appropriate provider and maintain consistent care with these providers. They detailed this experience, exhibiting the substantial labor of accessing transgender services in a system with limited transgender-informed providers,

> *"I've had three different providers…one person in that office who had experience working with transmasc folks…then she went to a different practice. I transferred my care to someone else in that office who hadn't worked with trans folks…Then she also*

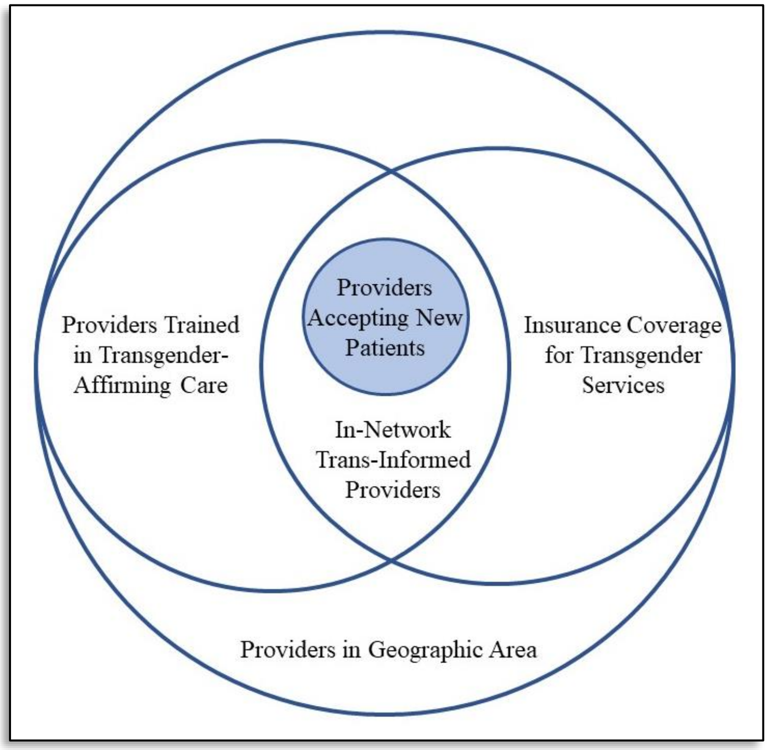
> *moved to a different practice, so I switched care again to a university provider… I'm going to graduate in the next year, so I will have to find yet another provider."*

The disparity of transgender-informed providers compounded this student's access to consistent appropriate care within his insurance network. He went further to describe his experience with his current provider,

> *"And a lot of the issues that come up with her [provider] are not directly focused on transness…Sort of ignoring the difference in experience that I have…"*

While this study only includes one person's experience with transmasculine care, this student outlined accumulating barriers throughout the process of seeking transgender services in the US. Transgender-affirming care access in a geographic area is limited by the interaction between service coverage and availability (Figure 9). To access appropriate care, this student described needing health insurance that covered transgender services and included in-network providers who were trained in transgender-affirming care. Once in-network trans-informed providers were identified, these providers needed to have the capacity to accept new patients.

Figure 9. Modeling Transgender Service Availability and Coverage in the US



**This figure is for illustrative purposes and not based on statistical data.*
It is not representative of any particular geographic area or reflect accurate proportions.

Though no CA student reported accessing transgender care, KI1 pointed toward lack of transgender care coverage and availability in British Columbia, and indicated variance between provincial and territorial insurances,

> *"Maybe it's partially covered in some places [provinces/territories], but there's definitely a lack there."*

While sex-reassignment surgeries are covered in every province/territory, coverage for masculinization services and procedures such as hormone therapy and "top surgery" are not universally covered.[231] In BC, both of these treatments are conditionally or partially covered. Relatedly, Canada's overall low availability of gender-affirming surgeries and uneven geographic distribution of Canadian surgeons specializing in gender-affirming procedures are cited as a transgender healthcare access issue.[232] Further, health outcome data related to these surgeries are scarce, resulting in no indicators of surgeon quality.[232] One participant suggested that Canada lacks reputable surgeons who perform masculinization surgeries, resulting in medical tourism to the US,

> *"I also know of a few Canadian trans men who have traveled to the US for surgery because they didn't trust the surgeons in Canada."*

A 2019 nationwide survey of Canadian transgender and non-binary individuals corroborated the above concerns about transgender healthcare access and access variability, finding that only 52% of respondents were comfortable discussing transgender issues with their primary care provider, and 41% of those who needed but had not completed gender-affirming services were on waitlists ranging from 31% in Quebec to 71% in the Northwest Territories/Yukon.[10]

The United States and Canada both demonstrate a need for developing specialization and training surrounding transgender care, more comprehensive coverage of existing services, and strengthened service standards. While provider training and sensitivity can be discussed as a factor of clinical level quality, the distinct needs and only recent medical attention to transgender health leaves a very evident sign that services unique to genderqueer individuals are not currently developed. That is, medical approaches and language surrounding transgender health still continue to evolve, and providers are generally unprepared to provide existing gender-affirming services.[233,234] In fact, if you are reading this thesis five, ten, or fifty years from now, the terms and "medical conditions" I use to describe transgender individuals and Western medicine's current gold standards of transgender care may be considered arbitrary and offensive.

Summary: Health Systems' Influence on Gynecology Care Access

Overall, Canada's health system provided students with simplified direction and support for reproductive healthcare navigation but limited reproductive care-seeking options and prolonged access to specialist services. The US health system theoretically provided students with reproductive care setting choices, but these choices were logistically complicated by health insurance variation and limited patients to in-network providers. Students in both countries expressed needing what the other country's system provided, altogether advocating for reproductive service navigation support within a system that provides timely options to appropriate care.

Healthcare models continued to shape access by influencing both university students' healthcare access expectations and clinical care delivery experiences. Students held negative perceptions about their health systems' capacity, indicated by their experienced and anticipated appointment durations and delayed care. These perceptions influenced care-seeking hesitancy and perceived barriers to quality care. Patient access to quality care may be improved by appropriate appointment durations and efficient clinical conversations centered on individual patient health and communication needs. Time to care may be decreased by assessing patient-provider distribution to mitigate provider capacity issues.

Participants showed that securing access to quality reproductive care was an active, iterative behavior that continued during and after students' initial clinical appointments. That is, simply getting to the reproductive care setting was not sufficient in providing access to specific reproductive services during appointments or as they continued to navigate subsequent health resources. Policy permeated into the clinical setting impacting students' access to specific services such as contraception, abortion, and gender-affirming care. Despite these policy implications, students stated ways providers demonstrated dedication to improving reproductive healthcare access within the clinical setting. Further, KIs exemplified ways that stakeholders can improve equitable reproductive healthcare access beyond the clinical setting (e.g., community and policy).

Chapter 5

Students' Personal Cues to Accessing Gynecology Care

Chapter five looks at ecosocial elements outside of the health system that prevented or promoted students' reproductive healthcare access, illustrating how students' social environments and lived experiences over time influenced personal cues to seek reproductive care.

Section 5.1 discusses how students reported adolescent experiences with sexuality education and social environments influenced sustained reproductive health knowledge, beliefs, and care navigation. Section 5.2 moves forward exploring how students' transition to adulthood, built upon adolescent reproductive health knowledge and choices, including the continued parental role in healthcare navigation, the university's impact on accessing reproductive health services, and individuals' personal influences of reproductive care-seeking.

Overall, chapter five shows drivers of students' reproductive care-seeking behaviors resulting from intersecting adolescent and transitional experiences. Using students' personal accounts, I make connections to adolescent and university setting factors that may facilitate supportive environments and equip students with self-efficacy to seek reproductive healthcare.

5.1 Adolescent Influences on University Students' Reproductive Care-Seeking

Participants reported reproductive health literacy as a determinant of knowing reproductive health options and when to seek care, as well as perceptions of STI and pregnancy risk. They showed how their reproductive health knowledge and perceptions were first developed as children, influenced by social and educational experiences throughout adolescence. One CA student synthesized her adolescence's positive impact on her reproductive health efficacy, recognizing the larger societal role in reinforcing sexual shame,

> *"There's a lot of stigma still around a lot of subjects. Especially even me just talking about sex now, I noticed I skirted around a few words specifically, but it is something that should be talked about more...I had a supportive environment in high school and that helped me realize 'yes, birth control is the next best step for me'. I felt empowered…just recognizing that you're in charge of your own health and there are supports in place that you can go to…It's just all about finding verified sources and knowing who or what to listen to. And that's all dependent on what's best for you."*

While others expressed that their reproductive knowledge empowered a dedicated effort to seeking services, not all students felt their adolescent sexuality education and social environment yielded the reproductive health tools and access they needed. For example, one US participant who was sheltered from adequate sexuality education until coming to university shared how lack of sexuality education impacts young people's ability to identify available services,

> *"Changing sex education would change so much about access because then people would know what kind of birth controls are out there and they would know what's available to them if they were to get pregnant...STIs are extremely real, it's like 80% of the population or something. Like, why is that happening?"*

Lack of reproductive health knowledge also contributed to difficulties identifying health risks and seeking reproductive care. For example, two students mentioned that they felt a lowered sense of risk, which sometimes resulted in not attending routine appointments or delaying care for specific reproductive needs such as STI testing and contraception. Similarly, some felt that they were unable to assess what is normal and were unsure when to seek care,

> *"I don't usually know exactly what's going on [with my reproductive health]…most of us are not knowledgeable with terms. It's just like, 'okay, this hurts. What do I do?' We're not taught…very basic information."*

Below, I discuss adolescent experiences that separate those who do and do not feel confident in their reproductive healthcare efficacy, including sexuality education approaches and content, and cultural and family dynamics.

5.1.1 Adolescent Sexuality Education Approaches and Content

A lack of comprehensive sexuality education was a major theme among students. That is, no participants reported receiving a holistic, inclusive education that promoted scientific accuracy, sexual rights, emotional and relationship skills, and a positive view toward sexuality and reproductive health.[147] Without this curriculum, students felt they had inadequate reproductive health knowledge, including lacking understanding of sexual functioning, behavior risk, and how to identify reproductive need and navigate available reproductive health services.

Many participants described their adolescent sexuality education ranging from anatomy-only or abstinence-based to a broad overview of contraception method options. While all who discussed school sexuality education felt there was need for improvement, the curriculum's comprehensiveness depended on the location of participants. Table 7 shows students' high-level curriculum descriptions, exemplifying curriculum variance with a uniform need for sexuality education improvement. Those who experienced little to no sexual education mentioned being from a "red state" and/or conservative area (US) or attending a faith-based school (US and CA). Those who experienced more comprehensive sexual education sometimes reported coming from a liberal area (US), schools with high pregnancy rates (US), Canadian public schools, or sought sexual education classes outside of their school system (US and CA).

Table 7. Students' Descriptions of Adolescent Sexuality Education Experiences

Student Identity/Lived Experience	Adolescent Sexual Education Source
US, white heterosexual cisgender, rural Mormon family, sexual assault survivor	Utah, Public school
“There's such a variety of school education standards…When you think of reproduction, there's so much more to that than anatomy…That's all that I ever got…I think that's a crime.”	
US, white queer transmasculine, suburban, supportive family	Maryland, Public school
“There was definitely nothing about queer sex ed. It's a very binary for sure…No mention of trans people and certainly no mention of queer people.”	
Canada, South Asian, heterosexual, cisgender, urban, immigrant family	Ontario, Public school
“We had sex ed and stuff, but still very basic information. Like, you're not really taught beyond that. So, I don't think I'm as knowledgeable as I should be.”	
Canada, white, bisexual, cisgender, suburban, supportive family	Province Unknown, Public and Catholic schools
“I remember in grade 7-8 we got the full rundown of like every single birth control there was versus Catholic High School, it was just ‘abstain’.”	

Participants in both countries reported that their abstinence-based education sometimes forced students to take “virginity” pledges and omitted other options to prevent STIs and pregnancy. One CA student shared how her faith-based school's abstinence-only curriculum failed to give her the education and tools needed to choose protective sexual behaviors,

> *“I don't think I've gotten much information about reproductive health…I didn't get any information about STIs…That information I had to look up myself and Google…it doesn't really become an issue until it happens to you or someone you know…It's probably better to know about it beforehand so you can protect yourself and other people.”*

Just as these approaches were perceived as ineffective by participants, abstinence-only and abstinence-based education approaches have continually been proven unsuccessful in preventing sexual engagement and increasing age at first sexual encounter.[235,236] In fact, abstinence-only education has been cited as a violation of adolescent rights to information and care, and a perpetrator of stigma and discrimination that can lead to adolescent isolation, risky behaviors, and gender and sexuality-based violence.[236]

Other sexuality education experiences included unengaged or unqualified teachers who used outdated textbooks or workbooks. Three US participants, all from different states (MD, IL, NY), mentioned that their sexual education was instructed by physical education teachers who assigned and graded workbook content without discussing content with the class. One student described his experience with disengaged physical education teachers using outdated content, expressing that it neglected to equip students with sexuality knowledge,

> *"The gym teachers taught it [sex ed], which went poorly…My instructor's method was to have us read the textbook published in the 80s…he would have us take notes on each section and then give us quizzes…He didn't lecture [or] have discussions; we sat in class silently…not an effective teaching method of anything, none less sex ed."*

Like these students reported, these sexual education approaches are shown ineffective in sexuality education curriculum evaluation literature. Evaluations find programs with unengaged facilitators and classroom environments ineffective due to the lack of teacher knowledge, critical thinking, and retention of learning objectives.[235,237]

Many students lacked perspectives of sex positivity and advocated for normalizing sexual health and behavior within their school-based education. Non-existent, unstructured, or misinformed curriculum as described by participants not only lacked crucial information about students' sexual and reproductive health, but also perpetuated stigma that manifested in participants' peer-to-peer shame. One student explained how her health class reinforced stigma through fear-based lessons on sexuality and drug-use,

> *"There was no talking about birth control, abortion…always very focused on alcohol, drugs, STIs…but not talking about the risk [mitigation]…it just gets a dirty vibe. Then, if you were to get it, you're like, 'whoa…you're disgusting.' There wasn't the right conversations being had."*

Others often reported that STIs were taught as dirty, shameful diseases, and they were therefore perceived by participants as rare. Consequently, even when students were given information about how to prevent STIs, some believed they were low risk for contracting STIs, which negatively impacted their decisions to use protection. One student encompassed how health classes influenced high schoolers' perceptions and conversations about STIs,

> *"…You grow up thinking that [STIs] are dirty and disgusting when really, anybody can get it…You grow up thinking it's hard to get…it was always like, 'Oh hErPeS' (taunting tone). And you think herpes is something – that word has a totally different connotation [than other illnesses]."*

Some referenced classroom incidences that disproportionately shamed female students. A prominent example of stigmatizing education and its lasting negative impact on care-seeking came from one participant's recollection of a classroom skit dialogue,

> *"…you're 16 reading a script…And I looked at the guy to say, 'my vagina smells like fish'…and everyone's giggling. It just becomes a weird, uncomfortable thing…So, it makes you think…seeking that kind of medical care is going to be embarrassing."*

Many students spoke to what they saw as missing components of their high school curriculum. Even those with more engaged courses mentioned a curriculum that did not reach beyond basic descriptions of reproduction and STIs. As one student stated, *"'Condoms are good, sex is bad, don't get gonorrhea.' That's all I learned."* While this participant received education on the topic of condoms, she was not given adequate information on condom-use, nor was she given information on other forms of contraception.

Some remembered teachers stating they were not allowed to discuss certain topics, such as birth control methods and abortion. In fact, one US student proposed that their high school's policy prohibiting family planning topics stemmed from a series of federal and state Comstock laws from the late 1800s until 1971, which outlawed distribution of "obscene" publications, including contraception information.[238] These laws are well-cited in academic literature as a historical influence on current policies, societal perceptions, and access to contraception.[70,238] This student shared,

> *"In every health or sex ed class I've ever had, the teacher was essentially under a gag rule regarding anything birth control, anything abortion related, which I feel must be a Comstock holdover…They told us straight up, 'These are the things that we can't answer questions about.' So, nobody asked because we already knew that they wouldn't answer."*

In addition to the above US student attributing historical legal precedent to current health curriculum, one CA student felt threatened by present-day US family planning policies. She cited the US impact on Canadian politics, and her fear of both countries regressing in reproductive health education and access,

> *"If you hear news headlines from the states, or like, this state has banned abortion…especially since the states and Canada are big influences of each other…That is kind of scary…the [Ontario] premier wanted to [repeal] sex ed…I went out to protest that. Going backwards in reproductive healthcare is a scary thing."*

The quote above refers to Ontario's 2018 repeal of progressive sexuality education curriculum established in 2015, and the resulting political discourse.[239] This curriculum was temporarily substituted by adoptions of previous sexuality education curriculums until new standards were implemented in 2019. However, during this year period, content specific to gender and sexual identities was taught through standards established in 1998.

Students from both countries and various identities reported gender and sexual orientation as critical topics left uncovered in their sexuality education. In addition to the importance of all students to be educated on these topics, a transmasculine student illuminated the personal impact non-inclusive curriculum can have on LGBTQIA+ youth. He reflected on his own experience, saying,

> *"There was definitely the narrative of, 'This is male. Male equals penis and testes. This is female. Female equals ovaries and vagina'…Not seeing people like me represented in any sort of educational material is pretty objectively harmful."*

Students also extended their concept of health literacy to healthcare navigation competence. Some participants discussed ways in which they felt unprepared in navigating knowing how to use the health system, especially as it related to sexual health. When explaining her sexuality education experience, one US student stated,

> *"I don't think that [healthcare navigation] information is given out enough. How I would go about doing that [accessing care]?...it definitely needs to be more incorporated ...Obviously, sex ed would be somewhere that would come into play, right?"*

A CA student also proposed policy standards to include care navigation in curriculum,

> *"There needs to be policies. It would start there...I need to be learning about that stuff way before in order to then go on to my health care provider and be able to have that conversation and figure it out. Give me that information in school."*

All KIs repeated students' concern about the quality of sexuality education. From local settings to the global level, most KIs reported having played a part in initiatives surrounding young people's sexuality education with the intention of giving the knowledge and tools necessary to make informed decisions. KIs shared rationales behind the need for these initiatives, connecting inadequate sexuality education to policies and health outcomes. KI2 demonstrated a need for standardized education to ensure equitable knowledge about sexual and reproductive health, as well as patient rights. Citing inter-provincial/territorial/state control over curriculum, she saw education disparities,

> *"The lack of sex ed in Canada and the fact that there's no...standard across provinces and territories. If we did have sex ed [standards], people would have a much stronger knowledge of sexual health and rights understanding what their bodies are doing, what their needs are, understanding how to access services...their rights as patients..."*

It should be noted that while national sexuality education standards would be ideal to ensure adolescents are receiving comprehensive information, both the US and Canada have experienced community and parental backlash in schools where sexuality education curriculum or related school policies have been changed. In the US, "Don't Say Gay" bills have highlighted a lack of community buy-in to discuss sexuality in schools.[240] In CA, efforts to improve adolescent education pertaining to gender and sexuality was met with protests accusing schools of "indoctrinating" children.[241]

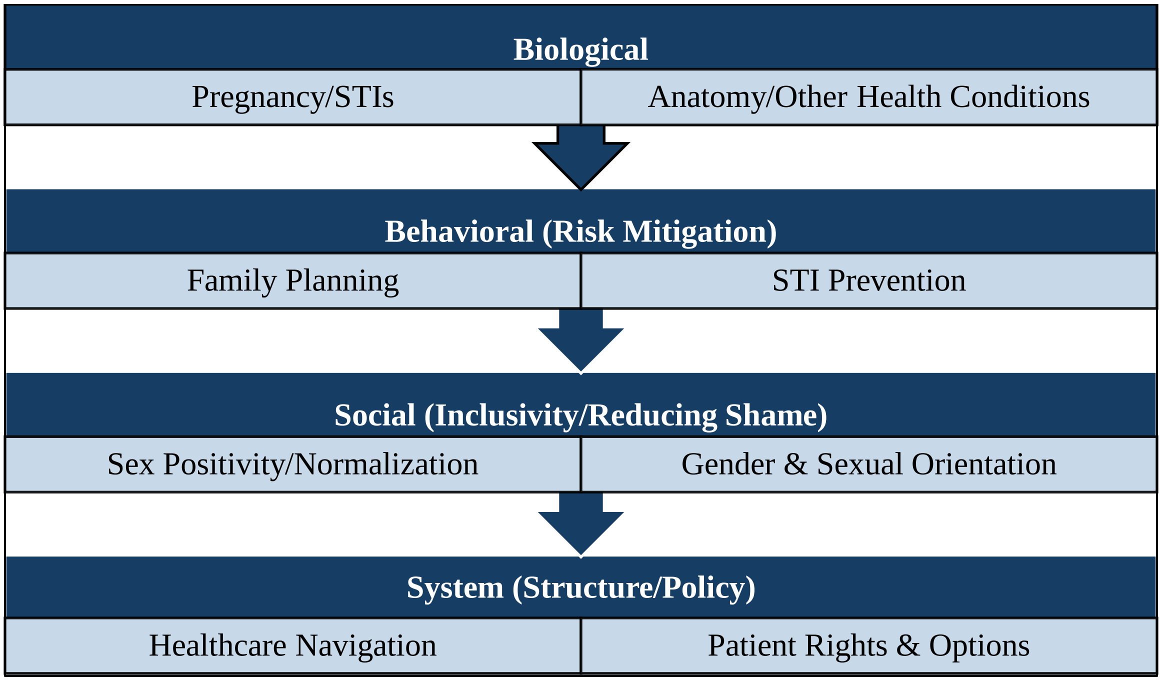
US key informants viewed sexual education as an armor for disinformation, misconceptions, and understanding reproductive health options. Both KI4 and KI5 saw comprehensive sexuality education as an ever-growing curriculum that adapted to new scientific information, health options, and geographic reproductive health policies. For example, KI4 discussed their organization's approach to ensuring young people know their reproductive health options and when or where to access these options,

> *"…Making sure that everybody is equipped to advocate for themselves, right? I mean, that's the spirit of autonomy and self-determination…to be like 'we want you to be fully informed so you could make the best decisions for yourselves and your families'…To really explore all of the options and know there's an abundance of possibilities."*

In addition to sexuality education's continuous policy-based adaptations, KI5 highlighted the need for curriculums to adapt with developing scientific information, including advancements pertaining to gender, sexuality, and medical technology.

