CONTRACEPTION TENSION: HOW CULTURE, SOCIETY AND NARRATIVE INFORM CONSUMER IDENTITY AND CONTRACEPTIVE USE

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ABSTRACT

Contraceptive advertising and use is a widely accepted practice within North America, and yet has received little attention within the scope of marketing research. For a mass consumption product considered to be highly private and individualized yet tied to significant social, political, and environmental outcomes, it is important to understand how these messages and outcomes are interpreted at the individual level of the consumer. The current study was undertaken to explore the relationship between consumer identity and contraceptive use; how user identities are constructed in contraceptive advertising and how this impacts consumers; and the ways in which social agents like healthcare providers influence consumer health identities and contraceptive uptake. Semi-structured interviews were conducted with seventeen community-based participants and five healthcare providers to gain a better understanding of the intrapersonal and interpersonal dynamics that impact consumer perceptions of contraceptives and decisions to incorporate contraceptives into their reproductive plans. Using a grounded theoretical approach, the findings resulted in a theoretical framework that outline the key social agents and identity narratives that are reproduced within these social agents that directly inform consumer health identities, beliefs, and contraceptive use. Peers, healthcare providers, parents and partners were identified as primary social agents that informed consumer health identities and contraceptive use, and are fed by larger cultural scripts that are enacted through media and advertising. The concepts of autonomy and control emerged in participant accounts as ***diametric,*** or oppositional identity narratives that are reproduced within the level of each social agent and result in conflict that women must negotiate. As a result of this conflict, women develop perspectives and practices that inform their self-concepts around their health which then dictate their contraceptive use and larger contraceptive beliefs. The findings present an agenda to pivot contraceptive marketing away from traditional advertising strategies to a social marketing approach that incorporates stakeholders including healthcare providers and public health bodies in promoting transparency, ethicality, and consumer agency in contraceptive use.

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CHAPTER 1: INTRODUCTION

1.1 Research Context

After the U.S. presidential election of Donald Trump in 2016, it was reported that appointments for installations of intrauterine devices (IUDs), a method of long-acting reversible contraceptive (LARC), skyrocketed at Planned Parenthood clinics across the United States (Dusenbery 2019). For what reason did droves of women, some of which may have already been users of some method of contraception decide at that point to incorporate the IUD into their reproductive plan? For many, it was fear that President Trump would repeal the Affordable Care Act that provided health and medical support to Americans for a significantly reduced or covered cost (Dusenbery 2019; Wu et al. 2016). Currently the IUD is promoted as the most effective long-term method of contraceptive available as the most recent addition to the suite of contraceptives that include synthetic options like the subdermal implant, oral contraceptive (OC), the vaginal ring, emergency contraception, hormonal patch, and the hormone injection; and non-synthetic versions such as condoms, withdrawal and cycle tracking (Dusenbery 2019; Wu et al. 2016). The high effectiveness and dependability of IUDs may qualify them the safest investment for a woman to make while waiting out a tumultuous political climate. Beyond election outcomes, for what other reasons are more women incorporating contraceptive technology into their reproductive plans?

A key historical consideration may explain contraceptive use as coinciding with shifts in social roles over time: more women are choosing to defer child-bearing and family planning, while others are choosing to not have children at all (Hill 2019; Watkins 2012). The introduction of the synthetic oral contraceptive in 1960 marked a milestone for female autonomy over their bodies, making it possible for women to reliably and effectively control their reproductive capacities in pursuit of career and educational goals (Hill 2019; Tone 2006). National birth rate trends are indicative of this social shift: the 2018 birth rates in Canada show an average of 10 births per 1,000 in a population, compared to the rate of 26 births per 1,000 in 1960 when contraception was first launched (Statistics Canada 2020). Birth rates are also increasing in pace with maternal age, where more Canadian women are having children in their early thirties compared to women in their mid- to late-twenties (Statistics Canada 2020). The role of contraceptives cannot be understated: not only has this technology contributed to significant shifts in demographic and birth rate trends, but it has also impacted the visibility and employment rates of women in the Canadian workforce and employment markets around the world (Hill 2019).

The social aspects of contraceptive use are only one side of the coin. Contraceptive use is a deeply personal and nuanced form of consumption in both men and women. For women especially, contraception assumes a larger role in their reproductive health management as they are consumed bodily either by ingestion or insertion for the purposes of unplanned pregnancy prevention, among other goals. Contraception embodied, then, becomes a part of the female identity (Kissling 2013; Sanabria 2014). Women can choose to use one method over another or not use contraception at all, and they will continuously negotiate these choices over the course of their reproductive lives. These decisions, in turn, are informed by a web of overlapping individual, social and cultural dynamics like the U.S presidential election, for example. The current COVID-19 global health crisis is another scenario that, like governmental changes, may have unique and significant implications for contraceptive use among populations. Where

phenomena like a pandemic can unilaterally shift personal health practices, healthcare services, and the wider social and cultural fabric of a population, these outcomes may have a combinatory effect on the reproductive decisions of women and families.