Overall, school-based sexuality education needed a holistic, inclusive approach including biological, behavioral, social, and system level components. Figure 10 illustrates summarized topics encouraged by interviewed students and experts to equip young people with adequate tools and knowledge to make decisions, engage in informed behaviors, and access appropriate care. First, students needed a scientific understanding of their reproductive systems including more than pregnancy and STIs. Participants needed to know about other conditions that could impact their reproductive health systems, including signs of abnormalities. For students to make informed choices reducing the likelihood of unintended sexual behavior consequences, sexuality education facilitators needed to communicate the consequences, risks, and prevention of sexual behaviors through a non-stigmatizing, comprehensive harm reduction approach. Students needed curriculum that resonated with their identities and the identities of others, including reaching beyond the heteronormative and cisgendered scope. Further, students needed to know how to access health services for preventive methods and treatments, including their patient pathways, rights, and healthcare coverage.

Figure 10. Levels of Sexuality Education Content



5.1.2 Cultural and Familial Roles in Reproductive Health Navigation

Participants conceptualized coming-of-age stories, comparing their past-selves to present-day university students. Almost all students (n = 21) reported that their family and community values played a long-standing role in reproductive health. Familial reproductive health support ranged from negative or non-existent talk about sexuality to open discussions and active family involvement, impacting students' reproductive health knowledge and healthcare navigation.

Students illuminated how culture and family intertwined with adolescent sexuality education. One student advocated for the education system's role in mitigating negative familial and cultural influence, stating,

> *"Teaching kids…educating them and giving them options outside of what people's religious or social beliefs might be. Giving them the tools and information to be able to take care of themselves if they're too afraid to speak to adults."*

Often, conservative approaches to school sexuality education were enforced by culture and family values stemming from religious beliefs. For example, a participant from an American Mormon community recalled abstinence-based education and a culture that supported abstinence-only information. Prior to university, she had thought tubal ligation was the only contraception option, and she intended to seek the procedure until she discovered that there were multiple other impermanent methods.

Those with particular ethnic upbringings commonly experienced cultural barriers to open sexual and reproductive health dialogs. Participants from Asian and Hispanic cultures frequently discussed ethnicity's role in their hesitation to involve their family in reproductive health conversations. As a Chinese international student in the US stated,

> *"We don't spread information out…They [Chinese culture and family] think it's kind of - Maybe indicates that you are not a good person, not good enough.".*

Other Asian students in Canada echoed the stigma surrounding reproductive health, with one student explaining how unsupportive family impacted her reproductive care approach,

> *"With Asian cultures…you learn on your own…When it comes to reproductive health, it's my responsibility to get whatever I need and leave my parents out of it…"*

Religious and ethnic culture sometimes intersected as factors preventing participants from being comfortable asking questions and disclosing reproductive health behaviors or issues to their family. As one Hispanic American from a Catholic family explained,

> *"I don't really feel comfortable discussing topics like that with my mom…I have to be discreet about what I'm using [for contraception]...I feel like that's largely due to religion because my family is like super Catholic...Kind of religion and culture [impacts reproductive health choices], because my family is super Hispanic."*

Further, this student's experience with religion negatively influenced her ability to have candid reproductive health conversations with her provider. Just as she anticipated her mother would call her a sinner, this student expressed why she was hesitant to seek care,

> *"The doctors…are like old ladies with big crosses. That's what I envision…big eyes checking if you're a sinner or not…"*

As cited in the literature, maternal values influence adolescent contraceptive behaviors.[139,242] Yet, this student's statement exemplifies a specific mechanism in which internalized values continue to influence young adults as they navigate reproductive care.

Some students reported reproductive health barriers stemming from low parental health and healthcare literacy due to parents' lack of reproductive health education, language barriers, or difficulty understanding the health system. Specific to the US health system, one participant shared her immigrant family's struggle to use health insurance, hindering her access to care as a child and limiting experience needed to access care as an adult. She stated,

> *"My parents said I'm not going to use it [California Medicaid insurance] because they were born outside of the US. So, they weren't sure how…it doesn't help when no one really explained it…I just didn't get to do a lot of those things."*

While participants in both countries were proficient in English, they expressed a need for effective language services such as patient-provider translation and multilingual information sources. Current related literature focuses on English-speaking relatives' role in assisting immigrants access care.[243] However, as children of non-English speaking parents, two participants in this study pointed to a generational importance of third-party translation services. That is, providing health services in parents' native language would allow their parents to better navigate reproductive healthcare for their family and teach their children the knowledge and tools needed to transition to autonomous healthcare access.

In contrast to the abovementioned cultural and familial hurdles, others saw their families as a positive source of information and support. Students with supportive families valued sibling and parental advice surrounding menstrual management, contraception methods, and provider recommendations. Parents' education level, medical knowledge, and bodily autonomy beliefs were often mentioned as factors of trustworthiness and support. In fact, one South Asian CA participant exemplified how simply being a certain ethnicity is not always a determinant of reproductive health values. With both parents employed in the medical field, this participant felt comfortable disclosing a STI diagnosis to her mother who then emotionally supported and helped her navigate care. She expressed the positive impact of her mother's support by comparing it to her other South Asian CA friends' experiences who lacked familial support,

> *"…[My mother's] support really helps me get through it [STI diagnosis], whereas I've seen in my friends, they would go to the opposite end. I try to be very [pro]active, they would be totally opposite because they didn't have the support system."*

Two students in each country (n = 4) mentioned their parents' medical occupation as an advantage in accessing quality providers. In the US, a participant's mother used medical professional connections to find appropriate care in a system with limited transgender services,

> *"[I found trans care] mostly through my mom, actually. I started trying to get on testosterone when I was 17. My mom works in the medical field…she eventually found someone who had experience working with trans folks and willing to start care for me."*

Other students conveyed positive familial support as a value of bodily autonomy. For example, one participant described her mother's beliefs as influencing her own reproductive health values and contraception access support,

> *"I've always been a proponent of being able, and so has my mom, to take your own reproductive choice in-hand…[my mom] was actually the one who told me, 'Okay, we're gonna get birth control…'. So, there hasn't really been any outside influence or culture saying, 'No, you can't [use contraception]'. It's always been very positive."*

As a whole, participants illuminated how adolescent structured education, culture, and family play an intertwined role in emerging adults' reproductive health knowledge and behaviors. These findings build upon previous research suggesting that reproductive health knowledge and attitudes learned toward contraception in adolescence can impact reproductive health behavior as adults. For example, one national longitudinal study in the US found that those with accurate reproductive health knowledge were more likely to use effective contraceptive methods in adulthood and suggested that contraception continuance and adherence is negatively influenced when users view contraception as a major undertaking rather than a normal part of a healthy life.[244]

5.2 The Student Transition to Autonomous Patient Roles

Sexual and reproductive health concepts overtly and covertly learned in adolescence persisted throughout students' transition to autonomous patient roles. Navigating care was a relatively new concept for many participants, as these steps were shared and sometimes led by a guardian prior to moving to university. Further, while all had experienced health appointments in their adolescence, some attended their first gynecology health appointment after becoming a university student. Seen separately from general health, students conveyed that seeking care for reproductive reasons added another unfamiliar layer of confidentiality and stigma to healthcare navigation.

Many emphasized the journey of gaining personhood through their experiences in an autonomous environment, which extended to patient self-agency and growth. Students shared cues to when they have sought care in the past, as well as what information and tools they needed to access care. As follows, three primary themes are detailed within this section, including continued parental roles in students' healthcare navigation, university setting's impact on reproductive care access, and students' ultimate drivers to care-seeking.

5.2.1 Continued Parental Roles in Student Healthcare Navigation

Student-parent relationship openness varied from participant to participant, but all had personal boundaries surrounding what sexual and reproductive health information they shared with their parent(s), uncovering three options of parental involvement in reproductive healthcare navigation while at university: no parental involvement, parental involvement with limitations and boundaries, or complete parental involvement in reproductive health choices and clinical care. Below, I discuss students' reasons for choosing parents' degree of reproductive health participation and the reported consequences for each involvement option.

Students who chose not to involve parents in any reproductive care were the same students who reported parents with unfavorable reproductive health values. Participants explained ways the university setting strengthened their ability to maintain reproductive health privacy from their parents. They used services away from home since it alleviated the burden of disclosing sensitive information to their parents, including the reason for seeking care and their whereabouts while attending appointments. Additionally, those who lived away from their parents were able to adhere to care plans without risking unintentional disclosure of their health choices (e.g., contraceptive pill maintenance, pregnancy termination). As one student mentioned,

> *"I started birth control when I started university…through the university system. I don't think I would have gotten it if I was still at home with my family doctor or my parents…"*

Another student echoed how living on-campus supported contraception adherence, noting that privacy concerns when she returned home negatively impacted adherence,

> *"When I go home…I usually forget to take birth control because I'm at home with my family, and I don't wanna pull it out and pop a pill in front of my mom and say that it's because I don't want to get pregnant."*

Other students' preferences for parental involvement in reproductive healthcare depended on the nature of the appointment and sought reproductive care both while at university and at home. These students wanted parental help with healthcare navigation and advice, yet valued boundary setting and privacy for sensitive, more sexual topics. This preference was especially observed from participants with chronic reproductive issues who needed familial support as they struggled with unknown etiologies or lack of solutions. As one student explained,

> *"My mom came with me…she has always been the number one support in my life. So, I think that sense of support really helps me get through it…you seek comfort in family."*

This participant also recalled that her mother initiated a conversation about contraception for pregnancy prevention purposes, but she set a personal boundary of attending the contraception appointment alone. This student felt she would be more comfortable having clinical conversations about sexual behaviors alone with the provider. Moreover, a private appointment gave this student the opportunity to take on the advocacy role her mother usually fills. She stated,

> *“When I go to my family doctor, I normally go with my mom. She's like the biggest advocate in there. But when I go by myself, it's a lot more comfortable”.*

Like this student, others who attributed their self-efficacy to parental influence exhibited confidence to set parental privacy boundaries and independently seek care. One student shared how her familial values and lessons allowed her to seek contraception care alone and informed her parents afterward. She illustrated how their feedback provided positive reinforcement in her beliefs and choices,

> *“[My mom said] ‘I'm glad you took responsibility for this on your own.’…My parents have taught me that I'm in control of my body… it's good to be responsible for yourself.”*

Students chose complete parental involvement when they lacked the resources or self-efficacy to access services by themselves. In fact, only US students reported complete parental involvement, perhaps due to the CA health system’s comparative patient supports as described in Section 4.1. These US students only used reproductive health services at home, which created hurdles to care during academic terms and additional parental roles. For example, two students reported their parents would mail them medications from their home pharmacy (e.g., oral contraception and antibiotics).

Further, some students felt their parents were better equipped to navigate their care, citing parents’ familiarity with insurance coverage as a factor in why they preferred parents to make appointments and manage prescriptions. Though involved parents acted as an informed and experienced health advocate for these students, completing tasks like identifying insurance-covered health providers and services hindered students’ ability to build patient skills and make autonomous health decisions. For example, three US students did not know the name of their health insurance or how to use it without their parents. When I asked one participant how her reproductive care could be improved, she responded,

> *“I don't know. I didn't do it. My mom just [navigates my care]. That's why I can't answer the question, I don't even know what those little steps were.”*

Despite the university setting allowing students to choose the degree of parental reproductive health involvement, some still felt limited access due to concerns at the intersection of financial and confidentiality barriers. For example, students worried about parents finding sensitive reproductive health information through insurance billing statements. In the US, three students discussed apprehensiveness toward asking parents for money to cover copayments. While one student simply felt asking for money made her more of a burden on her parents, the other two participants explained how asking for copayment money could force students to divulge sensitive services to their parents. One student used abortion as an example that would require a student to ask their parents for a large sum,

> *“It makes them [abortions] much less discrete. If you have to pay $500, and you're a broke college student, you have to ask your parents for $500. If that was covered by health insurance, that would be confidential and nobody else would know… [Abortions*

> *are] supposed to be confidential, and they're not really confidential if you have to go around telling everybody why you need $500 for this procedure."*

Though this student assumed that copayment elimination would ensure privacy, another US student pointed toward an additional way health insurance can breach patient confidentiality through billing statements: Billing statements that indicate care details are sent to the address listed on the insurance holder's plan. When this student needed reproductive health services, she grappled with the decision to forego confidentiality or pay out of pocket. After finding no alternative coverage options, she decided to pay out of pocket for both contraception and abortion services with her and her partner's savings.

While only US students mentioned the burden of asking parents to cover copayment costs and confidentiality concerns surrounding billing statements, CA students also incurred pharmacy copayments, and in some cases used their parent's supplemental insurance to cover contraception. KI2 confirmed this student's parents would have received billing statements for her oral contraception, expressing confidentiality concerns about Canadian supplementary insurance billing statements,

> *"On parents' private plans, [parents are] going to know that they're taking birth control... So, that's a really big issue around anonymity. People maybe won't take advantage of that [insurance coverage] because of those issues."*

These findings support another study that determined parenting style may be related to contraception use and reproductive self-efficacy in university students.[245] Further, in addition to two previous articles utilizing a paternalism lens to examine US young adults' similar experiences of parental interaction with existing physical, financial, and confidentiality barriers,[139,151] this study extends findings related to how paternalistic reproductive care access issues are mitigated by the CA health system and the university setting, while others persist. For example, Canada's universal model may mitigate the need for patients' detailed healthcare understanding to access care, and universities in both countries can provide a setting with multiple routes of physical and social healthcare access supports. However, both countries' health systems have an opportunity to make changes to ensure university students have billing statement confidentiality.

5.2.2 University's Social and Structural Impact on Reproductive Care Access

Students' university social and structural environments had a positive influence on accessing reproductive health information and services beyond fostering access without parents. University social initiatives created a semi-structured place to discuss reproductive and sexual health and to give tangible peer resources. Gender-based and health-centered clubs organized events addressing topics such as body image, consent, and safe sexual practices. While one student acknowledged the university's efforts to enhance reproductive health and well-being, she believed more attention should be given to women's initiatives, stating,

> *"There are clubs like Women's Centre, but it's a lesser talked about topic. We have panels and discussions about mental health now, which is really great compared to 2016, but not a lot has been talked about women's health."*

Others discussed student-run initiatives and groups that disseminated educational materials and condoms. One US participant highlighted a peer program that she felt improved accessibility for students residing on-campus,

> *"This is a student program. If you need condoms or whatever else, they just put it in paper bag and deliver it to you for free…things that have been the most helpful to me have not been through the university and not through my actual health insurance; it's been through student organizations. They also have a program right now for sexual wellness…they have peer educators…So, yeah, student orgs are really great on campus."*

A CA student recalled similar sexual and reproductive outreach programs at their university, and expanded on the need to increase students' awareness and participation in these programs,

> *"We have services within universities, but they're somewhat independent and optional…I think having those be marketed – more knowledgeable and aware around campus to educate people, and people don't necessarily know that they have access…"*

Students' approval of and calls to improve social programs and events lends toward a need for safe and empowering university as it relates to gender, sexuality, and reproductive health. While these students generally felt supported at their universities, it should be noted that safety is not always guaranteed and can be strengthened on university campuses. For example, in June 2023, the University of Waterloo experienced a "hate-motivated" triple stabbing targeting a Gender Studies classroom.[246] With some of this study's participants attending this university, it is relevant to the role of this university and other universities in fostering a safe culture. In response to this attack, University of Waterloo implemented a policy to no longer allow public access to course details, intending to protect students and instructors from future acts of violence.[246]

Almost all participants mentioned university peers as a source of reproductive health support. Students built their social networks consisting of diverse backgrounds, identities, and experiences. They discussed how friendships made at university influenced reproductive and sexual health knowledge and decisions. Like many other students, one noted this knowledge sharing as giving her a sense of validation,

> *"They [friends] kind of fill in the details, like their own experiences…So, I think just getting that validation from fellow peers".*

Most participants discussed the ease of having sensitive topic discussions with university friends. Some attributed this to feeling like being a university student gave them an opportunity to grow into their authentic selves. Though students with all gender and sexual identities conveyed the theme of self-exploration, Genderqueer and LGBPQ+ students expressed the critical role new university social networks played in their reproductive and sexual health empowerment. One queer participant explained the liberating feeling of authentically relating to people in a new place without the repercussions they felt in their home community,

> *"It was great to be in a space where I can just be whoever I wanted. 'Cause no one knew me... So, I could just be like, 'Hey, this is me.' And everyone's like, 'Alright, cool. That's you'…Then going back home you're [thinking], 'This is who you were. This* is not where *you are now. I just grew up…you just grew to be a different person.' And [in my home community] there's so much questions, but…you move somewhere new and you're like, 'Okay, my name is [preferred name].' No questions."*

Beyond acceptance and community, a transmasculine participant affirmed authentic university relationships had a significant impact on self-understanding and options to support his identity,

> *"Most of the knowledge that I had before starting testosterone was stuff that I had from people in my peer group…Since starting at a university and being in a place that has a structured community…a pretty accessible and pretty big LGBT community, that's been really helpful for me in knowledge acquisition and dispersal."*

Informal knowledge-sharing helped participants build reproductive health literacy and patient efficacy skills leading to tangible impacts on accessing reproductive health options and services. For example, one student described the positive influence university friends had on managing her menstrual cycle and different sanitary product options. Further, one US student who did not use the health system as a minor learned how to navigate care from university friends,

> *"You meet a lot of new people who are willing to help you navigate a new system. And I expressed to my roommate…, 'Hey, I have no idea how to use this [health insurance].' And they're like, 'Here, let me help you read through the policies; we'll navigate together.'…it helped to have a new community…to be able to access all these things."*

The students created and maintained reproductive health values within their social network that upheld their accountability in seeking reproductive care. Participants often cited their own reproductive health values using collective language and sharing friends' stories throughout their interviews. For example, one student frequently referred to her friends, exemplifying friendship's integral part in her life decisions, and especially reproductive care seeking,

> *"I was talking about [contraception] with friends and asking their experiences 'cause that dictated what I was going to do…they were talking about getting it, I was like 'oh I should probably do that too'...piggybacked my friends 'cause I had no idea where to go."*

Many students shared how they influenced their friends' reproductive care-seeking behaviors and accessed care for reproductive health solutions based on peer advice. For example, one student explained the candidness of reproductive health conversations with peers compared to her family, and the impact friends had on her contraception method choice,

> *"Friend groups play a big role because I don't really talk to my family about my sexuality or reproductive health…my decision to get an IUD was based off of my friends. [They] had them and said, 'Oh, so great, never have a period! Like, don't even think about it'."*

Participants' value of peer advice and peer influence on reproductive health behaviors aligns with general knowledge surrounding the co-construction of social norms and previous literature, especially related to contraception uptake and method choice.[247–250]

Though less common than peer reproductive health conversations, some participants reported going to appointments with their friends for emotional support. One student showed pride in her role attending health appointments with friends, stating,

> *"I like to accompany my friends to walk-in clinics…They seem more stressed because of the circumstance, obviously. I'm like, 'OK, let's go. It will be fine'…But I'm always a big pusher of going for health care. So, yeah, it's just kind of what I do."*

Another student illustrated that supporting friends in accessing services can also influence their own reproductive care use. She decided to get STI testing with a group of friends to support one friend who was concerned about having an infection. This participant shared,

> *"Was I concerned with getting an STD? No, but my one friend was so we went with her as like a little 'get-a-test-done'."*

Beyond university setting's ability to foster social influence on reproductive health, students referenced the university's built environment as providing opportunities to access structured reproductive health services. Students valued on-campus health services and used university clinics for reproductive care throughout academic terms. Many students highlighted inconsistent and busy schedules with alternating class schedules, part-time jobs, and other obligations and requiring them to have flexible, nearby options for care. The built environment allowed geographic access to confidential care flexible to student schedules. Thus, on-campus reproductive health services were preferred and more accessible compared to off-campus providers. As one student said,

> *"[University clinic appointments are] relatively easy to access...I think it's easy for university students on campus to get reproductive health appointments if you need them."*

In addition to student clinics, some mentioned the ease of picking up medications like oral contraception at their on-campus pharmacy. For example, one student reflected on their campus pharmacy's positive impact on birth control uptake and continuation,

> *"Accessibility is super important for me and for I feel like most university students. If we have to go out of our way or…bus 20 minutes to a pharmacy to get birth control, we're less likely to do it than if it was on campus. So, the physical environment is important…I think those are the factors that…have influenced the route I took to get my birth control."*

On-campus health services provided a unique opportunity for those who never accessed reproductive health services prior to university. In fact, five students reported that their university clinic was the only place they had ever sought reproductive care (CA: n = 3, US = 2). Students valued the navigation support that on-campus services provided. One international US student had only ever used her university's health clinic because she was unaware of her options or how to use her insurance outside of the university setting. She noted that on-campus services were all covered by her university-based health insurance. Similarly, KI1 shed light on how providing reproductive health services on-campus can protect students from seeking care from medical organizations that do not offer comprehensive reproductive health services. Referencing Canadian universities' high rate of international students, KI1 stressed students' potential vulnerability in becoming victim to ill-intentioned health organizations,

> *"Canadian universities attract many foreign students...and that automatically makes them more vulnerable…more difficult to find services or know where to go, questions to ask, and more easily deceived by the bodies like [anti-abortion] pregnancy centers…a lot of times, students have to go off campus…The pregnancy centers set up around nearby campuses. So, it makes it a lot easier for students to fall into that trap of going there… making it harder for students in general, but in particular, students of different countries and marginalized populations."*

5.2.3 Personal Identification of Reproductive Needs and Healthcare Access

The last theme encompassed ways students identified factors influencing personal decisions to seek reproductive care. Reproductive health appointment frequency varied between participants based on their reproductive needs. Those that experienced chronic issues sought reproductive care more often, sometimes from a younger age. Patients with chronic or complex needs had more biological and overlapping cues to seeking reproductive care, while others were cued only by preventive measures (e.g., family planning, reproductive screenings). As follows, students' current personal decisions to seek care depended on previous patient experience, health priorities and perceived urgency, and reproductive stigma.