It is these factors: the individual and social elements that inform contraceptive use, the administration effects of new contraceptive options in the suite of available (and long-established) methods, and the consumption patterns of contraceptive methods altogether that are of interest from a marketing lens. Contraceptive marketing primarily occupies the realm of direct-to-consumer (DTC) drug advertising by the pharmaceutical industry and bridged by clinician prescriptions (Wu et al. 2016). Where contraceptive advertising was historically limited to physicians, the approval of DTC advertising in the 1980s allowed for companies to increase their marketing scope directly to their target consumer audience (Watkins 2012). During this time, contraceptive technology also expanded where additional formulations of OCs were produced and the hormone shot Depo-Provera, vaginal ring and implant were introduced to consumer markets (Watkins 2012). The tech boom in the 1990s and early 2000s has had the effect of an information Renaissance for reproductive and sexual health resources for consumers as well. As a result, women today have more access to contraceptive information and product choices than previous generations. However, this means that women are more accessible from an industry standpoint and will be exposed to significantly more marketing messages and media compared to previous generations (Watkins 2012; Wu et al. 2016).

The transition from a limited to public promotion of contraception is interesting - contraceptives can be categorized as 'private goods', much like dental floss, deodorant or laxatives. Individuals consume these items in private on the basis that they offer some benefit to their overall health or appearance specifically, and to their identity generally (Smith 2007); yet these objects fit for personal consumption receive the same promotional mix as do more public goods like clothing and cars. How does contraception marketing so brazenly promote consumption of such a uniquely private material good? Conversely, how do individuals perceive of these marketing messages and incorporate them into their own identity? While women today may have a surplus of contraceptive options to consider, most still require physician intervention and, in the case of LARCS and injectables, clinical administration. For this reason, it is important to understand the role of healthcare providers as intermediaries for contraceptive marketing and access through a marketing lens. Contraceptive use is first and foremost an individual decision; however, it is also one that is often made in collaboration with other stakeholders like partners and healthcare providers. In this context, the marketing messages that women will encounter and negotiate are twofold: from external advertising (print, TV and digital ads) and in the settings of her physician's office. How healthcare providers disseminate industry advertising messages will inform how they approach patient consultations for contraceptive access. If a healthcare provider is a contraceptive user herself, she occupies the dual role of consumer and practitioner in her work. The link between external actors and private consumption raises another observation: What role do social agents like healthcare providers play in constructions of individual identity and contraception use?

Both consumer and provider perceptions on contraceptives and contraceptive advertising are an important avenue of exploration for marketing research in general as much of the existing research has occurred in the disciplines of public health, medicine, psychology and feminist studies, among others. This gap in marketing research on contraceptives may be explained by trends in DTC advertising expenditures, where prescription medications for managing

cholesterol, mood disorders, and even erectile dysfunction receive significantly higher ad spend at more than $3 billion USD for each drug class (Wu et al. 2016). DTC advertising for contraceptives, by comparison, accounts for a fraction of the total ad spend among the prescription drug classes (Wu et al. 2016). As research and advertising comprise a symbiotic relationship in marketing science, this would suggest that contraceptives are receiving less ad spend because they are receiving less research focus. This supports the mounting public criticism of the lag in developments for contraceptive technology where most current methods continue to rely on dated pharmacological properties that are more than fifty years old (Watson 2012). These findings in conjunction with the trending decline in birth rates suggest that there is an opportunity to expand understanding on the role of contraceptive marketing on individual reproductive decisions and their larger impact on consumer health identities.

Understanding contraceptive patterns and uptake are important from a marketing and a public health perspective: how and why women ascribe particular values or attitudes towards their reproductive health can have cascading effects for the community and population at large. Contraceptive use in and of itself can have medical, economic, environmental, social and cultural impacts (Hill 2019; Tone 2006). This places contraceptive access and use as an ethical consideration beyond simply as a consumer product. The responsibility of marketers to consider contraceptive use in human contexts instead of solely by advertising rates and figures means that the discipline must consider contraceptive marketing for the greater social good and not only for commercial gain. How major global events including climate change, resource scarcity, economic fluctuations, political upheavals and pandemics influence contraceptive uptake and reproductive decision-making are also critical to examine from a marketing standpoint as these phenomena can have direct impacts on managerial and consumer decisions.