Participants' previous reproductive care experiences impacted decisions to seek subsequent preventive gynecology services. Students who had positive clinical experiences found it easier to seek care as they became more comfortable in the patient role. As one participant described, her positive provider interactions empowered reproductive health autonomy,

> *"It's made me more confident in having knowledge about my health…made it seem easier to learn about things, interact with them…it's allowed me to be able to kind of take my own health and medicine into my hands because I want to."*

Others stated that negative clinical interactions hindered their willingness to seek timely care, negatively impacted their feelings about subsequent appointments, or made them more trusting of other reproductive health information sources such as internet queries or friends. One participant reported all three of these negative clinical interaction impacts, and elaborated on her clinical experiences afterward,

> *"I like going [to my new doctor]. But I have this triggering thing; every time I'm on a doctor's bed, I get a little teary eyed because my [previous] doctor never listened to me."*

Despite prior clinical interaction quality, both positive and negative experiences allowed students to practice being a patient and anticipate future appointment processes. Familiarity helped build health knowledge, improving students' clinical communication and comfort discussing sexual and reproductive health. One participant reflected on her growth from her first reproductive health appointment,

> *"I don't know why I was so worried about it…I was just putting too much pressure on myself to be the perfect patient…So, I guess it's like me adapting to that scenario."*

Students' self-reported health priorities and perceived urgency drove their decisions to access reproductive care. Those that frequently used preventive services portrayed pride in their reproductive health values, making statements like, *"I've always been a proponent of being able [to] take your own reproductive choices in hand,"* or *"I am a big advocate for taking care of your reproductive health."* In contrast, those that did not use preventive reproductive care attended their first reproductive health appointment later in life or had missed annual exams. Some expressed shame in what they felt was insufficient reproductive care appointments. For example, a student who had only attended one reproductive appointment shared,

> *"I was probably 19 by the time I even went [to seek reproductive care]. So, then I already feel uncomfortable going because I know they're probably looking at me like 'you should have already been here'…then, I finally did because I wanted to get on birth control… I've literally gone once; this sounds so bad."*

Participants felt urgency to seek care based on family history, sexual behaviors, or physically presenting symptoms. Some recognized reproductive concerns based on immediate family members' gynecology history. For example, one student experienced acute abdominal pain and immediately sought care due to her family's reproductive history,

> *"I was nervous because polycystic ovary syndrome and ovarian tumors run in my family…It made me like, 'Okay, I need to look into this now', because when my mom was my age, she got cysts frozen off her ovaries. I was nervous that could be what was going on with me, so I wanted to figure out what was going on..."*

Sexual behaviors such as not using contraception, condom failure, engaging with a new or multiple partners, or inconsistent birth control pill use signaled students to seek contraception, STI testing, and sometimes emergency contraception. One student discussed the monthly stress she felt waiting to menstruate after unprotected penile-vaginal sexual interactions. Though she was using oral contraception, she reported inconsistent use and was concerned with user-error failure. This student explained her anxiety as building up over time, driving her to prioritize seeking care for contraception services. She explained the mental relief she felt after getting an IUD and being more confident she would not have an unintended pregnancy,

> *"Having that freedom to know that I didn't have to worry about it anymore. It had that stress off your shoulder. You don't think about how that impacts your overall health. I felt much better not having to worry about it…every month."*

Another student sought reproductive care for the first time after experiencing increasingly worsened STI symptoms. After their initial appointment and diagnosis, they continued to seek routine reproductive services and improved their health behaviors. While they regretted not practicing safer sex and seeking reproductive care earlier, they attributed their diagnosis and care seeking to their now improved lifestyle:

> *"I only started going after my incident with the STI, so I kind of never reached out to reproductive health until after that… It's like when you notice the symptoms, then you have to make the appointments, and it's scary… I've changed a lot since I got my diagnosis a few years ago. I've been on the ball with being physically active and keeping my immune system good because I don't want it to happen again."*

Other participants often delayed seeking care for health issues while conditions progressed and became more painful. Participants reported prioritizing care for visible health issues, expressing visible conditions were more likely to be believed, diagnosed, and effectively treated. One student used a tangible health issue comparison to explain,

> *"Injuries are pretty easy to address and easy to access care for because it's very present. If you have a broken arm, you can see that your arm is broken. If you have period cramps that are so bad you can't walk, no one can see that. So, there's a disparity in accessing care based on what other people can see."*

In addition to participants commonly reporting this phenomenon with menstrual irregularities, one participant extended her tendency to delay reproductive care to other invisible health issues she experienced,

> *"It depends on how debilitating the symptoms are…I've got to the point where I was in an ambulance having to be carried out because I had just let it go on for so long and didn't want to go."*

Like those quoted above, several students compared seeking reproductive healthcare to seeking other health services. Reproductive health urgency competed with and was seen as separate from students' other health priorities. In fact, the separate, secretive, and often invisible nature of reproductive health added a complicated layer of students triaging between life priorities, general health concerns, and reproductive needs. Among the few participants citing student schedules and workload as a barrier to care, one encapsulated her decision-making process behind care-seeking,

> *"Having such a heavy workload definitely doesn't encourage students to, you know, allocate the time to check up on their health, especially reproductive health, because I feel like sometimes people think that, 'oh, I'm sick, I have flu, this requires immediate action'. But when it comes to reproductive health…I've been pushing it off because I'm*

> *just like 'Irregular period. Yeah, whatever. That's great. I don't get my period every month.'...Just like being in school and knowing how busy I am has been one of the reasons why I have been pushing the appointments back."*

Though many participants prioritized general health issues over reproductive concerns, one student had a unique outlook on how the secrecy of reproductive health forced them to take personal responsibility for prioritizing reproductive healthcare seeking over other health issues,

> *"I've got to make it a priority…just because it's on me to do it. I feel more pressure to do it, and I can't be like, 'oh, my thing hurts, so, I don't know what to do about it.' Obviously, we can ask advice for like your knee or other pains, but usually when it comes to stuff about reproductive health, I feel like I have to do it myself. So, I do prioritize it over other health conditions."*

Similar to this student's perceived forced self-efficacy, a preventive reproductive health mindset seemed to counteract stigma and allow a more positive outlook on seeking gynecology services. However, stigma itself generally negatively influenced students' reproductive health knowledge, self-efficacy, and care-seeking behaviors. Sexual and reproductive stigma exacerbated students' general tendency to delay care. Students felt it was more difficult to seek reproductive care due to societal secrecy surrounding sex and sexual organs. Despite confidentiality within the clinical setting, stigma and privacy concerns were a hurdle to making and attending reproductive health appointments. Students sometimes felt that their social environment obliged them to report their whereabouts. Compared to other health appointments, some students were nervous giving a reason for their absence from events (e.g., school, work, social) when attending a gynecology appointment. When asked to describe the process of making and attending a reproductive health appointment, one participant shared,

> *"That is usually very secretive. Like, you don't tell everyone. You're not going to be like, 'I'm going to go [to the doctor] for this problem' I think making [reproductive health] appointments and actually getting there is more – It's not like a normal appointment. You kind of hold it in I guess, especially being of a different culture."*

In addition to this participant feeling like they had to keep reproductive health appointments a secret, their above phrase "being of a different culture" centered whiteness/westernized culture as the norm, alluding to their experience of internalized cultural stigma and othering of non-white/westernized ethnicities and cultures.

One student discussed the stigmatizing difference between disclosing to others the reason of a reproductive health appointment compared to other health appointments, such as general health checkups and eye appointments. Due to societal reproductive health stigma, she felt uncomfortable telling others about attending reproductive appointments. She advocated for reproductive health to be normalized just as seeking care for other reasons,

> *"A reproductive appointment should be treated the same as an optometry appointment or an ear appointment. I feel like they should all be treated the same…that's just another thing that makes me healthy. But everybody else would be like, 'Why'd you go to the*

> *reproductive clinic?' I was like, 'Well, because I wanted to get checked up.' It's treated differently than every other exam."*

Summary: Students' Personal Cues to Accessing Gynecology Care

In sum, individual factors interacted to influence students' ultimate decisions and behaviors surrounding reproductive health care. Care-seeking required cues stemming from participants' life experience and social networks over time, spanning their adolescent development to their current emerging adulthood environment.

Culture, beliefs, and health knowledge learned in adolescence cued participants' underlying reproductive health perceptions and care-seeking efficacy. These findings support a need for evidence-based, comprehensive sexuality education curriculum strengthening non-stigmatizing content on family planning, STIs, and LGBTQIA+ health. Further, students identified a critical need for integrating applied healthcare utilization content with sexuality education. Participants' experiences with unsupportive families often stemmed from lack of reproductive health or healthcare knowledge, exhibited by stigma and parents' own difficulty navigating care. This indicates that identifying how to appropriately involve parents in students' adolescent curriculum could foster more supportive relationships by improving parental opinions, knowledge, and approaches to reproductive health conversations. Moreover, students illuminated that improving family support and boundaries during adolescence better prepared students for the transition to autonomous patient roles at university.

The university setting can sustain and improve reproductive healthcare access through social programs and informal knowledge sharing, as well as on-campus healthcare facilities providing proximate, confidential care and pharmacy services. Students advocated for an increase in the availability, visibility, and frequency of reproductive health-oriented programs and services on-campus.

Altogether, students illuminated how early proactive reproductive health knowledge and continuous reproductive health supports from social and built environments can improve personal reproductive care access by giving students the tools to identify when and how to seek care and prepare for the patient role in effective clinical interactions.

Chapter 6
Students' Person-Centered Care Needs

Chapter six delves into aim two of this thesis, revealing clinical nuances that affected university students' ability to participate in person-centered gynecology services in CA and the US. Here, I discuss survey and interview findings of participants' clinical care experiences, giving insight on participants' gynecology appointments from a person-centered lens.

In Section 6.1, I focus on interview and survey reports to illustrate students' experiences of clinical services and patient-provider communication. Further, I connect their experiences to clinical standards and best practices. Section 6.2 explores ways students felt the clinical environment and provider protocols influenced care quality. First, I discuss how students perceived their clinical environment and provider type influenced belongingness and trust. Then, I share students' insights on how clinical approaches affect patient engagement and confidentiality outside of the clinical setting.

Overall, this chapter shares variation between current reproductive care standards, participants' clinical experiences, and participants' perceptions and values of what person-centered care means to them. In lay terms, chapter six presents what is currently recommended to happen during clinical encounters, what actually happens, and what university students expressed wanting to happen.

6.1 Students' Clinical Experiences: Providers' Role in Meeting Person-Centered Care Needs

Together, survey and interview data constructed which clinical services participants were offered and how they felt about care delivery. I first summarize survey data describing the number of students who experienced clinical screening questions, shared decision-making components, and standard clinical services. I then further contextualize survey findings with interview data to show student experiences and perceptions about the providers' role in establishing patient familiarity and ensuring informed care necessary for person-centered care.

6.1.1 Survey Data Summary: Students' Reports of Standard Screening Questions, Shared Decision-Making, and Clinical Services

On average, the students reported that their provider asked 7.1 out of the survey's eleven ACOG screening questions, with no total mean difference between CA and US students. Ten US students were asked about their HPV vaccination status compared to only six students in Canada (Table 8). HPV vaccination may be assumed for CA participants, as all provinces and territories established school-based HPV vaccination programs prior to and during the years (est. 2007-2010) participants would have been in the included grades (grades 4-8).[251]

Table 8. Counts (n) and proportions (%) of participants who recalled provider asking ACOG's recommended age-based screening questions

Wellness Exam Question	**Total (n=22)**	**CA (n=11)**	**US (n=11)**
Provider asked patient about…	n (%)	n (%)	n (%)
Date of last menstrual cycle	22 (100)	11 (100)	11 (100)
Mental health	9 (40.9)	4 (36.4)	5 (45.5)
***Unsure**	*1 (4.5)*	--	*1 (9.1)*
Medications	20 (90.9)	10 (90.9)	10 (90.9)
***Unsure**	*2 (9.1)*	*1 (9.1)*	*1 (9.1)*
Tobacco/alcohol/drug use	18 (81.8)	9 (81.8)	9 (81.8)
Abuse	2 (9.1)	1 (9.1)	1 (9.1)
***Unsure**	*3 (13.6)*	--	*3 (27.3)*
HPV vaccination	16 (72.7)	6 (54.5)	10 (90.9)
***Unsure**	*1 (4.5)*	--	*1 (9.1)*
Sexually active	22 (100)	11 (100)	11 (100)
Vaginal/anal/oral Sex	5 (22.7)	4 (36.4)	1 (9.1)
***Unsure**	*2 (9.1)*	--	*2 (18.2)*
Sexual orientation	8 (36.4)	4 (36.4)	4 (36.4)
***Unsure**	*1 (4.5)*	*1 (9.1)*	--
Number of partners	16 (72.7)	9 (81.8)	7 (63.7)
***Unsure**	*1 (4.5)*	--	*1 (9.1)*
Birth control use	19 (86.4)	10 (90.9)	9 (81.8)

Students focused on the provider's role in determining the quality of services and how that influenced informed SDM. Survey responses showed most students felt their provider encouraged decision-making (72.7%), respected their choices (81.8%), listened to their concerns (63.7%), and answered their questions (86.4%) (Table 9). However, students took time to audibly deliberate and carefully choose between yes, somewhat, and no response options. Especially when answering “listened to concerns”, students struggled with their perception, resulting in six participants responding “somewhat”. This indicated the survey’s inability to capture nuanced experiences of these SDM components.

Table 9. Counts (n) and proportions (%) of participants who felt their provider facilitated shared decision-making components

SDM Component	**Total (n=22)**	**CA (n=11)**	**US (n=11)**
Student felt provider…	n (%)	n (%)	n (%)
Encouraged decision making	16 (72.7)	9 (81.8)	7 (63.7)
***Somewhat**	*3 (13.6)*	--	*3 (27.3)*
Respected patient choices	18 (81.8)	10 (90.9)	8 (72.7)
***Somewhat**	*2 (9.1)*	--	*2 (18.2)*
Listened to concerns	14 (63.7)	9 (81.8)	5 (45.5)
***Somewhat**	*6 (27.3)*	*1 (9.1)*	*5 (45.5)*
Answered questions	19 (86.4)	9 (81.8)	10 (90.9)
***Somewhat**	*1 (4.5)*	--	*1 (9.1)*

As shown in Section 5.2, students needed cues to seek reproductive care, which resulted in making appointments for specific preventive services (e.g., STI testing) or to address reproductive issues (e.g., pelvic pain). Therefore, many students did not report seeking care through a comprehensive routine prevention appointment, which was supported by survey responses showing overall low prevalence of being offered ACOG’s 2013 “well-woman” recommended services (Tables 10 – 11). In fact, no student reported that they had been offered all seven exams and tests included in the survey. Further, on average, US students reported being offered more services than CA students (US: $\bar{x} = 3.64$, CA: $\bar{x} = 2.91$). Since “well-woman” visits intend to maintain wellbeing through comprehensive education, screenings, exams, and testing,[252] this study indicates that students who seek reproductive care for a single reproductive service may miss preventive care components that promote holistic reproductive wellness. However, we cannot determine providers’ medical assessments that may have led decisions to ask certain screening questions or offer each service.

According to survey responses, half or less than half of students recalled an abdomen, pelvic, thyroid, and breast exam (Table 10). The prevalence of abdomen and pelvic exams were similar between CA and US students. However, US students more commonly reported thyroid exams, and compared to four US students, no CA students reported ever having a breast exam.

Table 10. Counts (n) and proportions (%) of participants who reported being offered ACOG's recommended age-based wellness exams

Clinical Exam	**Total (n=22)**	**CA (n=11)**	**US (n=11)**
Provider offered…	n (%)	n (%)	n (%)
Thyroid exam	6 (27.3)	1 (9.1)	5 (45.5)
***Unsure**	*1 (4.5)*	*1 (9.1)*	--
Breast exam	4 (18.2)	0 (0)	4 (36.4)
Abdomen exam	11 (50)	6 (54.5)	5 (45.5)
***Unsure**	*2 (9.1)*	*1 (9.1)*	*1 (9.1)*
Pelvic exam	11 (50)	6 (54.5)	5 (45.5)
***Unsure**	*4 (18.2)*	*1 (9.1)*	*3 (27.3)*

During interviews, no students explicitly reported their perceived necessity of these exams. In fact, when answering survey questions about exams, some students verbally expressed being uninformed and unengaged in exams that their provider was performing. I explained to them what specific exams may include to contextualize their experience. For example, some participants did not know what a thyroid exam was but understood once I described this service as a neck exam. As one student stated, *"Oh, I always wondered what that was for…"*. Therefore, perhaps students' indifference toward these exams was due to lacking the information necessary to self-evaluate their perceived value of these exams, exhibiting a need for better exam engagement to identify the reason for each exam.

Since students often mentioned that their perceptions surrounding STI risk influenced them to seek care for testing (Section 5.2.3), participants were more familiar with testing services. In fact, students' testing familiarity and values aligned with survey responses, with most reporting they have been offered bacterial STI (n = 15) and HPV testing (n = 16) (Table 11). Despite valuing STI services, survey responses revealed that HIV tests were only offered to nine students. Interviews further indicated lack of routine HIV tests, with only a few participants mentioning having bloodwork for STI testing, the current gold-standard and most common method of HIV testing.[253,254]

Table 11. Counts (n) and proportions (%) of participants who reported being offered ACOG's recommended age-based wellness tests

Clinical Test	Total (n=22)	CA (n=11)	US (n=11)
Provider Offered…	n (%)	n (%)	n (%)
HPV Test/Pap Smear	16 (72.7)	7 (63.7)	9 (81.8)
***Unsure**	*1 (4.5)*	*1 (9.1)*	--
Bacterial STI Test	15 (68.2)	7 (63.7)	9 (81.8)
***Unsure**	*1 (4.5)*	--	*1 (9.1)*
HIV Test	9 (40.9)	5 (45.5)	4 (36.4)
***Unsure**	*1 (4.5)*	*1 (9.1)*	--

As follows, interviews shed light on the context of clinical experiences, including how screening questions, SDM approaches, and clinical services can strengthen provider alignment with GYN practice standards and person-centered care concepts. Below, I discuss students experiences and expectations of providers' communication and care delivery roles.

6.1.2 Student-Provider Familiarity's Influence on Trust, Knowledge Translation, and Health Solutions

Students' experiences of standard screening questions (Table 7) and SDM (Table 9). overlapped with qualitative findings surrounding providers' role in fostering person-centered care. Students discussed both negative and positive clinical communication experiences, identifying the need for providers to know their biopsychosocial characteristics prior to approaching clinical counseling and treatment. Below, I provide qualitative insight on how students felt providers' approach to asking standard screening questions contributed to student familiarity, the providers' leadership role in establishing student-provider familiarity, and how this familiarity positively influenced care.

Providers who worked toward building relationships with students made students feel that providers were invested in improving their wellbeing. As one student mentioned,

> *"There is a little bit of lead up conversation like, 'hey, how's it going? How's your day?'…setting up the basis for like, 'This is who I am. This is why I'm here to help you. I'm interested in hearing about what's going on with you'…as opposed to just like 'You're here, let's get your appointment over with'."*

Establishing familiarity with students contributed to participant comfort and trust in their provider. Further, students showed how providers' knowledge about their values and biopsychosocial history improved care experiences. For example, one student recalled how her provider's intentional approach to know her as a person helped to identify the difference between hormonal and non-hormonal health concerns,

> *"Before doing anything medical, she had me sit down in her office with her to talk like normal…She was just like, 'I just want to know you as a person before we get into this', which was cool…It was nice that she wanted to get to know me…so we could establish what was hormonal and what wasn't…That was the best office I've ever been to."*

Students felt it was important for their providers to ask about their identities (e.g., gender, sexuality, race, ethnicity) to create a sense of safety and inform subsequent clinical communication and care. Even those with more privileged identities mentioned being more comfortable with their provider if they asked how they identify. One participant described the importance of providers' verbiage to avoid making patients feel judged,

> *"It makes me more comfortable with a doctor [who] doesn't assume things…So, instead of being like, 'oh, do you have a boyfriend?' or something like that. Then, it's less like they might be judging me."*

Other students exemplified how providers' failure to capture their identities caused discomfort. For example, one Hispanic student saw her provider misdocument her as non-Hispanic and decided not to correct them, despite feeling annoyed and confused why the provider would make assumptions about her ethnicity. Similarly, survey responses showed most providers did not consider students' sexual orientation, with a minority of students recalling that their provider asked about their sexuality (n = 8) and what kind of sexual interactions they partake in (vaginal, anal, oral) (n = 5) (Table 8).

Similarly, students' survey and interview reports exemplified a need for providers to know about their medical history and needs. Alarmingly, few participants remembered their provider asking about their mental health (n = 9) and if they are experiencing abuse (n = 2) (Table 8). With participants' frequent reference to the relationship between mental and reproductive wellbeing, not asking these questions limited providers' ability to address patients' needs (See Section 3.2.2). Indeed, participant verbal reactions to these survey questions suggested that these students did not know that reproductive health providers are recommended to screen for mental health and abuse. Yet, as one student said, *"It seems like a no-brainer"*.

In addition to knowing student histories, participants needed providers to further integrate their holistic patient knowledge to improve person-centered care. Students demonstrated that even when they disclosed their identities and medical histories, providers sometimes failed to integrate this information with subsequent communication approaches. For example, some students illustrated how standard screening questions may not be appropriate for all patients. Specifically, while all 22 participants recalled their provider asking for the date of their last menstrual cycle (Table 8), those on progesterone-only contraception or testosterone therapy did not menstruate and challenged the relevance of their last menstruation date. A transmasculine participant shared how this question felt insensitive, serving as a reminder that gynecology care standards exclude transgender people,

> *"The nurse always asks when my last period was. It's like, well I have no idea…And they're never happy with that response, oddly enough. Things like that, where it's sort of a microaggression…"*

Relatedly, one genderqueer student described their clinic's failure to adequately review and refer to the pronouns and name they self-identified on their intake form. They stated,

> *"…From the waiting room, they call my legal name, which I'm not comfortable with…they still don't use my pronouns in the examination room…I'm asking for basic respect, and I'm not getting it."*

Beyond communication appropriateness, one student explained their provider's failure to integrate their medical history into proactive care. After being diagnosed with HPV, this student regretted her initial vaccination refusal, stating, *"If I could go back in time, I'd [say], 'let's get that vaccine'…That's a regret".* Yet, no providers offered this student an HPV vaccination after her diagnosis, and therefore she did not think she was eligible for the vaccination to prevent other HPV types. In fact, the HPV vaccination can prevent those with HPV from contracting other high-risk HPV, and it may reduce some reoccurring HPV-related health effects.[255] This shows the importance of provider vigilance as patients look to providers to identify care needs, provide options, and educate patients on health benefits.

Students also showed how student-provider familiarity could improve clinical knowledge translation and understanding. For example, one participant recognized that a white provider's inattention to her racial and ethnic background contributed to communication barriers,

> *"She has a different racial ethnicity than I do, so that can sometimes clash with her understanding…She understands general health care, but she doesn't understand that I don't understand all the terms…It's like, 'I didn't grow up in the same area as you did'."*

Students felt it was the provider's responsibility to appropriately translate knowledge about reproductive health and healthcare resources. Even those who reported asking providers for clarification demonstrated the courage it took to do so. For example, one student recalled having to initiate a conversation about pain management alternatives after taking ibuprofen daily for a prolonged period. They explained their expected role as a patient, stating,

> *"I had to advocate for myself. I feel like that's not my role. I'm the one going through something. I shouldn't have to, like, burden myself."*

Other students were generally anxious to please their provider, with some explaining that they lacked the ability to advocate for their reproductive needs and struggled to admit to their providers that they did not understand information. In fact, three students reported worrying that their provider would question their intelligence or discount their health needs if they failed to communicate their concerns or needed further explanation. As one mentioned,

> *"I don't really know too much about reproductive health…I was trying to come up with questions in my mind. I was thinking, 'oh I need to make sure it's not a dumb question.'… I don't want to portray myself as someone who doesn't know about their own health."*

Similarly, students reported that they sometimes did not understand their provider's questions. For example, despite all participants being asked if they were sexually active (Table 8), some were unsure how to define the term "sexually active" and struggled to answer this question. Students' interpretations of "sexually active" ranged from penetrative intercourse to any act that risks STI transmission, and from ever having sexual interactions to sexual interactions since their last reproductive health screening. As one participant explained,

> *"I know kissing can transmit STIs, but it's not really something that I feel like a doctor would ask. 'Have you ever kissed someone?' It's kind of weird."*

Some students felt that providers' tone and verbiage when asking about sexual behaviors could reinforce or mitigate sexual stigma. For example, one participant shared how their provider asked about sexual activity to reduce stigma and better address the question's intention,

> *"[My provider] asked, 'How many times have you had unprotected sex?' And she would start from zero, one, two, three…she would go up so it's not like she's making assumptions. She's really capturing all types of different scenarios."*

Participants gave insight on power dynamics that influenced their clinical experiences. One student showed how power dynamics could contribute to the need for providers to lead reproductive health conversations. Using the term "white coat syndrome", she described worries leading up to her appointment that hindered her ability to communicate effectively. This student reported that her provider's supportive communication made her feel more comfortable and lessened the pressure to perform,

> *"I was just putting too much pressure on myself to be the perfect patient…things get lost and jumbled up…it's generally a lot more worry leading up to it than what it was worth."*

Exemplifying how providers can mitigate power dynamics, another student shared how their provider prompted them to self-advocate, letting them know they are in control of their health choices and care,

> *"[My provider said] 'One way we can do it is by…that's an option you can think about.' Her language and the way she phrases things…It's like the decision is back to me."*

Outside of the clinical setting, one participant from an immigrant community explained how patient-provider relationships extended beyond clinical interactions. Having a provider who participated in and was visible throughout the community built trust for her and other community members. She stated,

> *"We all respect this one clinic, and we all go there…Just, how they treat us since a lot of us are Brown folks who are low income…if we see them in the community, we see that*

> *they're actually showing up. They're not someone coming…into our community and then leaving. They're…embedded…We see them at church…at the grocery store."*

This student's reason for trusting her provider aligns with community health promotion approaches that seek immersive relationships between organizations and individuals to better identify and address community needs (e.g., social capital theory).[256] Especially when providing services to marginalized or at-risk communities, this student showed how clinical providers' community integration can build reciprocal familiarity and maintain individual patient trust. In fact, this student's appreciation for providers' community involvement aligns with KI5's community advocacy efforts discussed in Section 4.3.2 and illustrated by Figure 8 as it relates to abortion access.

In sum, for students to engage in positive, effective communication, providers needed to, in the words of one participant, *"make it personal because it is personal."*. "Making it personal" included providers' transparency about their own values and lives, and a commitment to knowing the whole person both inside and outside of the clinical setting. Altogether, students highlighted providers' potential to strengthen and bridge the gap between community health promotion and clinical care by building familiarity with individual patients and their surrounding environment, positively influencing trust, knowledge translation, and health solutions.

6.1.3 Informed Reproductive Care: Educating and Validating Student Concerns

Students reported negative experiences with provider practices that misaligned with GYN practice standards and informed care. Many often felt their providers did not give adequate information necessary to understand their conditions or make informed decisions about reproductive health options. In fact, some providers directed students to find information on the internet rather than educating students during appointments (e.g., contraception, PCOS). One Hispanic US participant encapsulated these mechanisms of uninformed care, describing a contraception counseling experience where her provider constrained method choice, failed to give adequate information about other contraception options, and provided misleading information about the prescribed method,

> *"The pill was not my suggestion; it was my doctor's. She was like, 'This is the cheapest, the fastest…Everybody like you is on the pill…You get this brand with this label and you can search it up on your own time.'…I feel like she meant…demographics, or people that look like me...that's kind of the opposite of what I expected, and when I surveyed [my peers], nobody took the pill…I feel like that was so wrong…I trusted her."*

While it is unclear exactly what the abovementioned provider meant by describing oral contraception as the "cheapest, fastest" method, this student was protected by law requiring her health insurance to cover 100% of any contraception method. Further, oral contraception is not the fastest method to prevent pregnancy, taking up to seven days to become effective compared to the copper IUD which is immediately effective after insertion.[257] As this Hispanic student suspected the provider's statement was demographically charged, she explained that Hispanic culture influenced her need for a more discrete, low maintenance method. This student's qualitative account may provide insight on US national data showing that, in fact, only 7.9% of Hispanic contraception users used oral contraception compared to 17.8% of their non-Hispanic white counterparts.[258]

Another student experienced provider discrimination and misinformation, feeling "fat-shamed" when her provider told her she was not eligible for an IUD due to her weight, despite her not seeking the IUD method. This student said,

> *"She [the provider] was just like, 'Okay, you're overweight. You're not getting the IUD'…I went in knowing I was going to take the [contraceptive] pills… It was just a very – I didn't ask for an IUD…It was just very uncomfortable. It was a weird experience".*

In fact, both copper and hormonal IUDs are appropriate and effective contraception methods for larger bodied individuals.[259] Further, the needless reference to the student's weight in regard to a method she was not seeking created a hostile environment.

Like the above examples of the relationship between provider bias and misinformation, students commonly felt their provider did not believe and dismissed their reproductive concerns, sometimes attributing dismissal to their age, ethnic background, and gender. Further, K12 encompassed this discrimination as a historical mechanism, exemplifying how patient dismissal persists disproportionately at the intersections of race and gender,

> *"There's just general sexism in health and medicine, and that brings in the equity issue as well. But there's a long history of doctors dismissing women's issues or reproductive health issues…the undermining of Black women's pain, for example."*

Failing to validate students' reproductive health concerns led to distrust and future hesitancy to address reproductive health issues, and ultimately limited access to quality care options. Students reported providers dismissed their reproductive health symptoms by not asking follow-up questions and failing to investigate further through testing. Interestingly, students' reluctance to seek care for invisible health issues (Section 5.2.3) was validated by experiences when providers disregarded reproductive issues they could not physically see. Among the many students who came to their provider seeking solutions to pelvic pain, one explained that premenstrual pain inhibited her from attending health appointments. When she sought care after this monthly pain subsided, she felt the provider did not believe her because she did not present in a way that she was in pain,

> *"[My provider] disregarded [my pain] because I think when you're not in it, you seem like a totally normal person. But when you're in pain, you're like a zombie monster. And so, I was feeling fine [at my appointment]."*

She went on to explain that this interaction influenced her unwillingness to seek care. Despite her continued symptoms, this student did not return to this provider and prolonged seeking care in fear that other providers would not believe or address her pain. Others explained how provider dismissiveness could negatively impact patients' care plan adherence and willingness to seek care. While many students felt their provider acted in their best interest, they still needed to be heard in order to trust their care plan. As one student advocated,

> *"Even if the doctor is sure that the patient has the thing they think they have, not making them feel bad for wanting to be treated for something or for wanting to be tested…Believe your patients – don't be dismissive because it could turn off someone from wanting to pursue…something they need treatment for."*

Some students recalled instances when concern dismissal escalated to providers' refusal to provide services (e.g., STI testing, contraception). For example, while US and Canada's professional ob-gyn and pediatric societies recommend STI testing for all "sexually active" minors,[260–262] one CA student reported that her family provider denied STI testing at the age of 17. This student then sought care at a clinic and received STI testing. She explained her concerns around her family provider's reluctancy and how that impacts the patient-provider relationship,

> *"I asked if I could get an STI test done, and they said, no,'we don't do it until you're' – I think it was 18 or something. I was 17… This is just a regular family provider…then I went to a walk-in clinic, and they were like, 'yup, no problem'….if someone's asking for something 'cause they're concerned, especially something like sexual health where a lot of people aren't gonna tell you the truth even if you are their doctor…That just doesn't make any sense to me…I just think that's too high to not do it until that age."*

While most participants undergoing family planning procedures described mild to moderate pain, two participants reported situations when their IUD insertions were more painful than expected. One student's IUD pain was later explained by discovering a uterine abnormality. Though IUDs are currently considered suitable for those with abnormalities, some studies suggest there may be an elevated risk of mispositioned IUDs in abnormal uterine shapes.[263] This student's experience supports a need for more research to establish clear guidelines surrounding IUD insertion for those who have abnormal uterine anatomy. Another student's provider prescribed her misoprostol to dilate her cervix for IUD insertion. This student described the excruciating pain that this medication caused,

> *"The night before they gave me a pill…it was like 10 hours of contractions, which was so, so painful…I was already in so much pain, then, getting it [the IUD] in took 10 minutes and I was screaming and crying…I could not handle it. I had to just grasp on to the seat for dear life because it was so painful…I would have rather it just been a little more difficult…and not have been in that much pain…I had to leave my car downtown and take an Uber home. I could not stand up from how much pain I was in."*

This student not only felt uninformed about the severity of pain this medication would cause, but she reflected on her feelings about being part of an experimental insertion process without adequate knowledge about the medications' labeled use,

> *"[My provider] just [told me] that it would expand my cervix and stuff. But then I was like looking it up after I took it and was like, 'this is so horrible'. And I was looking up*

> *the things it's used for…was the same pill they might prescribe to a very early-stage abortion…I hate that. I wish I had known that much before I agreed to it."*

This participant also acknowledged that she was not fully informed of the insertion method's experimental nature prior to the procedure, and she did not provide written consent regarding participation in what she perceived as a medical study.

During the time of this student's procedure (2015), some providers routinely used misoprostol for IUD insertion, despite clinical trial evidence published in 2013 that showed misoprostol does not improve ease of insertion but increases pain and insertion side effects.[264] However, it was not until 2016 when practice standards advised against the use of misoprostol for routine IUD insertion.[265,266] The time from 2013 clinical trial evidence to 2016 published standards demonstrates a lag in best practices. Further, with rapidly changing contraception standards and information, it is unclear how quickly individual providers learn and implement best practices.

Further, participants from both countries experienced providers who refused to remove their LARC methods (IUD and contraceptive implant), despite students' physical and mental health side effects. One student who was refused implant removal shared that her provider said her body needed time to adjust to this method,

> *"[The provider] she's like, 'I'm not going to take it out…you're just adjusting', and she didn't believe me when I said…I'd been in a worse place, super miserable and it was because of that…I thought I was just stuck with it forever."*

In addition to feeling her provider didn't believe her, this student's situation brings forward an ethical issue of providers' exercising authoritative power over their patients. That is, this provider made an executive decision that the benefit of this contraception method outweighed the risk of prolonged mental health impact without offering other supports or options to alleviate hormonal struggles. Given the historical and prevailing forces of reproductive coercion, exploitation, and paternalism,[135,136,267] these students exemplified the critical need for providers to be mindful of power dynamics in fertility control. In fact, family planning stakeholders are specifically concerned with the potential for LARC method coercion as a means to control fertility of marginalized groups.[268] While LARC coercion concerns and research are commonly focused on contraception initiation stage, this thesis extends the limited data on coercive practices when LARC users request removal,[269] suggesting a need to monitor coercion throughout the duration of LARC use.

Some students emphasized feelings of being violated when their providers did not ask for consent or inform them of the purpose for an exam. One student described a provider performing her first pelvic examination without verbal explanation of the process or asking for consent,

> *"When I was like 16…the doctor was a male and he like (participant hesitates) used his finger to like do a check…a pelvic exam, and that was very painful for me."*

This student has felt uncomfortable in the reproductive health setting since this interaction, and attributed this clinical experience to her foregoing an ultrasound to investigate menstrual pain,

> *"That experience made me a little scared to do the wand ultrasound…I had no idea what's going on [during my first pelvic exam]…So, I ended up not going to get the ultrasound done…"*

Overall, those who experienced inadvisable provider approaches to care showed the potential for individual providers to cause undue patient burden through inadequate or misinformation, concern dismissal or service refusal, and failure to ensure informed consent. These findings exemplify the role of provider bias and authority in limiting students' ability to take part in informed SDM. For a provider to adequately inform students of reproductive information and options, students indicated that their provider needed to first have accurate and comprehensive reproductive care knowledge to share with patients, and confirm patient understanding and consent.

6.2 Clinical Environment, Protocols, and Influences Beyond the Clinical Setting

Students reported the clinical environment and protocols as permitting or limiting their ability to receive positive reproductive care experiences. Below, I first discuss how the clinical environment and provider type influenced students' comfort and perceived care quality. Then, I describe how students felt clinical protocols and approaches affected their ability to stay engaged in their care and maintain confidentiality outside of the clinical setting.

6.2.1 Clinical Environment and Provider Type Influence on Students' Perceived Care Quality

Though provider quality and services were at the forefront of what students attributed to person-centered care, the environment within the clinical setting also influenced clinical culture and played a role in determining students' care perceptions. In the US, differences in clinical environments were observed between those that had private insurance and those who reported using Medicaid. For example, one student using private health insurance described her gynecology office as a day spa. She found this environment encouraging, adding to a clinical culture that made her feel the provider's team was invested in her health. This student explained,

> *"It was just an unbelievable space…It was aesthetically pleasing…The people were so nice…The women called everyone that came in 'beautiful' like that was their name…They had Keurigs and made you tea…so welcoming. They felt like women who really loved being around women. Everything made you feel like 'yeah, I'm doing a great job at this appointment, man. I'm like, I'm nailing it.'"*

In contrast, one student using Medicaid insurance described her gynecologist's office environment as intimidating and displeasing with unpleasant employees,

> *"In the gynecologist office, everything's like super white, super grim, super confusing… I feel like they all kind of look the same, all pale and sad. It might be the white walls…kind of makes me not want to go back to the reproductive care center, because I don't want to be here cause it's kind of grim, kind of scary. It kind of looks like I might die here."*

While Medicaid funding constraints may financially limit providers'[64] ability to provide non-essential aesthetics like the private practice above, prioritizing environments that support patient comfort was important to students and allowed them to feel a sense of wellness. In fact, this is supported by research indicating clinical design can serve as a distraction to the stressors patients might have when seeking care or coping with health issues.[270] Students who have received care at Planned Parenthood mentioned that this nation-wide health organization demonstrated an environment that supported therapeutic wellness, despite the organization's acceptance of Medicaid insurance and underinsured individuals. In addition to using inclusive language, artistic waiting rooms, and offering free Planned Parenthood merchandise such as stickers, pins, pens, and condoms, one student expressed her clinic's dedication to ensuring comfort and care as she recovered from her surgical pregnancy termination,

> *"They had me go sit in this lounge room in these nice lazy boys that you lay back on and they want you to wait there for half an hour…it's kind of the recovery room. Then, they want you to use the bathroom so you can tell them what your bleeding level is."*

Beyond general physical aesthetics and a culture of compassion, Planned Parenthood was also cited as an affirming space for LGBTQIA+ individuals to seek care. The abovementioned merchandise included gender-inclusive materials such as pins that displayed pronouns and displayed pride flags within and outside clinic locations. This was important for queer students as gynecology clinics were reported to typically center heteronormative cisgender individuals. For example, gynecology clinics commonly have the word "women" within the clinic name, indicating to those who do not identify as a woman that these clinics are not for them. Indeed, one student reported anxiety and hesitancy to seek reproductive care, citing a surge in dysphoria and fear of making other patients and providers uncomfortable in a "woman space". He stated,

> *"There are really two options when it comes to finding a gynecologist…a cis-woman gynecologist…they are walking into the room expecting to see another cis woman, and to see a man there feels like an invasion of their privacy somehow. The alternative, being a cis-man gynecologist, which I am not comfortable with in the slightest."*

Another student mentioned seeking care at an LGBT center, and described how that clinic's inclusive environment and culture led to higher quality care,

> *"The doctor I saw…was very affirming and supportive. We talked about different options, and she prescribed an estrogen cream to help…soften the lining of my vagina because I don't have penetrative sex very often and that makes Paps more difficult…she said it was okay if my girlfriend was with me…I asked if I could insert the speculum myself and she said yes. It was uncomfortable, but it wasn't traumatizing and painful…She didn't say*

> *'women' have problems with Pap smears. She was like 'people' have problems with this…It was affirming of my gender or lack thereof…I felt really proud of myself."*

Indeed, prescribing estrogen prior to a Pap smear is supported by WPATH and other transgender reproductive care recommendations if a patient is using testosterone, has experienced sexual trauma, or has conditions such as Vestibulodynia like the above participant reported.[119,271]

Overall, 13 students reported having received care from a gynecologist (GYN) (US: n = 9, CA: n = 4) (Table 12). As discussed in Section 4.1, healthcare systems influenced students' access to GYN specialists. Due to the referral system in Canada, all students received GYN services from their family provider. Only four CA students were referred to a GYN specialist because their reproductive health issue was beyond their primary care provider's scope. Due to the US health system permitting GYN specialist access without referrals, many US students have sought reproductive care directly from a GYN.

Table 12. Students' Reproductive Care Provider Type by Country

Country	PCP Only	GYN Only	PCP and GYN
Canada	7	--	4
US	2	4	5
Total	9	4	9

While CA students' reasons to seek reproductive care from a GYN were straightforward and directed by a primary care provider (PCP), US students' reasons were more nuanced. Five US students reported having received reproductive care from both their PCP and GYN throughout their lives. Factors surrounding these students' provider type decision included physical location and the nature of their concern. For example, some students used PCPs for reproductive services at their university clinic but chose to seek care from GYN specialists when they returned home during university breaks. Others began contraception counseling with their PCP, resulting in a follow-up LARC insertion appointment with a GYN.

Further, age seemed to play a role in provider type, with US students reporting that they sought reproductive care from their pediatricians (i.e., PCP) until they felt they matured into the need for a GYN specialist. Similarly, one student discussed her GYN's role as she transitioned out of pediatrics at age 21. During her interview, she realized she was not established as a patient with a PCP, remembering her pediatrician informed her that he could no longer provide care at her last appointment over a year prior. Since this student's only frequent health need was contraception prescribed by her previously established GYN, she continued receiving routine services and used urgent care clinics for any acute non-gynecology needs.

Only two US students reported never seeing a GYN specialist. Both students came from cultures valuing Eastern health approaches (i.e., herbal medicine) and families with conservative reproductive health beliefs. These students sought reproductive care for the first time while at university and have only used their university health clinic's PCPs for gynecology needs.

Most importantly, participants' level of trust in their provider played a role in their preferred provider type. Trust in a provider varied among participants, depending on patient-provider rapport and students' perception of provider expertise. Benefits of seeking care from a gynecologist included a specialized insight into reproductive health, a separate location providing confidentiality and safety, and willingness to discuss candidly with a provider who students felt was less likely to stigmatize sexual and reproductive issues. Conversely, some patients preferred receiving reproductive care from their family/primary care provider due to previously built rapport and centralized records that permitted a holistic health approach.

Students reported that providers' reproductive knowledge proficiency was an important factor in clinical interaction quality. Most participants who have received care from GYNs and PCPs preferred to see GYNs for their reproductive needs. Due to the nature of the gynecology profession, some students felt GYNs would lead to better health outcomes. As one CA participant explained,

> *"I feel more cared for because they're [GYNs] more knowledgeable…I think a gynecologist is a more specialized kind of thing…they know what they're talking about."*

In support of this student and other participants shared beliefs about GYN's superior reproductive health knowledge and perceived higher quality of care, students provided tangible examples of when their PCPs fell short of their needs. Detailed in Section 6.1.3 above, students revealed instances where both PCPs and GYNs lacked knowledge and misinformed patients. Yet, interview data show more instances of accurate and current reproductive health information from GYNs compared to PCPs. While students felt PCPs demonstrated broad medical knowledge, they were exemplified as being less equipped with the depth of information needed for students to find appropriate health solutions. For example, PCPs in both US and CA deterred students from choosing their preferred contraception method due to their lack of contraception knowledge. Three students reported instances where their PCPs misinformed them with outdated, anecdotal information sometimes leading to uptake of an unpreferred method. Comparatively, only one student described a situation where her GYN provided contraceptive misinformation.

One US student reported that her PCP would not prescribe the IUD method due to her being a nulliparous patient, stating,

> *"I went in [to my PCPs office] and I was like, 'I want an IUD, I know what I want', and she's like, 'No, you don't want that.' She walked me through why it's not great for somebody my age who's never had a child to have an IUD."*

While provider hesitancy to prescribe LARCs to nulliparous and adolescent patients is well cited, reproductive health expert associations in both countries recommend LARCs as best-fit methods to ensure low-maintenance and long-term pregnancy prevention, values that are generally held by young nulliparous patients.[272–275] Data show LARC methods are of no higher complication risk to this population compared to the uncommon LARC risks in the general population.[276]

In contrast to the above student's PCP experience, another nulliparous US student who received contraception counseling from a GYN shared a comprehensive, informed interaction with her provider,

> *"She walked me through all the different kinds [of contraceptives] and she was like, 'this (Liletta) is the one that will probably last longest. It just keeps getting approved for longer and longer…this is the one that most women report completely stops their period. I know that's what you need'. So, she made it real by connecting it to other women rather than just say '80 percent'. She was very honest like, 'This is a pretty new one, but I don't know anyone who has had bad side effects.' I already trusted her a lot at that point, so I was like, 'okay'."*

In addition to the GYN providing a comprehensive contraception list and pertinent information, this student conveyed that her GYN triangulated factual information with insights on specialized knowledge and personal experience, and was careful about the language used to convey these insights. As a GYN, this provider showed her patient the breadth and depth of her knowledge, demonstrated continuous monitoring of new developments (i.e., FDA duration extension approvals),[277] and they related the method brand back to personal observations of patients like this student. In fact, this GYN's educated prediction about the FDA approvals extending IUD effectiveness was well founded as this IUD brand has been extended a number of times from three years at the time of this students' insertion to eight years most recently in November 2022.[278]

CA students mentioned situations where their PCP recognized they were not knowledgeable enough to adequately treat reproductive health concerns. For example, one student's PCP did not believe her skin abnormalities was an STI, so they referred her to a specialist where she was ultimately diagnosed with an STI. Another student requested oral contraception, but her PCP did not want to prescribe pills without full understanding of how oral contraception would impact the student's cardiac condition. This PCP referred the student to a GYN where they were appropriately prescribed this medication,

> *"The gynecologists that I've seen have been amazing. They have all listened really well, asked the right questions, and I think that just has to do with specializing. My [family] doctor sent me to the gynecologist because of my heart condition…then, the other person was like, 'You're fine. You can take them.'"*

Oftentimes, students experienced or anticipated that their PCP would know them better than a GYN specialist. Students' preferences for including their PCP in their reproductive care were primarily due to existing, long-standing relationships. Student-provider familiarity not only instilled rapport-based trust, but it was mentioned as a component that could better integrate their reproductive care in a more holistic way. For example, one participant stated that despite her GYN being "friendly", they lacked a patient-provider relationship and mentioned, *"she doesn't really know me".* Another student recalled how having a strong relationship with her PCP allowed for her PCP to consider more than biological reproductive health needs when assessing care plan approaches. She discussed her PCP’s familiarity with her developmental health, her mother’s health history, and psychological stressors in her life,

> *“I've been seeing her [my PCP] since I was little…she kind of knew what was going on with me. She's my mom's doctor…She looks out for me…A friend of mine had passed in high school and she knew him as well. She…took extra care because she knew all that.”*

Despite students repeatedly proposing this level of familiarity as being helpful in receiving quality care, other students recognized their personal histories with their PCPs as influencing the way they report sexual and reproductive health behaviors. Among those admitting to withholding this information from their provider, a few students mentioned how failing to be honest with PCPs could have negative reproductive-health related impacts. For example, one student stated,

> *“I don't know when I actually told her that I was sexually active. I don't think I did at the beginning, and that might have just been 'cause she's known me since I was like 10, and I didn't want to unveil that yet…I went on Accutane when I was 19 and she said, ‘You know, normally when I'm putting someone on Accutane, I'll recommend that they go on birth control because Accutane – The effects are so detrimental to the fetus’.”*

Another student echoed a concern about medication side effects, grappling between disclosing contraception use to her PCP and potential interactions with other medications,

> *“If I go in for a different health concern and she asks, ‘Are you taking any other medications?’ I mention that I am taking birth control. I remember the first time that I said that she's like, ‘Why didn't you tell me?’. Because there are drug interactions with different drugs that I was taking. I think because I was uncomfortable with talking to her about my sex life, I didn't mention it. I didn't realize that it would be a concern...”*

Like students’ tendency to omit sexual and reproductive information to PCPs, students also gauged a difference between their expected values of PCPs and GYNs. Some participants attended GYN appointments with the expectation of non-judgement and sex positivity, compared to how they viewed their PCP’s openness to sensitive or stigmatized topics. For example, one US student felt that reproductive health conversations with her PCP were unsettling because she did not know their values compared to a GYN where she felt she already knew they were accepting of her sexual history and choices.

In addition to students feeling GYNs were generally better at navigating sensitive sexual and reproductive health conversations, the GYN provided a separation from less stigmatized general health needs, thereby creating a greater sense of confidentiality and independence. As one CA student stated,

> *“There comes privacy and stuff when it comes to like gynecology. I feel older[in GYN appointments], and since we’re really just getting introduced to reproductive health, you feel more like a woman…at the family doctor, it becomes everyone's problem kind of thing.”*

Further, coupled with CA participants' difficultly changing PCPs (Section 4.2.2), one student illuminated how her assigned male PCP gave her limited options to receive comfortable reproductive health services,

> *"That makes me a little bit uncomfortable because again, he's male…I can't get access to a gynecologist either. It's really, really hard to get an appointment, so it has to be with the family physician… I go to him [PCP] for all of my problems, it's a little uncomfortable, like, 'We did a Pap test…and we're having this conversation' and then…I still have to come see you [PCP]. It just makes me uncomfortable."*

While students reported a clear difference in the way they perceived provider knowledge, values, and patient experiences with PCPs and GYNs, one participant demonstrated further insight on PCP-GYN differences. She indicated that it may not be the official GYN title that invites patients into a comfortable, informative space. This student mentioned that her PCP at the student clinic is proficient in reproductive health knowledge and skills, and often works with the student population who frequently require reproductive health services,

> *"She has a little bit of a specialty in women's health…she mentioned that she deals with [reproductive health] a lot…It definitely makes me feel more comfortable because I know that this is something that's a common encounter for her...So, it's not something that I'm just like suddenly throwing onto her. It's not out of the ordinary for her."*

In fact, survey responses capture very little difference between those that answered clinical experience questions about their GYN and those that answered about their PCP. The only notable variation between the two provider types was that all six respondents reporting on their GYN experiences felt their provider adequately answered their reproductive health questions (100%), compared to 13 out of 16 students who reported on their PCP experiences (81.3%).

Perhaps a specific GYN certification is not an absolute necessity to adequately address students' reproductive health needs; However, a provider's demonstrated commitment to continuing reproductive health education, training and skills, and frequent experience treating reproductive issues in this population makes students more comfortable.

6.2.2 Care Protocols Influence Beyond the Clinical Setting

University students spoke of care practices that extended beyond the clinical setting as impacting communication and confidentiality. Practices that limited these factors outside of health appointments were reported as a barrier to patient engagement. In contrast, provisions supporting communication and confidentiality helped students feel informed and supported as they navigated the sensitive nature of reproductive health.

Many students mentioned that their providers only followed up on test results if there were issues. This "no news is good news" approach caused stress as students waited for STI, Pap smear, and other reproductive-related testing results. Without follow-up confirming normal test results, students reported waiting for periods of time with underlying worry, questioning if and when their provider would review lab reports. Among the participants advocating for follow-up confirmation calls, one student emphasized,

> *"It's kind of just like, worry. I got a…test for STIs and it always makes me nervous leaving because then they're like, 'oh, we'll call you if something happens'. But I'd prefer a call to say everything's fine. Because even though I do practice safe sex, it's always like, 'oh, my God, what if I do have something?'. So, I think it would be reassuring if they could call and be like, 'oh, your tests came back. It's totally fine'. Otherwise, they didn't call me back. And you're like, 'oh, I hope that isn't a thing that I have'."*

STI stigma contributed to some participants feeling isolated as they waited for results. Not being able to share her worry about STI results with others, one student advocated for faster STI results follow-up,

> *"I wish it was shorter [test results turnaround] just because…with reproductive health, you kind of just keep to yourself and you feel isolated. So, if I was given support sooner, I think that would be helpful."*

Other students reported how their providers' approaches added barriers to accessing their test results. For example, one student recalled feeling anxiety when her provider told her she would call with STI results but never did. Another student mentioned that her provider would only give STI results in-person. This required a follow-up appointment, resulting in stress due to additional patient effort and prolonged time to receiving results. She stated,

> *"They don't call me if I have my results in. The last two times I've had to call them and book an appointment by myself. I have to keep reminding myself that I need to book an appointment to check my results…It's also like something to worry about…So the waiting process is kind of dreadful a little bit…Usually takes at least two weeks."*

When provider offices did call with abnormal test results, students exemplified that their providers needed a more careful approach to these conversations. Students needed support, detailed information about results, and next steps they should take to find a health solution. One participant recalled receiving their hormone test results from a receptionist who was not equipped or qualified to answer their questions. Rather than immediate explanation from the provider, this student described searching for answers online, which increased worry as they waited for a follow-up appointment,

> *"They told me over the phone that I had low levels of a certain hormone, and I was like, 'Is that significant? What needs to be done with that…?' And the receptionist couldn't answer that. [They said] 'Well, I'm not sure about that. You can discuss it in your next appointment'…So just waiting now for my next appointment…I do wonder if this is a significant thing, or how long have I had this or is this a recent thing? That is something that I would want to be answered while I'm on the call with that person because now I'm thinking 'I'll Google it' and WebMD is like, 'oh, you're dying'."*

Students indicated that providers' utilization of online "patient portals" strengthened their ability to maintain timely and informative communication. The online platform used students' preferred communication medium, allowing them to be more engaged in care through messaging and status updates. One participant mentioned her provider offering medical advice via her student clinic's app,

> *"It was cool that she gave me options…and it was over messages…we have a student chart app. So, it's like a healthcare app for my insurance…We can just message our providers through there. You can put different categories, like non-urgent question or to a nurse…I don't like to call. I'm not a calling person. I'm glad I could message."*

Another student mentioned how communicating with her provider through the patient portal removed the hesitancy to ask questions that she felt during in-person appointments,

> *"You can chat with your doctor, you can schedule an appointment, they'll give you your test results on the app. Then you can immediately be like, what does that mean? And someone will respond to you…That kind of degree of disconnection is kind of nice when it's something scary or I feel dumb for not understanding medical jargon."*

In addition to direct communication with providers, patient portals offered transparency in their personal health records. Portals provided students with a central location to review all information, including lab results and providers' notes. Students' immediate access to medical records gave them more control over their health. In fact, one participant used her portal to download and take medical records to another provider rather than going through the official process of requesting these records.

Students discussed reproductive health appointment scheduling processes and preferred making appointments online. Patient portals and other online appointment scheduling platforms helped maintain confidentiality outside of the clinical appointment. Since making an appointment required patients to disclose the reason for their visit, health offices that required scheduling appointments by phone hindered confidentiality. For example, one participant explained that making gynecology appointments via phone was challenging because she was always around others during clinic hours. She stated,

> *"I have to call and be like 'Hi, this is my entire life story', but I'm trying to not let anybody else hear… I'm in a public area for the most part when I have time to actually make these calls and I'm like, 'how do I make sure that the receptionist has heard everything?'...But the people around me, I don't want them to be hearing..."*

Other participants shared experiences of when lack of protocols hindered their right to privacy. For example, many students recalled their experiences receiving reproductive care as a minor. While most remembered that their providers required their parents to leave the exam room while they spoke about sensitive sexual topics, others reported that their provider failed to ensure clinical sexuality conversations were kept between the provider and the minor. One student described an appointment where the provider repeatedly asked if she was sexually active while her mom was present. She stated that even though she was not "sexually active" at that age, she felt the provider was inconsiderate when he asked, *"If your mom left, would your answer change?"*.

While students knew they had the right to confidential care, some students mentioned feeling more comfortable when their provider explicitly promised privacy. As one stated,

> *"She [my provider] did have the confidentiality thing that I was really looking for – Obviously, all health care professionals are supposed to have that rule that you can't tell anybody what your patient is going through. But I feel like hers was super sincere, versus other ones who just distribute the files."*

Summary: Students' Person-Centered Care Needs

Chapter six revealed students' clinical experiences to identify what they needed from their reproductive appointments and providers. Students expressed the importance of reproductive health providers knowing their individual biopsychosocial characteristics to improve patient respect, integrate holistic health needs, and ensure time spent within appointments addressed appropriate concerns.

Section 6.1 documented what students needed from their providers to feel engaged in person-centered care: establish familiarity with individual patients, be informed and informative about reproductive health, translate their knowledge appropriately, and believe patient concerns. While SDM frameworks include respecting patient choices as a component of empowering autonomous informed decisions,[20,113] this study recognizes a broader need to *respect patients.* For these participants, patient respect was illustrated by providers who were familiar with students' identities and histories, and critically applied this knowledge to meet students' communication and care needs to take actionable approaches to a solution. That is, respecting patients started the SDM pathway to ensure effective knowledge translation, identify appropriate health options, and encourage autonomous decision-making to fulfill students' person-centered care needs. Section 6.2 moved beyond clinical interactions and services, finding that the built clinical environment, provider training and experience, and protocols influenced participants' clinical perceptions and experiences during and after their appointments. The clinical environment, including aesthetics, branding, and demeaner of all clinic employees influenced students' sense of belonging and safety. Care protocols influenced confidentiality, care continuity, and patient engagement beyond clinical appointments.

Chapter 7
Thesis Conclusion

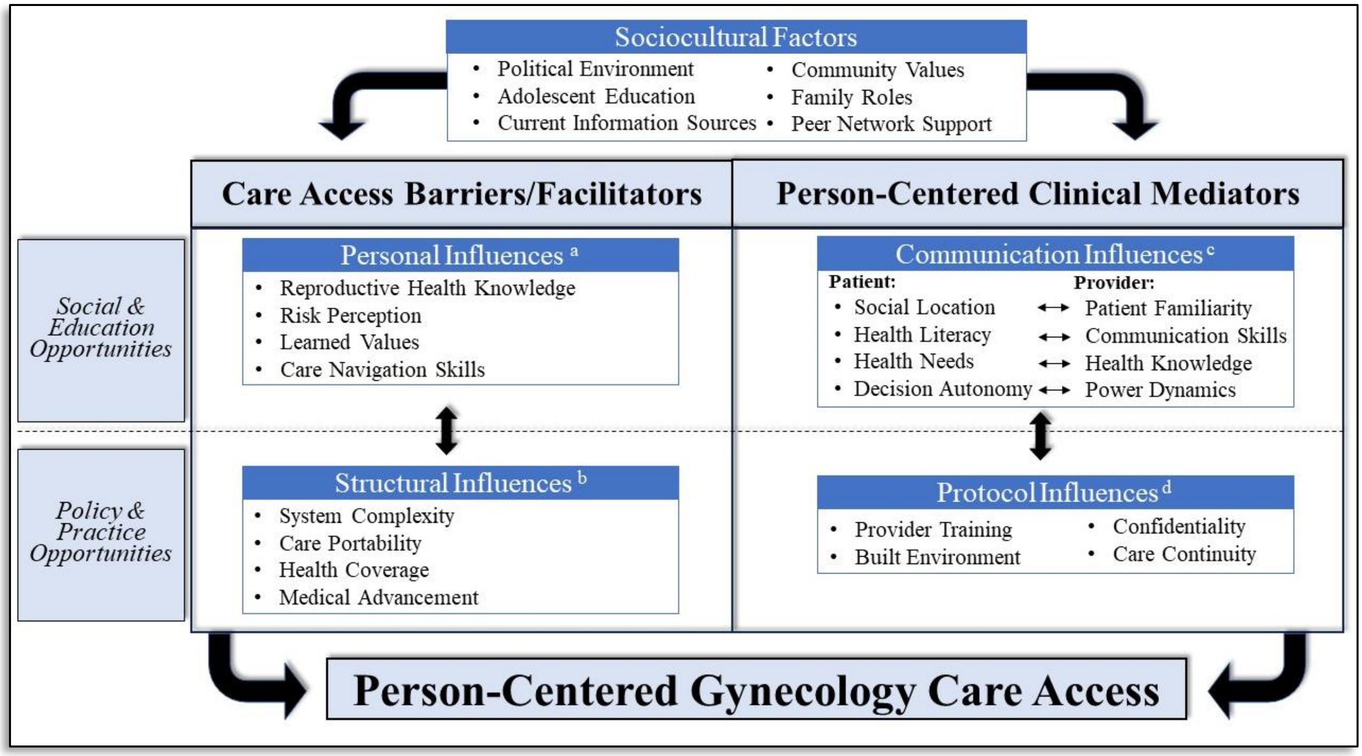
To conclude this thesis, I collate the contributions of this research through the lens of equitable access and reflect on the strengths and limitations of these findings. Section 7.1 extends the IOM equitable access model, using findings of students' barriers or facilitators to person-centered access to develop a model for equitable access to person-centered gynecology care. I situate mechanisms that influenced participants' gynecology experiences within existing literature and efforts to propose comprehensive opportunities to improve person-centered gynecology access through social, education, policy, and clinical protocol initiatives. In Sections 7.2 and 7.3, I share my takeaways on this thesis' methodological strengths, limitations, and my suggestions for future research within the field. Lastly, I share my final thoughts on the research process and contributions resulting from this thesis in Section 7.4.

7.1 Extending Knowledge and Opportunities to Improve Equitable Access to Person-Centered Gynecology

The IOM equitable access model (EAM) broadly accounts for "personal barriers" to healthcare access, which include culture, education, and other demographic determinants.[11] This study moves beyond categorizing these barriers as "personal", illuminating the upstream influence of sociocultural factors on both healthcare access *and* person-centeredness in the clinical setting (Figure 11). While the EAM focuses on intervention opportunities at the individual level as they relate to demographic groups (e.g., clinical translators for non-English speaking patients),[11] my findings indicate a wider need for prevention strategies at the sociocultural level that could improve the overall population's "personal" and "structural" person-centered care access. Opportunities to improve access to person-centered gynecology care occur throughout individuals' lifespan, constructing knowledge, perceptions, and self-efficacy.

Specific to gynecology care, study participants identified a need for improvements in their political, cultural, social, and educational environments to mitigate personal and structural barriers to person-centered care access. Adolescent and present-day sociocultural environments influenced emerging adults' degree of internalized reproductive health stigma, and ability to identify reproductive needs, seek services, and participate in clinical care. Further, as socially constructed institutions, healthcare systems and clinical protocols interacted with personal access and clinical experience factors, either compounding or mitigating personal healthcare navigation and clinical participation barriers. As follows, I first detail key social and education opportunities to improve personal influences of gynecology care utilization and clinical communication. Then, I discuss healthcare policies and practice opportunities to improve system level access and clinical protocols. Comprehensively, this study extends exploration of what needs to be structurally modified within and outside of health systems to promote inclusive, yet non-uniform reproductive care.

Figure 11. Equitable Access to Person-Centered Gynecology Care Model



[a] *Findings: Chapter 5*
[b] *Findings: Chapter 4*
[c] *Findings: Chapter 6, Section 1*
[d] *Findings: Chapter 6, Section 2*

7.1.1 Social and Education Opportunities to Improve Personal Access and Clinical Communication

Thesis findings related to personal influences of care utilization and patient-provider communication strengthen our understanding of young people's formal and informal social support and education needs to access gynecology care and improve clinical experiences. Key stakeholders in improving participants' care-seeking and participation included communities, K-12 schools and universities, families, peers, and providers throughout adolescence and while at university. Opportunities detailed below seek to use social influence and education engagement to comprehensively improve emerging adults' reproductive health knowledge and care navigation skills, foster social network and program support, and allow providers to communicate more effectively to reach best-fit gynecology solutions.

Integrating Adolescent Social and Educational Opportunities

There are critical opportunities for integrating social and educational improvements during adolescence, as students reported that their lived experiences and reproductive health literacy during formative years influenced their gynecology care experiences as emerging adults (Section 5.1). Students' discussions surrounding adolescent social and education influences highlighted the intersecting roles of culture and community, family values, and school-based education programs in reproductive health care-utilization and clinical communication behaviors over time. This thesis illuminated the need for the continuous development and standardization of comprehensive health education, including content that reaches beyond sexuality to give students the tools to use their respective health systems, assume patient roles, and exercise patient rights. Moreover, study results show a need for parents to seek ways to stay informed on reproductive health topics, maintain open communication with their children, and foster autonomy in reproductive choices and care navigation. These findings contextualize and substantiate a literature review which indicated that community and parental engagement within sexuality education curriculum promotes adolescent reproductive health more effectively than classroom-only programs.[279] Yet, my investigation of related online evidence-based programs show a lack of interventions proven to comprehensively address cultural stigma, parent-child reproductive health conversations, and supportive roles in gender and sexuality outcomes.[280] While the Society for Adolescent Health and Medicine offers a reputable list of resources for parents to learn about and communicate with adolescents and emerging adults on a wide range of gender and sexuality topic,[281] I suggest efforts toward the development and implementation of evidence-based programs for parents to help them navigate healthy relationships with their adolescent and young adult children relating to and beyond gynecology care.

University Social and Educational Support Opportunities

The university setting can serve as a place for diverse and informative social and educational support for learning how to navigate reproductive services as students transition to more autonomous roles (Section 5.2). Further, based on previous research indicating transgender youth with intellectual disabilities struggle to gain sexual autonomy from authority figures (e.g., parents),[282] the university setting may provide an equitable opportunity for those of diverse backgrounds and identities to develop and practice safer reproductive health behaviors. This study highlighted participants' value of student-led organizations and programs that disseminated reproductive health information, tools, and risk prevention materials. However, findings pointed toward a need for institutional improvements to sustain formal health promotion programs to educate and protect students on matters related to reproductive health, gender, and sexuality. Aligning with previous literature on limitations of peer information-sharing,[139,151,249] the combination of expert and peer education may improve information that is both evidence-based and valued by students. Universities can promote reproductive wellness through establishing and maintaining community partnerships with aligned stakeholders, connecting students with reliable information sources, and assisting with health navigation.[283] Specific institutional opportunities identified in this thesis include on-campus health services (i.e., counseling, reproductive care, and pharmacies), transportation to off-campus resources, student engagement in gender/sexuality inclusivity events, and an online university platform to navigate reproductive health information, resources, and events.

Provider Knowledge and Communication Training Opportunities

Based on students' reports of providers sharing misinformation, abductive inquiry showed a potential gap in providers' contraception technology knowledge (e.g., method side effects, effectiveness, and age-appropriateness) (Section 6.1.3). This study suggests that providers may benefit from continuous family planning education opportunities. These data add to the limited research on provider IUD misinformation,[284] method prescribing differences between provider-types,[285] and broadens the need to strengthen providers' knowledge about all contraception methods. Given providers have reported being overburdened by the growing training and technology demands of their roles,[274,286] reproductive healthcare bodies may provide contraception prescribing stakeholders (e.g., providers, nurses, pharmacists) with centralized access to real-time contraception resources, removing provider capacity barriers to stay informed about rapid contraception advancements.

This study also explored students' needs for provider improvement on communication and respect (Section 6.1.2), identifying an opportunity for provider training to better engage young people in person-centered care. Based on my findings, provider communication training may seek to improve rapport-building and using knowledge about patients to determine communication approaches (e.g., knowledge translation and identifying patient health needs). With an empathetic understanding of historical reproductive exploitation, providers may learn tools to mitigate power roles by respecting the whole individual. Providers may show respect by engaging patients in informal communication appropriate to patient health literacy, empowering patient decision-making, and being visible within the community. At the intersection of providers' contraception knowledge and communication, student data and supporting literature exhibited a need for approaches to promote engaged and informative clinical conversations within the short appointment durations. One article suggests that PCPs should present contraception method information in the order of most effective to least effective methods, including details on the safety and side effects.[209] Further, providers can take SDM into account, considering that method efficacy may not be the primary decision-maker for all patients, and some methods may be preferred based on patients' health or lifestyle needs.[209]

Opportunities to Improve Medical Education Standards

There are many opportunities to improve cultural competence of our provider workforce, such as diversifying our providers to reflect various backgrounds and identities, framing medicine through a health justice lens, and integrating cultural safety within institutional values. Thus, health professional education and training programs, such as medical school, are opportune for establishing and maintaining cultural safety. Provider diversification can be supported by efforts to improve admission and retention equity at all education, training, and occupational levels (e.g., education cost, standardized testing content, admission requirements, and institutional belongingness).[287–289] Using health justice as a foundation for medical training can improve the provider workforce through cultural safety in patient communication and appropriate medical treatment.[290–292] Currently, the CA and US medical school accreditation standards (LCME) include aspects of social determinants of health and patient communication education, but do not specify content or explicitly require integrating concepts such as historical medical exploitation, cultural considerations, and continued discrimination within each medical field.[293] Integrating this information and adjacent critical service approaches throughout medical course content could be beneficial to patients of oppressed identities and increase medical development focus beyond the historically centered white cisgender male. In fact, I suggest that medical education accreditation bodies and universities adopt public health program accreditation criteria (CEPH), which integrates social determinants of health within each course and applied learning experience.[294] Further, I encourage medical and public health school degree partnerships, offering joint degree or admission pathway programs.

7.1.2 Care Policy and Practice Opportunities to Improve Structural Access and Clinical Protocols

Study participants pointed toward the influence of healthcare structure complexities on useability and pathways of care navigation. As discussed in chapter four, the CA health system's streamlined model allowed easier navigation but less choice than those using the US health system. Thus, this research supports the broader health system calls for CA to improve healthcare navigation autonomy and patient involvement,[24,46] and for the US to improve portability and regulation to avoid convoluted ways of accessing care.[40,41,295,296]

Opportunities to Improve Portability, Healthcare Navigation, and Confidentiality

Mechanisms of privately funded, fragmented, and unregulated bodies contribute to healthcare system access barriers, including user confusion and exorbitant overhead costs taken on by patients.[297] The issue of insurance portability was often cited by US students, encompassing issues pertaining to being limited to in-network providers and accessing covered services outside of their home state (Section 4.1.2). Though the US Public Health Service Act and the Canada Health Act both require some services be covered out-of-province/territory/state, the US strictly requires "emergency service coverage" and offers a narrow definition of this term.[298] In contrast, the Canada Health Act requires provincial and territorial insurances to provide some coverage out-of-province, but provinces decide how these services are covered.[45] While out-of-province student health coverage experiences were not discussed by CA participants, Canada's decentralized health system may yield similar barriers for CA university students. To transparently fill the Canada Health Act's promise of portability, CA provincial/ territorial and federal governments can increase efforts toward structured collaboration and providing timely, publicly accessible information on interprovincial and territorial coverage. Clear language surrounding all provincial and territorial coverage details and how to use coverage out-of-province could be accessed in a central location. Overall, both the US and CA health systems show a need for improved insurance portability and patient navigation support. Thus, supporting policies that strengthen insurance provider standards related to out of state/province coverage, as well as insurance plan transparency and support for beneficiaries.

Other CA reproductive care system opportunities surrounded the role of family/PCP as the first point of contact for gynecology services. These findings indicate an opportunity to strengthen GYN referral process by creating more specialty access avenues to decrease wait times. One identified method is to use a centralized intake process whereby specialist availability is pooled and suggest providers who have the soonest availabilities.[299] While applicable to both health systems' PCPs, this study illuminated an important need for the CA health system to address provider gatekeeping. Students who reported issues with PCPs' gatekeeping specialist services pointed toward issues of provider "conscientious objection" and reproductive health competency. As noted in previous research, providing such care first requires PCPs to hold a foundational medical value of family planning.[300] The current study's participant reports of negative provider interactions and feeling judged (Section 6.1.2) suggest that providers' current right to conscientious objection could protect patients from unethical care. However, sexuality discriminating providers and conscientious objectors limit care location options,[301] contributing further to what this study found to be already restricted avenues of reproductive care access. Thus, both CA and the US health systems may improve access by better integrating reproductive autonomy values within medical culture and duty to provide care.

This study's participant reports of PCP's insufficient family planning care (Section 6.2.1) identified how healthcare structure can improve reproductive care integration within the primary care setting. Studies suggest that CA and US primary care providers feel limited in their ability to provide abortion care due to lack of training and system support.[302,303] This thesis extends the need for comprehensive family planning integration within the primary care setting, given findings related to primary care provider lack of contraception counseling and LARC insertion skills.

Participants illustrated the unintended consequences of permitting emerging adults to remain on parental-based insurance (Section 5.2.1), showing a need for policies surrounding health insurance billing statements and out-of-pocket costs to better protect their right to confidential care. As recommended by The Society of Adolescent Medicine and American Academy of Pediatrics, governments and health organizations can strengthen policies and procedures to prevent insurance disclosure, as the combined confidentiality and financial concerns act as barriers to care and can endanger patients.[304] Moreover, financial health support access for young people, such as OHIP+ and Title X, can be improved to cover current out-of-pocket costs for comprehensive, sensitive healthcare services and medications (e.g., family planning, transgender care, mental health treatment).

Opportunities to Improve Medical Advancement and Service Availability

Changes are undoubtedly needed within the US and CA health systems to address the evolving complexities in human health and technological advancements.[46,47,49] Overall, students expressed frustration with the lack of reproductive health solutions available to address chronic conditions and services that were appropriate to their needs and identities (Section 4.3). Contextualized with the knowledge of historical and current underfunding of women and LGBTQIA+ health research,[15,16] this study supports a call for government research funding that integrates sex and gender within all health research and focuses on health issues specific to these populations. Moreover, at the time of student interviews, CA participants pointed toward Health Canada's prescription approval process as hindering their ability to select their preferred contraception method (i.e., contraceptive implant). With Canada's lag in drug approval compared to other countries, CA reproductive health patients have been limited in their family planning options, including medical abortion and the contraceptive implant.[92] This indicates that improvements to Health Canada's timely approval process may be especially beneficial to uterus-having individuals as family planning technologies continue to advance.

While US preventive GYN care is currently in part protected by the PPACA provisions referenced throughout this thesis, the current broader US social context surrounding LGBTQIA+ and abortion care indicates a threat to adjacent policies such as contraception coverage and availability.[305] Despite most of this study's participants not reporting previous use of abortion and transgender services, the advocacy and fear shared between student and KI interviews amplified a call for protecting uterus-having individuals' reproductive rights in both countries. Stakeholders were identified throughout all communities and settings, but both students and KIs specifically called upon providers and community health leaders to sustain their roles in reproductive rights policy activism while also mitigating negative impacts of policies that limited access.

Opportunities to Improve Clinical Practice

Delving into university students' needs for a welcoming clinical environment, participants who described aesthetically pleasing clinical environments also felt comfortable and satisfied with their care compared to others who reported feeling anxious in unaesthetically pleasing clinics (Section 6.2.1). The clinic environment's role in participants' comfort level aligns with what we know about the built environment's impact on health and wellbeing,[306] including some evidence showing clinic design's influence on patient engagement.[307] Since physical architecture and design are influenced by sociocultural contexts,[308] thesis findings support a gynecology care setting designed for those seeking services at clinical locations. Moreover, the name of clinics was shown to be a part of organizational design that influenced participants' initial perceptions and comfort, indicating the importance of clinic branding in establishing a place of belonging, especially for LGBTQIA+ patients. Overall, clinical designs guided by intersectionality theory would represent inclusivity and non-uniformity of patients served within each clinic,[155] aiming to decrease medical anxiety, and contribute to person-centered care, confidentiality, and trust.[309]

This thesis identified students' needs for improved care continuity, especially as they related to transparency, and continuous communication before, during, and after gynecology appointments. With participants reporting varying levels of access to their provider and health records, those who sought care from organizations with patient portals felt engaged and empowered in their care (Section 6.2.2). While patient portals are a relatively new health information technology tools, research shows these portals can improve patient engagement and adherence outside of the clinical setting, but has not yet been linked to improved health outcomes.[310] Thesis findings indicate that implementing and maintaining a gynecology patient portal could improve young people's perceived confidentiality, ability to make appointments, autonomous access to their personal health records and health resources, and timely documented communication with their provider.

Findings also identified care improvements needed to better address university students' intersecting holistic health needs. Specifically, participants identified how mental and reproductive conditions interacted (e.g., PMDD, gender dysphoria) (Sections 3.2.2 and 6.1.1), pointing toward a need to integrate psychological and gynecology care. While the relationship between mental and reproductive health is well-documented throughout the life course of uterus-having individuals,[311] current clinical standards to appropriately address this intersection primarily focus on obstetrics care.[311–314] With university students in this study experiencing intersecting mental and reproductive health issues as non-perinatal individuals, thesis findings support improving clinical standards to appropriately address this intersection outside of obstetrics care.

Participants identified some clinical questions and services that may not be appropriate for patients based on their identities and health needs (Section 6.1.1), supporting clinical standards that better assess the necessity of asking specific screening questions and the potential harm questions may cause people of differing identities. Thus, this thesis validates standard clinical recommendations as only a suggestive tool that should not be uniformly applied to individuals. In fact, the version of ACOG's "well-woman recommendations" used to develop this study's survey has since been retracted,[115] and it is now annually reviewed and revised by a task force to ensure continuous evidence-based medicine developments.[252] While this iterative initiative intends to build more effective recommendations and has improved language to overtly show its adaptability to individual patients, the recommendation tool and the developed task-force still entitles itself as "Well-Woman Recommendations" and "Women's Preventive Services Initiative" (WPSI). Further, the most recent version of recommendations (2023) does not include explicit screening questions surrounding identities (e.g., gender, sexual orientation) or sexual behaviors (e.g., "sexually active" inquiry), but it does include a comprehensive list of recommendations that are applicable to any uterus-having individual.[115] That is, current WPSI recommendations do not include services that would be appropriate for penis-having women (e.g., prostate and testicular exams). Yet, according to the WPSI's equity statement "WPSI supports and promotes access to healthcare for all women, regardless of race…gender assignment, gender identity, sexual orientation...".[117] Therefore, as it seems these recommendations serve as an inclusive, non-uniform guideline appropriate to *uterus-having* people of all genders, this study's findings of gender-diverse participants feeling unwelcome in gynecology spaces indicate that ACOG's "well-woman" recommendations verbiage ought be changed to include those that do not identify as women.

Overall, by adopting a "health in all policy and practice" approach, governments and organizations can appropriately create supports that uphold the well-being of its people. That is, even in policies and practices that are seemingly not related to health, assessing potential health impacts may strengthen policy and practice to avoid unintended health consequences.[315] When developing bills, it is necessary for policymakers to work interdisciplinarily and with lay constituents to consider health consequences and social determinants of health.[195] Comprehensive policy contemplates and plans for the capacity to support health, and it holds policymakers accountable for unintended consequences that may arise. To solidify its long-term impact, all stakeholders can come together to compromise with the population's diverse experiences, beliefs, and interests[44] that promote bodily autonomy and collective well-being for all states, provinces, and territories within the US and CA. As one US student advocated,

> *"States can make policies regarding their own view – Not their own views, but the policy makers' views, about reproductive clinics…And since the federal level of policies is super vague, these states are allowed to do that because nobody's really regulating it. Policy-wise… make those rules…more concrete, not so bendable like they are now."*

7.2 Thesis Strengths and Limitations

The use of a transformative qualitative research methodology permitted a critical approach to data collection and analysis, bridging intersections of personal participant experiences with the mechanisms of power which produce these experiences.[108,155,193] Thus, findings illustrated that students' reproductive health considerations extend beyond the biological lens to include interpersonal, cultural, and structural powers. Moreover, the philosophical underpinnings of transformative research using intersectionality theory permitted an investigation of actionable solutions to issues identified by participants and contextualized by existing knowledge. While there are few comprehensive guides and examples on rigorous operationalization of intersectionality theory, I was able to expand intersectionality's application by using existing intersectional methods and abstract concepts. For example, chapter three gives further insight on the development of my intersectionality methods and how these methods led to thesis findings, serving as a use-case for further development of this theory's research applications.

The social context surrounding public health, social justice, and reproductive rights served as both a strength and limitation of this research. The rapid development of changing realities (i.e., COVID-19) and policies (e.g., abortion restrictions) created resources to contextualize data and transfer participant realities to potential societal influences. Yet, these everchanging social realities as they relate to person-centered gynecology care access may hinder the usefulness of these findings since policies, procedures, and norms could continue to alter these contexts over time. One example already realized in this study is the retraction of the ACOG "well-woman" recommendations used to develop my clinical survey tool during the study period. Thus, my survey findings, which used ACOG's retracted recommendations, may not be as applicable to future clinical standard improvements.

While the recruited participants represented 22 unique university students with various reproductive health and healthcare experiences and five reproductive healthcare experts, this study did not account for all possible intersectional identities, reproductive health issues, services, and expert positions. I was unable to recruit participants I felt were necessary to include, such as students that have experienced birthing, Indigenous students, and students with physical disabilities. COVID-19 limitations on in-person activity hindered initial recruitment strategies and interviews held online may have influenced data differently than in-person interviews prior to the pandemic. However, the variation sampling approach permitted adaptable recruitment strategies[170,178] to reach potential participants remotely and to improve inclusivity of recruitment material language. Interestingly, as I was located in the US during online recruitment, social media platforms would not permit my advertisements in CA due to standards preventing social and political advertisements during that time. This potentially negatively impacted my ability to recruit diverse CA participants, as evident in the CA sample's lack of genderqueer representation. Similarly, KI low response rate and the subsequent small KI sample limited the variation of expert perspectives, possibly hindering my ability to contextualize students' experiences.

Lastly, my own intersectional identities served as both a strength and weakness. As a uterus-having individual who values integrity and justice, I continuously advocated for the use of non-traditional methods that contradict historical understandings of rigor. Yet, as a white, cisgender woman, I often questioned if I was fit for conducting research that expands intersectionality theory application and addresses a field that has historically exploited and harmed people of color. While my intention was to decenter white feminist ideologies, my whiteness may unintentionally colonize intersectionality theory, despite my attempts to amplify and contextualize intersectionally oppressed voices.

7.3 Research Suggestions

My thesis findings contribute to a multitude of research opportunities surrounding healthcare access, person-centered care, clinical gynecology advancement, and the role of social and built environments in influencing these interrelated concepts. Firstly, this study's healthcare access results show a future research need to investigate identified "personal" access barriers such as developing evidence-based approaches to improve emerging adults' reproductive health knowledge and healthcare navigation skills. Moreover, identified "structural" reproductive access barriers such as time to receiving appropriate care can be explored through factors such as provider availability, referral processes, and insurance networks (US). Some structural gynecology care barriers identified in this thesis were due to lack of availability of medically advanced gynecology care services, supporting the need for prioritization of clinical gynecology research, especially as it relates to the availability and safety of gender affirming and family planning care.

Relatedly, as this thesis integrates person-centered care concepts within healthcare access frameworks, research may seek to expand what we know about person-centeredness and embed this principle within future healthcare access initiatives. To improve and fully integrate person-centered care within the IOM's equitable access model (EAM), more research is needed to replicate the influence of patients' previous clinical experiences on subsequent care-seeking. Future steps to validate how to integrate person-centered care concepts within the EAM may focus on better understanding diverse patients’ definitions of person-centered care, and the relationship between patients’ perceived experience of person-centered care and specific health outcomes.

Inquiry of person-centered gynecology care can be explored beyond this thesis, researching how patients’ person-centered care needs for stigmatized health issues or sensitive services like gynecology may differ from other health services. In addition, research related to provider education curriculum, cultural safety, and reproductive health values may lead to identifying more areas of person-centered care improvement. Pertaining to clinical gynecology services, my research tools can be adapted to further assess appropriateness of standard screening questions, exams, tests, treatments, and clinical tools among differing populations. The use of patient portals particularly sparks my interest, as research can play a role in improving provider uptake and clinic implementation, portal quality, maintenance, and useability, and identify any differences in patient satisfaction, engagement, and health outcomes among different patient populations.

Lastly, as this thesis centered university students’ person-centered gynecology access, findings uncovered a need for deeper exploration of the university’s role in students’ reproductive health and safety. For example, given thesis findings that university clinics mitigated student barriers to contraception services, does contraception use differ depending on university health resources (e.g., pharmacies), university type (e.g., private, public, faith-based), or students’ living situation (e.g., on-campus or off-campus housing, roommates or parents)? How do university-based programs and culture influence students’ reproductive wellness? With many US and CA students in this study reporting little to no income, their frequent references to health insurance coverage and copayment costs lead to further questions about the financial burden of seeking care while attending university, including investigating potential disparities based on residency status, health needs, income-level, and other lived experiences.

7.4 Final Thoughts

The purpose of this research was to provide qualitative insight into university students’ experiences accessing person-centered care in two countries with differing health systems. I interviewed US and CA students and KIs, and I connected these individual and grouped data to existing policy, practices, and literature to make inferences about mechanisms which may influence these phenomena. Analyzing a subset of experiences from similar populations within a universal and hybrid healthcare system allowed me to critically investigate nuances that may exist due to structural, social, or combined factors. In fact, I constructed differing ways in which both systems contributed to the same issues and mitigated others. For example, the US insurance network fragmentation and Canada’s referral system both limited students’ access to preferred providers, while programs like Ontario’s OHIP+ and the Affordable Care Act ensured young people remained insured while at university, but they permitted limitations on medication brand coverage. Further, throughout this study, I grappled with underlying values of healthcare access and health autonomy, ultimately identifying a need to commit a definition of equitable healthcare access that requires adaptable approaches to person-centered care. That is, to reach equitable access to person-centered care, we can employ a health justice framework, which stands on the tenant of intersectionality theory: “Inclusive but non-uniform” of all individuals in all fields of prevention and medicine.

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Appendices

Appendix 1. Stage three participant screening survey

You are being asked these screening questions to assess how you may add to a sample that represents and includes diverse individuals. We hope to interview those with a wide variety of identities and experiences to address reproductive healthcare equity. Answers to these questions will not be shared outside of the study team. You may choose to skip questions if you prefer not to answer. If you are not selected to participate in this study, your responses to this questionnaire will be deleted. Please email completed form to Nicole Richards at Nicole.Richards@UWaterloo.ca or if you would like to set up a phone call to answer this questionnaire.

Participant Interest Identity Screening Questions

1. Race:
2. Ethnicity:
3. Country of Origin:
4. Age:
5. Gender Identity:
6. Sexual Orientation:
7. Religion/Spirituality:
8. Political Party:
9. Academic Program:

Growing up, what best represents your family?

1. Low-income, Middle-income, or High-income:
2. Rural, Suburban, or Urban:

Please list examples of the kinds of reproductive care you have received (examples: Birth control, chronic conditions, abortion services, STI testing/treatment):

Appendix 2. Terminology Rationale: “People with Uteruses”

1. After joining a Facebook group "Sounds like you need to be educated on transgender individuals but ok" and observing diverse gender perspectives about their preferences, terms like "assigned female at birth (AFAB)" or “Female to Male” were seen as unfavorable. Though recent literature uses AFAB/FTM, this terminology issue was also raised within the family planning research community at the Society of Family Planning's 2020 annual meeting. AFAB/FTM is useful for scientific categorization but can be hurtful to patients. This is similar to the term “complex patient”, which identifies patients with interacting chronic health conditions. Yet, it is inappropriate for providers to tell their patients they are complex. They are not complex, they *have* complex health determinants.[316]

2. One study participant identified as gender-fluid with a trans partner. This individual expressed concern with the term "womxn" and after our discussion, we agreed that "people with uteruses" would indicate that transmen/non-binary fit this study's criteria. There has been a recent turn in pregnancy research to refer to patients as “pregnant people”.[317] Since this study includes a more general population, it would not be appropriate to list multiple “[condition] people”.

3. Much of the scientific community defines sex as biological. Yet, it can be difficult to identify where biology and social gender constructs impact health. The sex and gender interaction theory discusses this concept at length.[318] Currently, reproductive health research approaches gender in three ways: 1. Generalizes people with uteruses as women, resulting in misgendering study participants/respondents 2. Only includes cisgender females 3. Focuses specifically on trans and non-binary individuals.

4. This study seeks to represent accounts of all individuals with a uterus, outlining that all individuals do not experience reproductive health in a uniform manner. Thus, this phrasing indicates to participants that the study is not about gender but seeks to include diverse gender experiences about those that use ob-gyn services. This is also a concept included in intersectionality theory, a major theory driving this study.[155] "Students with uteruses" follows person-centered language, removing wording that assigns gender to any individual interested in this study.[319]

5. If we were to use "any gender diverse person born with a uterus", this would also include transmasculine individuals that have had their uterus, ovaries, etc. removed and may not have a need for ob-gyn services.

Appendix 3. Participant Information Letter

Background/Purpose:

You are being asked to participate in a research study as a Canadian or American university student with a uterus to discuss your experience in receiving reproductive healthcare. Please take your time to make your decision and ask the researcher to explain anything that you do not understand.

People with uteruses make health choices and use health services differently than those with male reproductive systems. Talking with providers plays a large role in making informed health choices. A positive experience in healthcare can be influenced by practices and policy of a larger health system. The purpose of this study is to compare the perceptions and experiences of diverse University patients in both Canada and the United States as they use these health systems. The results of this study will be used to find approaches that improve patients' individual reproductive health decisions so that we can apply best practices and policies in both Canada and the United States.

The School of Public Health and Health Systems at University of Waterloo takes on a diverse set of research issues that impact the health of Canadian and global citizens. This project is sponsored by a HeForShe Equity Grant. **This research is <u>not</u> affiliated with any external institutions/facilities used for interview locations.**

Forty (40) University students are expected to participate in this survey and interview-based research study. We will interview 20 key experts in reproductive health policy in Canada and the US.

Study Procedures:

If you choose to participate, we ask for about 40 minutes of your time. First, you will answer a survey that will take about 10 minutes. Then you will participate in a private interview of about 30 minutes in length. The interview will take place on a video conference platform comfortable and accessible to you and the researcher. Interviews will be conducted by Nicole Richards, a PhD student at University of Waterloo.

The survey will ask questions about interactions and procedures you may or may not experience at your reproductive health appointments. During the interview I will ask some questions about these experiences and perceptions of these appointments. If you have any concerns or decide you don't want to participate anymore, you may choose to not respond to particular questions, and you may leave at any time.

Risks/Discomforts:

The risks involved with participating in this study are:

- **Discomfort:** You may experience discomfort talking about your personal experience with private reproductive health experiences. **Participants are free to withdraw at any time**
- **Privacy*:*** Participants are potentially risking their privacy through their participation, audio recording, and transcription of the interview. **Researchers will protect participant information by storing data in a locked filing cabinet, password protected computer, and only requires verbal consent to further protect your identity.** When information is transmitted over the internet privacy cannot be guaranteed. 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.**
- Answering study questions should not pose any risk to you.

Benefits:

There is not an immediate benefit to you for agreeing to participate in this study. The information gained from this research may be used to help improve future patient-provider interactions and reproductive health navigation.

Future Use:

The information you share here may be used in future health research by this study team after the conclusion of this project. This data may be used in uncovering emergent information and used to develop further research questions

Voluntary Participation:

Your participation in this study is voluntary and you may stop participation at any time without penalty.

Alternatives:

If you decide not to participate in this study, you will not be contacted again about the study. If you decide to discontinue participation, you will be given $20 CAD (e-transfer) or $15 USD (Venmo) at the time you leave.

Will I receive anything for my time?:

You will receive $20 CAD or $15 USD in appreciation of your time.

The amount received is taxable. It is your responsibility to report this amount for income tax purposes

Questions:

If you have any questions or comments about the research or your participation, please contact Nicole Richards (N6richar@Uwaterloo.ca), Frank Arocha (JfArocha@Uwaterloo.ca).

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# 41355) 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.

Confidentiality of Records for Research:

If you agree to participate in this research, the survey will be collected and kept in a locked filing cabinet. The interview conversations will be audio recorded and will be used to make a transcript of the conversation. Only the research team will have access to the surveys and transcripts.

We will remove all information that could identify you from the data we have collected within one year and delete it permanently. You can withdraw your consent to participate and have your data destroyed by contacting us within this time period. After this time, it is not possible to withdraw your consent to participate as we have no way of knowing which responses are yours. Additionally, you will not be able to withdraw consent once papers and publications have been submitted to publishers. Only those associated with this study will have access to these records which are secured by a password protected computer. We will keep our study records for a minimum of seven years. All records are destroyed according to University of Waterloo policy.

Thank you for volunteering to be part of this study.

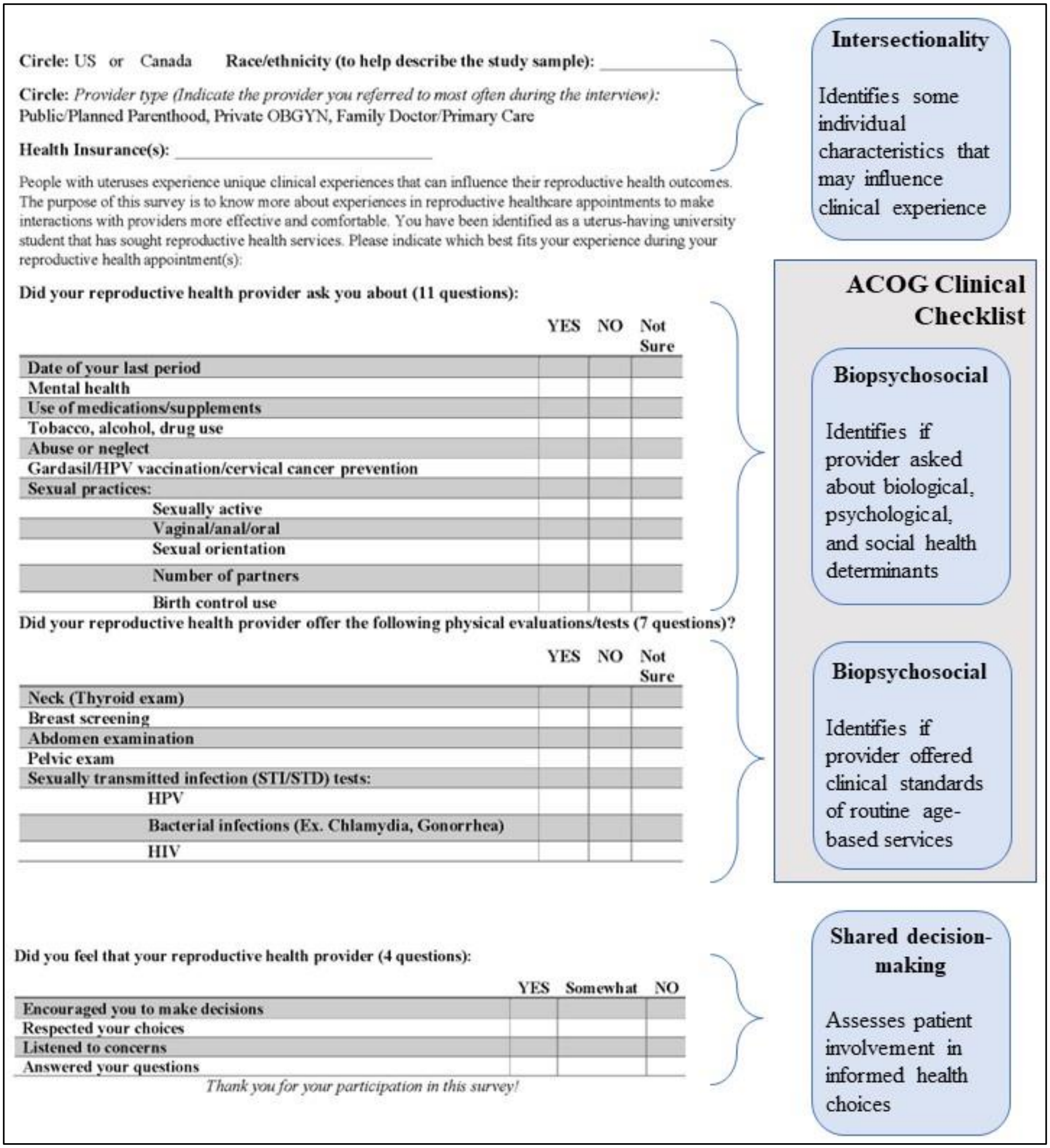
Appendix 4. University Student Interview Guide Rationale

*INT – Intersectionality Theory; EAM = Equitable Access Model; PC=Person-Centeredness

Interview Questions	Theory*	Application
How would you describe yourself? **a. Your background** **b. Your culture and beliefs** **c. Your position in the world**	INT	Gives researcher an idea of participant's intersecting identities, how they see themselves, and general life experiences that relate to these self-identities.
	EAM	_______
	PC	_______
Can you give me an overview of what "reproductive rights" mean to you? **a. How would you go about exercising these rights?**	INT	Shows understanding of rights and ability to use resources based on self-identity. E.g., a homosexual student may not perceive high pregnancy risk
	EAM	Elicits knowledge of potential structural and personal barriers.
	PC	_______
Referring to how you described yourself as [characteristics mentioned], can you identify how the healthcare system impacts you specifically? **a. Finding a provider and making an appointment?** **b. Reproductive services or options you weren't able to access?**	INT	Can identify ways health policies/protocols support or hinder access to identity-related services.
	EAM	Informs researcher of possible connections between reported identities and barriers to care.
	PC	Informs researcher of possible connections between identities and addressing personal health preferences/needs.
Can you walk me through your typical reproductive health appointment? **a. What is good about this experience?** **b. What don't you like about this experience?**	INT	Empowers participant to identify what they value in their health experience. These answers may differ based on their background.
	EAM	______
	PC	Gives information about what person-centered care means for the individual. Assesses the clinical experience process.
How would you describe your relationship with your reproductive health provider?	INT	Uncovers identity-related aspects of rapport, support, respect, and comfort.
	EAM	______

a. Anything that they have said or done that made an impression on you? **b. How do other health workers affect your experience?**	PC	Delves deeper into patient-provider communication, shared decision-making, and biopsychosocial considerations.
In what ways do you feel your reproductive health appointment influences your overall wellbeing? **a. Offer services that impact your life?** **b. Help you make health decisions?**	INT	Connects reproductive health to holistic wellbeing. Shows how they are impacted by these services.
	EAM	Can identify how the clinical experience influences patients' personal health barriers.
	PC	Can identify clinical impact on services, treatments, and external resources appropriate for the individual.
Can you tell me how any other factors influence your reproductive health choices? a. **Any sex education?** b. **Things you see as limiting or allowing you to make decisions?**	INT	Steps outside of clinical setting, includes healthcare as a construct within larger society.
	EAM	Identifies potential barriers/facilitators to seeking care (structural, financial, personal).
	PC	Identifies societal role in accessing person-centered health options.
Please speak about what your overall message is to people who design how you access/receive reproductive health care. a. **If you could ask them to make changes to what services you receive, or how you receive those services, what would you say to them?**	INT	Invites participant to voice what is important to them and advocate for their own needs.
	EAM	Highlights participants' most prominent barrier to seeking reproductive care.
	PC	Highlights participants' most prominent barrier to receiving perceived quality person-centered care.

Appendix 5. Survey Tool Rationale



Circle: US or Canada **Race/ethnicity (to help describe the study sample):** ____________

Circle: *Provider type (Indicate the provider you referred to most often during the interview):*
Public/Planned Parenthood, Private OBGYN, Family Doctor/Primary Care

Health Insurance(s): ______________________

Intersectionality

Identifies some individual characteristics that may influence clinical experience

People with uteruses experience unique clinical experiences that can influence their reproductive health outcomes. The purpose of this survey is to know more about experiences in reproductive healthcare appointments to make interactions with providers more effective and comfortable. You have been identified as a uterus-having university student that has sought reproductive health services. Please indicate which best fits your experience during your reproductive health appointment(s):

ACOG Clinical Checklist

Did your reproductive health provider ask you about (11 questions):

	YES	NO	Not Sure
Date of your last period			
Mental health			
Use of medications/supplements			
Tobacco, alcohol, drug use			
Abuse or neglect			
Gardasil/HPV vaccination/cervical cancer prevention			
Sexual practices:			
Sexually active			
Vaginal/anal/oral			
Sexual orientation			
Number of partners			
Birth control use			

Biopsychosocial

Identifies if provider asked about biological, psychological, and social health determinants

Did your reproductive health provider offer the following physical evaluations/tests (7 questions)?

	YES	NO	Not Sure
Neck (Thyroid exam)			
Breast screening			
Abdomen examination			
Pelvic exam			
Sexually transmitted infection (STI/STD) tests:			
HPV			
Bacterial infections (Ex. Chlamydia, Gonorrhea)			
HIV			

Biopsychosocial

Identifies if provider offered clinical standards of routine age-based services

Did you feel that your reproductive health provider (4 questions):

	YES	Somewhat	NO
Encouraged you to make decisions			
Respected your choices			
Listened to concerns			
Answered your questions			

Thank you for your participation in this survey!

Shared decision-making

Assesses patient involvement in informed health choices

Appendix 6. Key Informant Interview Guide Rationale

*INT – Intersectionality Theory; EAM = Equitable Access Model; PC=Person-Centeredness

Interview Questions	Theory*	Application
How would you describe your individual role in reproductive rights and/or reproductive health?	INT EAM	Identifies KI values and experiences, elicits personal and professional background related to reproductive health equity
Reproductive health policy has been cited as providing good intentions but lacks actionable steps toward equity and quality. What do you think about this? **a. How does this fit within your field?** **b. What would you like to see changed to address this?**	INT EAM	Seeks professional insight on policy and actionable approaches to promote equity.
University students mentioned having difficulty navigating health services and treatment options. Can you speak to your knowledge about barriers to solving these problems?	INT EAM PC	Invites KI to identify demographic groups and services which may need improvements in health system usability.
Participants generally talked about experiencing pelvic/menstrual pain, valuing controlling their fertility, and the importance of STI testing. **a. Thinking about policy, how does access to preferred options differ for patients in [country]? (i.e., age, coverage, geographic, race)** **b. Can you describe any ways you know can increase access to a wide variety of contraceptive options?** **c. What are your thoughts on current access to pelvic pain solutions?**	INT EAM PC	Connects KI expertise to student concerns based on interrelated identities, health needs, and services availability.
Participants talked about differences in receiving reproductive health services from their family doctor versus a gynecologist. What do you know about these differences and how they may impact reproductive autonomy/health?	EAM	Invites KI to assess equitable access through the quality mediator through an expert lens.
The women I talked to were all university students. How might non-students' health care navigation differ? Any different or additional barriers to accessing reproductive healthcare?	INT EAM PC	Opens discussion to policies related to lived experience, health equity, and concepts of person-centeredness.

Appendix 7. Participant Narrative Summaries

Participant 1 (P1)

Identities and Background: P1 identified as a middle-class heterosexual, cisgender, Hispanic white woman residing and attending university in Ontario, Canada. She noted that she may not physically present as Hispanic to others. She described a close relationship with her mother who has frequently attended reproductive health appointments with her. P1 reported using the Ontario Health Insurance Plan (OHIP) for her healthcare needs, including reproductive care for polycystic ovarian syndrome (PCOS) and pregnancy prevention.

Reproductive Healthcare Experience: P1 was diagnosed with PCOS after heavy, inconsistent menstruation. P1 sees her family physician for reproductive care and also uses her university's health clinic during school terms due to her frequent reproductive health needs. Her family physician prescribed birth control pills, however, P1 reported not using this medication until she became sexually active. Though she stated she had a positive relationship with her family provider's practice, P1 felt that her provider has not adequately informed her about her PCOS diagnosis and treatment side effects, nor has she received sufficient follow-up after her appointments. In addition to these clinical experiences, P1 was concerned that her provider assumed her sexuality and misdocumented her ethnicity.

Participant 2 (P2)

Identities and Background: P2 described herself as a first-generation immigrant heterosexual woman from a South Asian culture attending university in Ontario, Canada. She mentioned that reproductive health is an unmentionable topic in her family and culture. Due to her parent's limited English proficiency, she has been helping her family navigate Canadian life, including healthcare, from a young age. Despite her experience navigating health services, P2 reports feeling she could improve her ability to self-advocate in the clinical setting, especially with her care plan for PCOS.

Reproductive Healthcare Experience: P2 has both a family provider and gynecologist. Her family doctor serves as a care coordinator, including prescribing birth control to manage PCOS symptoms. Her parents accompany her to appointments, but the provider asks them to leave the room when discussing sexually natured topics. P2's gynecologist's role is to perform specialized screenings, tests, and patient counseling. Throughout the interview, P2 advocated for more culturally appropriate health services, including cultural knowledge and language translation resources.

Participant 3 (P3)

Identities and Background: P3 described herself as a heterosexual, cisgender, East Asian-Canadian female currently attending University in Ontario, Canada. Her family is conservative about sexual and reproductive health, and reported that being a university student has enabled her to engage with healthcare outside her family dynamic. P3 has used reproductive health services for frequent urinary tract infection treatment and pregnancy prevention.

Reproductive Healthcare Experience: While she has a close relationship with her long-time family doctor, she feels uncomfortable discussing sexual health with him. Therefore, she uses the university health clinic for birth control pill prescriptions. P3 discussed the process of researching and choosing a contraception method by herself, preparing for her appointment, and leading the patient-provider conversation. While P3 reported no structural barriers to reproductive healthcare, she felt that her clinical experiences have not been comprehensive or engaging.

Participant 4 (P4)

Identities and Background: P4 described herself as a heterosexual, cisgender white woman currently attending university in Ontario, Canada. She reported having complex health issues both related and unrelated to reproductive health that inhibit her quality of life. Due to her frequent health concerns, family and friends dismiss her complaints which discourages and delays her from seeking medical care. P4 suffered from painful menstruation before being diagnosed with mild endometriosis and a retroverted uterus.

Reproductive Healthcare Experience: P4 uses a family provider and gynecology services for her reproductive health. She stated that her family provider does not believe her health complaints and she commonly needs to advocate for further investigation. However, she feels limited in her ability to establish care with a new family provider. Her family provider refused to prescribe birth control and referred her to gynecologist. The gynecologist recommended and inserted an Intrauterine Device (IUD). P4 described pain both during and months after insertion, yet she reported her gynecologist would not remove the IUD because an ultrasound showed it was placed correctly. P4 was referred to another gynecologist in her university's town who discovered she had a retroverted uterus and mild endometriosis, removed the IUD, prescribed birth control pills, and referred her for surgery. Though P4 felt satisfied with where her care was during the time of the interview, she was nervous about future birth control prescription coverage after graduating and aging out of OHIP+ coverage.

Participant 5 (P5)

Identities and Background: P5 described herself as a South Asian Canadian heterosexual cisgender woman attending university in Ontario, Canada. She reported having a candid relationship with her mother. Both of her parents are health workers providing a middle-high family income and contributing to P5's high health literacy and efficacy. However, she reflected on the stigmatizing nature of her sexual education and felt that it contributed to her low risk perception of both contracting STIs and the severity of their consequences. P5 disclosed that she has a chronic sexually transmitted infection that requires lifestyle behavior maintenance.

Reproductive Healthcare Experience: P5 has received reproductive health services from her family provider, dermatologist, and university clinic. She has a strong relationship with her family doctor and reported comfortable discussions surrounding reproductive and sexual health. P5 experienced sexually transmitted infection (STI) symptoms but delayed medical care for two months. Her family provider referred her to dermatologist, thinking these symptoms may be a skin condition. P5 waited another two months for her dermatologist appointment where they confirmed an STI diagnosis.

Participant 6 (P6)

Identities and Background: P6 self-identified as a heterosexual cisgender white rural Canadian woman attending university in her home province of Ontario. She told her reproductive health story through an empowered lens, feeling reciprocal support from her social network that encourages preventive sexual behaviors and appointments. She is comfortable informally discussing sexual and reproductive health with her family, especially her mother. P6 reported using reproductive healthcare for pregnancy prevention and STI testing, and used birth control pills prior to getting an IUD.

Reproductive Healthcare Experience: P6 remembered being anxious when she started receiving reproductive care at age 17 but has become more comfortable with reproductive health appointments over time. Her previous provider established rapport and credibility through a genuine and holistic approach, but P6 now attends appointments at her university clinic. She expressed feeling pressure to perform well as a patient by preparing concise effective conversations that fit within the clinic's 15-minute appointment slot.

Participant 7 (P7)

Identities and Background: P7 described herself as a cisgender heterosexual South Asian Canadian woman attending university in Ontario. Coming from a culturally conservative family, she discussed her family as a barrier to sexual health knowledge and reproductive healthcare access during her teenage years. She also reported her high school's curriculum lacked adequate sexual education. P7 was diagnosed with PCOS after experiencing irregular menstruation.

Reproductive Healthcare Experience: P7 has felt anxious when preparing for and engaging in reproductive health appointments, and often delays her reproductive concerns. She did not start seeking reproductive services until she started university and now uses her student clinic for all health needs. She uses birth control pills to regulate her cycle and is comfortable with a female provider who P7 felt had specialized gynecology knowledge. While being a university student increased her perception of confidential reproductive health behaviors and appointments, P7 has found it difficult to make time and effort towards non-urgent health issues such as reproductive health.

Participant 8 (P8)

Identities and Background: P8 self-identified as a cisgender pansexual urban white woman attending university in Ontario, Canada. She reported being self-directed in her beliefs but values her friends' reproductive health experiences and opinions. However, she has been more cautious when considering her family's traditional conservative values. P8 described having hormone imbalance causing painful menstruation.

Reproductive Healthcare Experience: In addition to preventive reproductive health appointments with her family doctor, P8 has used ultrasound and bloodwork services to investigate the cause of her hormone imbalance. While she described an uncomfortable relationship with her previous older family provider, she expressed a more candid experience with her current physician. P8 stated she always has initiated sexual and reproductive health conversations but feels her family doctor is experienced in reproductive health knowledge and actively works to find solutions.

Participant 9 (P9)

Identities and Background: P9 self-identified as an urban East Asian Canadian cisgender heterosexual woman attending university in her home province of Ontario. She was raised in a catholic family and attended catholic school which she reported hindered her reproductive health literacy and ability to self-advocate in her patient-provider interactions. Though she lacked sexual education and general healthcare knowledge, she has worked to improve her ability to seek reproductive health answers. She reported not having any chronic reproductive health issues and has used reproductive services for pregnancy prevention and urinary tract infection treatment.

Reproductive Healthcare Experience: Overall, P9 reported that she has positive experiences with reproductive care. She has used her university's health clinic and found her appointments to be fast and efficient. However, she felt providers did not educate and engage her in contraception method decisions. P9 recounted a time when she was honest about having unprotected sex and her provider pushed her to take emergency contraception (EC) without education and shared decision making. She expressed the additional burden that she feels as a heterosexual woman, taking time for appointments and paying for birth control despite her partner(s) also contributing to pregnancy risk.

Participant 10 (P10)

Identities and Background: P10 described herself as a low-income, Hispanic American cisgender heterosexual woman from urban Illinois attending a private university in New York. She did not know what insurance plan she had but after discussing different insurance plan types, eligibility, and mechanisms of healthcare navigation, we deduced that she is a dependent on her parents' Medicaid health insurance plan. P10 comes from a catholic family that values abstinence but learned about condoms and STIs in what she described as a basic high school sexual education unit in gym class. While she does not discuss reproductive and sexual health with her family, she values her friends as a reproductive health information source. P10 uses reproductive services for pregnancy prevention.

Reproductive Healthcare Experience: P10 reported not yet having to use health services in New York since she has not had any major health concerns during academic terms. When P10 is not at university, she has seen both a primary care provider and gynecologist for reproductive care. She felt her primary care provider did not listen to her health concerns, and she was not properly educated or supported when she initiated contraception conversations. P10 struggled finding an in-network gynecologist appointment prior to returning to New York for the academic term. She found a gynecologist that agreed to see her outside of standard office hours for a contraceptive implant insertion. Yet, P10 felt the gynecologist did not provide sufficient information about the procedure or the implant's potential side effects.

Participant 11 (P11)

Identities and Background: P11 is an out-of-state student at a private university in New York. She describes herself as a cisgender suburban white American woman coming from a liberal area. She attributed having access to reproductive healthcare and knowledge to her mother being a well-connected doctor in her home city. P11 reported having high reproductive health literacy and is comfortable accessing care, citing a strong social network with feminist values. Her health costs are covered under parental insurance when she is home, but also purchased her university's health insurance to use health services in New York. She has a long history of debilitating menstrual pain and was diagnosed with pre-menstrual dysphoric disorder (PMDD).

Reproductive Healthcare Experience: P11 reported multiple poor patient experiences and barriers to quality care. She received her PMDD diagnosis after seeking care from gynecologists in both her home state and New York. She described the diagnosing gynecologist as a "top doctor in New York" who effectively treated her condition by prescribing both birth control pills and inserting a hormonal IUD. P11 recalled that the IUD insertion was painful and was not adequately informed about the process, including consent to a trial approach of using misoprostol to dilate the cervix prior to insertion.

Participant 12 (P12)

Identities and Background: P12 self-identified as a cisgender heterosexual white American woman attending a private New York university as an out-of-state student. Coming from a low-income family, she chose not to buy health insurance coverage while at university due to the high cost. However, she is a dependent on her mother's health insurance plan in her state of residence.

Reproductive Healthcare Experience: During academic terms, P12 mentioned preventing and self-treating health issues through lifestyle choices and stocking medications and supplements. While she can access prescription refills and emergency services out-of-state, she is unable to receive new prescriptions until she attends an in-person health appointment with her provider. She has also used an online nurse hotline but decided that was not a reliable resource after a nurse misinformed her about her contraceptive implant's side effects.

P12 organizes preventive health appointments during university breaks. She chose the contraceptive implant so that she only had to coordinate reinsertion every three years. Since her primary care office has an interdisciplinary team of providers, her implant can be inserted at her primary care appointment. While much of P12's interview focused around navigating her general healthcare needs as an out-of-state student, she advocated for reproductive health as a component of holistic wellbeing.

Participant 13 (P13)

Identities and Background: P13 self-identified as an international Chinese graduate student attending a private university in New York. She described herself as cisgender, heteronormative, and from a conservative culture and family. She struggled to talk about her perception of reproductive rights, explaining that she had no sexual experience or education, and her culture stigmatized talking about sexuality and reproduction. However, she noted that moving away from her culture and family provided individual growth and privacy to manage her lifestyle and health choices. While in the United States, she has university-based insurance which she pays for in addition to tuition and housing. P13 reported irregular menstruation and has sought care for this issue.

Reproductive Healthcare Experience: P13 discussed having heavy menstruation problems in China which were diagnosed as a psychological issue and treated with medication and herbal supplements. Her menstruation became infrequent and irregular once she moved to the United States, and she sought reproductive care at her university clinic. The university provider attributed her irregular menses to stress and lifestyle changes, offering her information how to improve sleep, but did not offer any medication. Other than accessing her university clinic a few times, P13 did not have experience using the US healthcare system.

Participant 14 (P14)

Identities and Background: P14 described herself as a rural white cisgender heterosexual woman attending university in an urban New York university. While she remained in her home state for higher education, moving to an urban university empowered her to express her opinions, including reproductive rights. She discussed not having high school sexual education in way that centered sexuality and informed decisions. Instead, health classes taught the science behind STIs and pregnancy through a stigmatizing narrative. P14 also grew up with Christian values and parents that initiated and attended her teenage health appointments. She uses her mother's insurance, but has never used health services while at university. Instead, her mother would contact P14's providers and coordinate sending her medications. P14 felt she does not have the skills or knowledge to access a gynecologist. She reported not having chronic reproductive conditions and used reproductive services for pregnancy prevention.

Reproductive Healthcare Experience: P14 has only attended one reproductive health appointment with a gynecologist. Since she aged out of her pediatric primary care provider, P14 has not established care with an adult general physician. P14 recalls being nervous and embarrassed for her gynecology appointment because she felt she should have established gynecological care prior to her age and sexual experience. During her contraception counseling appointment, the gynecologist insulted her weight, immediately noting that an IUD would not be effective for her size and indicated that birth control pills were her only option. P14 was using birth control pills but stopped after experiencing mental health issues and seeing others on the internet testify that they feel better after not using pills.

Participant 15 (P15)

Identities and Background: P15 self-identified as a biracial cisgender Canadian woman with a Caribbean immigrant father and white Canada-born mother. She attributed her family support within their middle class means to many of her successes, including encouraging education and helping navigate healthcare. In addition to valuing her mother's health knowledge as a nurse, P15 discussed having frequent health conversations with friends. P15 attended a catholic school with abstinence only education. She spoke with high general health literacy but struggled with terms like "birth control/contraception" and other terms related to reproductive health. She also stated she does not have very complex health needs, and only uses reproductive health services for pregnancy prevention and STI testing.

Reproductive Healthcare Experience: P15 has had the same family doctor since she can remember. In addition to the welcoming familiarity during her appointments, P15's provider has an online portal and emails health information links to patients periodically. She has felt that her provider actively educates and involves her in decision making. P15 advocated for the need to reframe Canadian reproductive health to a proactive approach rather than only providing care as a reaction to a patient's acute needs.

Participant 16 (P16)

Identities and Background: P16 self-identified as white lesbian-queer American without a categorical description for their gender identity. They are an out-of-state PhD student at a private New York university using university-based health insurance. P16 is from rural Midwest and discussed abstinence-only high school sexual education as limiting their understanding of sexuality and reproductive health. Despite the culture described in her hometown, they felt that they had a supportive candid relationship with their family. Once they attended university, P16 began to seek sexual education and found social connections through LGBTQI+ community involvement. While P16 does not have pregnancy prevention needs, they have used contraception to manage menstrual pain. They also have a bicornuate uterus, which is an abnormally "heart shaped" uterus that limited their contraceptive method options.

Reproductive Healthcare Experience: Though P16 has had both favorable and unfavorable interactions with providers, they do not feel health institutions are equipped to provide for patients outside the cisgender heteronormative scope. For example, P16 went to a private gynecologist that told them to go to a woman's health center, which made them feel they were too complex for the gynecologist to learn and serve a patient that was not a cisgender woman. P16 shared their frustration of wanting a hysterectomy and being dismissed by several providers that have told them they are too young, despite their attempts to self-advocate. P16 then sought care at a LGBTQ health office and cited this as a much better experience with more flexible ways to make appointments, affirming language, gynecology knowledge outside the cisgender binary. P16 has experienced painful Pap smears due to vaginal muscle contraction, often hindering viability of samples. The LGBTQ center was the first to offer person-centered Pap smear methods such as prescribing estrogen cream to soften the vaginal lining, allow self-insertion of the speculum, and offered an at-home HPV test. P16 reported satisfaction with actively participating and having control of their own health. They also have their transgender partner on their insurance which covered over half of the cost for transmasculine chest reconstruction.

Participant 17 (P17)

Identities and Background: P17 describes herself as a white cisgender bisexual Canadian attending teachers' college in Ontario. She attended public schools until grade nine when she transferred to a catholic high school. Her public school sexual education taught a comprehensive list of contraception methods, but her catholic school education was abstinence-only. She emphasizes valuing supportive relationships with family and friends, and feels comfortable having sexual and reproductive health conversations with both. P17 has accessed reproductive care for pregnancy prevention, cancer screenings, and STI testing.

Reproductive Healthcare Experience: P17 has seen both family and gynecology providers for reproductive care. She found reproductive health appointments with her ob-gyn more comfortable than with her family provider. However, P17 mentioned her family providers' holistic considerations to reproductive health, offering contraception when she was taking dermatology medications that may negatively impact a fetus. While her gynecologist created a welcoming and communicative environment during the appointment, P17 reflected on the office's approach to STI test results, which she described as "no contact is good contact". P17 experienced many hurdles in accessing her preferred IUD contraception method due to the referral process, moving, and an ob-gyn office's policy requiring the procedure at a particular stage of her menstrual cycle. She arrived at the pharmacy to pick up her preferred brand device, but it was not covered by OHIP+. Therefore, she was limited to the brand that was covered.

Participant 18 (P18)

Identities and Background: P18 described herself as a white cisgender heterosexual American woman from a rural Midwest Mormon community attending a Master's program at a public New York university. P18's high school sexual education only involved anatomy and she did not learn about social and medical aspects sexuality and reproduction until university. She finds support and reproductive health knowledge through peers such as other women who have left the Mormon church. P18 reflected on a man sexually assaulting her and discussed her culture's role in permitting misogynistic and abusive behavior. After the assault, she decided to graduate high school early and leave for university. She was married at a young age and has periodically moved throughout the United States due to her husband's career requirements. During her time as a university student, she has used parental, university, and employer-based health insurances but only discussed her reproductive healthcare while using parental-based insurance as an in-state university student. P18 has accessed reproductive care for contraceptive shots and IUD, surgical abortion, and STI testing.

Reproductive Healthcare Experience: P18 has received all reproductive care at Planned Parenthood and paid out-of-pocket while she was a dependent on her father's insurance to avoid breaching confidentiality. She first decided to get the Depo-Provera contraception injection at age 17 and discontinued using after experiencing negative side effects. P18 became pregnant two years later and had a surgical abortion in Utah. She chose to have an ultrasound at four weeks gestation and waited 72 hours until the procedure due to Utah law at the time. Since she was not using health insurance, she and her partner paid $500 for the procedure but could not afford and additional $350 for anesthetics. She asked for immediate IUD placement which was performed by trainee provider to decrease the cost of the procedure. P18 recalled feeling nauseous after her abortion and immediate IUD insertion but described a comfortable recovery room where she waited for the required 30 minutes until the doctor assessed her bleeding level. She described the providers as sweet and understanding, but other staff made the process "feel like a conveyer belt". She felt that the providers communicated well during the procedure and informed her of the proper steps for at-home recovery. P18 recently removed her IUD after 6.5 years because she is ready to have children.

Participant 19 (P19)

Identities and Background: P19 self-identified as a cisgender heterosexual African-Filipino American attending a public university in California. Since she comes from a low-income family, she uses California's publicly funded Medicaid health insurance. While P19 frequently changed school districts throughout Florida, she describes sexual education as outside organizations visiting her schools to focus on reducing teen pregnancy. When she moved to a California charter school, she noticed the curriculum was more scientific without education about services, personal health, and wellness. P19 has a close relationship with her younger sister and frequently shares reproductive and sexual knowledge with her. She also discussed her mother's role in reproductive health advice and cultural remedies that have been passed around her female family members. P19 has previously tried using birth control and herbal medicine to manage menstrual pain with no success. She currently uses contraception for pregnancy prevention.

Reproductive Healthcare Experience: P19 usually sees her primary care provider for reproductive health but has also received care from ob-gyn providers. She reported a negative first reproductive healthcare interaction at age 16 when she first sought solutions to menstrual pain. She disclosed that a male gynecologist performed a vaginal exam with his finger without proper communication and consent. This made her uncomfortable and reported it has negatively impacted her ability to engage with reproductive healthcare. She has tried to manage her pain with birth control pills since she was a young teenager but reported not adhering when she felt that they did not help. After years of menstrual pain, P19 was recently referred to a gynecologist for an external ultrasound. Since the external ultrasound did not identify any irregularities, her primary care provider has encouraged her to get an internal ultrasound. However, P19 reported being hesitant to get an internal ultrasound due to her previous vaginal screening experience and the invasiveness of this procedure.

Participant 20 (P20)

Identities and Background: P20 described herself as a white cisgender bisexual middle-income woman from Michigan, and an out-of-state PhD student at a public Florida university. She mentioned a close relationship with her mother and sister, sharing reproductive health information and how to navigate reproductive healthcare within their family's insurance network. P20 purchased her university-based insurance when she moved to Florida and uses that coverage for pregnancy prevention services.

Reproductive Healthcare Experience: P20's primary care provider first prescribed birth control pills for acne at age 11, and she has used several brands over the years as she struggled with side effects and began using contraception for pregnancy prevention. P20's mother was hesitant to vaccinate her against HPV due to it being new at the time she was eligible. However, P20 was diagnosed with HPV when she had her first Pap smear at the recommended age of 21. She then needed annual Pap smears with a gynecologist for three years before her cervix cells returned to normal.

Before moving to Florida, P20's gynecologist prescribed three months of her birth control pills while she transitioned to a new provider. She now uses her university's health clinic due to proximity and insurance access, but stated that they only have a gynecologist at the clinic one day per week. She decided to change contraception methods and chose the IUD. P20 reflected on the perfect timing of receiving a low-maintenance, long-acting contraception method just prior to COVID-19's health system strain and inaccessible elective procedures.

Participant 21 (P21)

Identities and Background: P21 described himself as a rural white transmasculine nonbinary individual using He/They pronouns. They identified as a member of the queer community and attends public university in an urban area of his home state of Maryland. He discussed his high school sexual education as self-directed and textbook-based. P21 recalled that the teacher was not permitted to talk about topics like birth control and the curriculum lacked information about LGBTQI+ and social aspects of sexual and reproductive health. P21 discussed the LGBTQI+ community as a major support and information source relating to navigating sexuality, likeminded values, and health resources. The university setting broadened these communities and his knowledge, being in a structured situation with diverse individuals on-campus and throughout an urban area. In addition, they mention their mother as a key player in their healthcare access, using her healthcare job as a resource to find transgender appropriate providers and financially supporting him through parental-based health insurance. P21 uses reproductive services for his hormone replacement therapy (HRT).

Reproductive Healthcare Experience: P21 illustrated the process of beginning HRT, first seeking testosterone at age 17 and starting HRT at 20 after experiencing combined health insurance and provider barriers. They have seen three different HRT providers within 2.5 years, including two midwives that had moved to other practices and now a university clinic primary care provider. He supplements his testosterone prescriptions with psychological health services, attending frequent appointments with a gender therapist for gender dysphoria. P21 plans to get transmasculine chest reconstruction but cites the surgical insurance copayment as a financial barrier. Overall, P21 stated that his HRT providers have involved him and attempted to make him feel comfortable in the clinical setting. However, they felt their primary care provider is not adequately trained to serve gender non-conforming patients. P21 reported that this provider fails to account for differences in his personal experience compared to a cis-gendered patient. For example, his primary provider has asked about his last period without consideration that they do not have a period due to HRT, has referred him to a woman's health center, and generally exhibits subtle stigmatizing behavior. P21 does not use women's health or gynecology clinics because he feels that he makes cisgender patients and providers uncomfortable by invading a "women-only" space.

Participant 22 (P22)

Identities and Background: P22 described themself as an urban Filipino queer non-binary individual (she/they) living and attending public university in California. Coming from a low-income immigrant family, she sometimes did not have health insurance or used California's Medicaid plan. They are now required to have health insurance through their university. Their family and community values cultural remedies and rarely seek healthcare services. P22 discussed her home community's role in sharing health information and resources, and the importance of trust in health provider-community member relationships. Her family did not discuss reproductive health and they describe their high school sexual education as "surface-level". They have not disclosed their gender and preferred name to her family or community due to traditional cultural norms. P22 describes the university setting as a safe space to discover their sexuality, learn more about reproductive health, and gain experience using healthcare. In addition to menstrual pain management, P22 uses reproductive health services for pregnancy prevention.

Reproductive Healthcare Experience: P22 now sees a university health clinic provider for her reproductive health needs. They chose the contraceptive implant because it was low-maintenance and caused less frequent, lighter menstruation. While she is content with her current health provider, she sometimes does not understand when they use medical terms and concepts. However, they report having the agency to ask the provider to reframe the information at her literacy level. Though the clinic's patient forms ask about pronouns and preferred name, their provider often use P22's legal name instead. When she sought care for irregular menstruation, their provider suggested that situational stress may have been the cause of these irregularities and recommended psychological counseling.

Key Informant Narratives

Key informant one (KI1) is a Canadian grassroots abortion rights advocate. Coming from a religious culture, KI1 reflected on her reproductive care access experiences, and how Canada's reproductive-related policies have been proposed and changed since 1988. KI1 has taken on multiple abortion access roles in the US and Canada. Further, she continues to expand her scope to support other reproductive health issues. KI1's major Canadian reproductive health concerns included contraception coverage and availability, transgender care, geographic and cultural healthcare barriers, provider cultural safety, and preventing anti-abortion policies.

Key informant two (KI2) is a sexual health policy analyst and serves as an abortion doula connecting individuals with abortion services. Her combined roles give her a unique insight into the disconnect between the policy and clinical levels. KI2's reproductive health concerns in Canada include comprehensive sexuality education, healthcare users' information about existing services, supports, and patient rights. Further, KI2 discussed Canada's failure to capture race-based data and low political will for reproductive health improvements.

Key informant three (KI3) is a Canadian lawyer advocating for anti-abortion laws. She was motivated to do this work after observing others' struggles after pregnancy termination. KI3's focuses on mobilizing citizens and lobbying the Canadian government for abortion limitations. While KI3 supported full access to contraception, she did not believe contraception access reduces abortion rates. KI3 seeks a holistic reproductive health approach, including emotional, physical, and social wellbeing. Overall, KI3 advocated for supporting those with unplanned pregnancies through social programs to mitigate reasons to choose termination.

Key informant four (KI4) is an abortion fund organization leader supporting abortion access in the US. KI4 resonated with community-based abortion work due to their own othered identities. Rather than focusing solely on policy determinants of abortion access, KI4 aims to mitigate barriers by directly interacting with those needing care through funding, transportation, and education. They discuss the importance of individuals' knowledge about local reproductive health laws, clinic locations, and patient rights. They stressed the importance of person-centered and authentic communication that broke down power dynamics and validated identities.

Key informant five (KI5) is a US Ob-gyn doctor committed to inclusive reproductive care, having specialized training in family planning and LGBTQI+ populations. KI5 is part of her profession's political action group where she contacts legislators to support reproductive health policy protections. She leverages her expertise to advocate within the clinical setting and in her community. KI5's primary concerns surround lack of insurance coverage for a broad range of patient needs, inadequate training and knowledge surrounding marginalized patients, and creating a safe space according to patient identities and backgrounds.

Glossary

Genderqueer – Individuals who do not subscribe to the cisgender binary of AMAB/man/masculine and AFAB/woman/feminine. Includes transgender, non-binary, genderfluid, agender, intergender, xenogender, demigender, two-spirit (Indigenous-only), and more.

Gynecology – This thesis defines gynecology as the field of medicine focusing on specific health prevention and treatment related to the female biological reproductive system, including overlapping components of endocrinology, oncology, and urology. Gynecology does not include obstetric care.

Long-Acting Reversable Contraception (LARC) – Effective and long-lasting (3 – 12 years) low-maintenance contraceptive methods. These methods are either progestin-only (hormonal IUDs and implant) or non-hormonal (copper IUD), and are inserted subdermally (implant) or within the cervix (IUD).

Transmasculine – Individuals born with feminine/female social expectations who identify with and/or express gender that is more closely aligned with masculinity/maleness. This includes transgender individuals and others who identify between the non-binary – transgender spectrum.

Uterus-having – This thesis uses the term “uterus-having” to describe individuals who have biologically female anatomy. This term intends to include all genders and those with intersex variations who may have a need for gynecology care.