This study intends to explore how contraceptive marketing and advertising is currently framed towards consumers, how consumers interpret these marketing messages, how social agents shape consumer attitudes towards contraceptive use or non-use in their reproductive decisions, and finally how contraceptive use informs user identities as a whole. These areas of inquiry will be examined as the following research questions:

RQ1: In what ways does consumer identity inform contraceptive use?
RQ2: How are user identities constructed in contraceptive advertising and how does this impact consumers?
RQ3: How and in what ways do social actors like healthcare providers influence consumer health identities and contraceptive use?

The following sections will begin with an overview of applicable marketing theory as it relates to contraceptive marketing research and a review of the existing literature will be conducted to assess extant research in contraception marketing to set the context for the current study.

CHAPTER 2: LITERATURE REVIEW

2.1 Theoretical Background

How and to what degree individuals consume contraceptives can be tied to their view of themselves. Individual self-concept – the combination of qualities and beliefs an individual has about themselves and how they evaluate those qualities – is a key concept in consumer behaviour and marketing research (Solomon, Zaichowsky and Polegato 2011). A main question that arises with self-concept is to what degree it is focused internally (based on introspection and psyche) or externally (based on social indicators) (Reed 2002). This will also inform the belief in the degree to which self-concept changes over time, and in what capacity. In his analysis on the conceptualizations of self-concept among different psychological paradigms, Reed (2002) argued that consumer research on identity will adopt a different view of the internal and external attributes of self-concept depending on the particular theory applied. Self-concept is another way of understanding the elements that combine to form an individual's ***identity***. Identity in marketing, defined by Reed et al. (2012), is understood as "***any*** [original emphasis] category label to which a consumer self-associates either by choice or endowment" (p. 312). From a consumer behaviour perspective, individual identity, as with self-concept, is not a fixed aspect, nor is it unidimensional. Rather, individuals can assume multiple identities or 'selves', where some identities remain stable over the life course (identifying as a daughter, South Korean, male) while other identities will fluctuate (a Roughriders fan, practicing yogi, Liberal) (Reed et al. 2012). In this way, some identities may assume more importance than others in an individual's self-concept.

The fact that an individual possesses different identities or 'selves' at different levels of importance does not guarantee that they will necessarily respond to a marketing strategy or product aligned to a particular held identity (Reed 2002). Consumer behaviour is concerned with understanding the mix of different contexts to best align consumer identities with products that they will be likely to invest in. Of the identity-relevant principles Reed and colleagues proposed to guide future consumer behaviour research, four are applicable to contraceptive marketing. The identity salience principle stipulates that factors that increase the salience – the extent to which a particular identity is available and accessible in one's working self-concept (Reed 2002) – of a particular identity will increase identity-congruent attitudes and behaviours (Reed et al. 2012). The identity association principle describes how stimuli associated with a positively-held identity will be processed more positively in turn and will activate additional identity-related content, while the identity relevance principle assumes that when intentional identity-related information is processed, it will influence behaviour and judgements that align with that identity (Reed et al. 2012). Finally, the identity conflict principle describes that individuals strive to minimize conflict across their identities by adjusting the degree of salience of particular identities (Reed et al. 2012).

These principles are relevant for understanding the relationship between consumer identity and contraceptive use; however, a more apt explanation could be borrowed from the realm of archaeology, in Monica Smith's (2007) application of 'reflexive identity' as a process in which an individual identity is informed by both "elements of self-awareness or self-construction that are not wholly public" (p. 413) in her examination of inconspicuous consumption practices of non-display products. The principles and concepts proposed by Reed et al. (2012) and Smith (2007) provide a comprehensive start at understanding consumer identity, however the focus

within this study lies on individual identity management and response to specific external stimuli. A theoretical understanding of the social and cultural influences of identity and consumption is warranted.

As Reed (2002) argued previously, consumer research will need to incorporate a definition of self-concept that is both individually and socially constructed. The definition of self-concept posed earlier clearly frames consumer identity at a micro-level of analysis but does not appear to incorporate at a macro-level the larger social and cultural factors that directly influence self-identity. Consumer decision-making on product consumption does not occur in a vacuum, devoid of any external factors; it is deeply informed by social and cultural stimuli that in turn influence different individual-held identities. Social identity theory thus incorporates the role of social and cultural elements that inform how one constructs their individual and social identities using motivational and subconscious processes (Reed 2002). Social identity theory essentially states that individuals self-categorize to a particular social or cultural identity like race or nationality, and will adopt certain processes (practices) to integrate those identities into their working self-concept. This will have implications for how individuals interpret marketing stimuli that is perceived as relevant to their respective social identity.

Bagozzi and Van Loo (1978) provided one of the earliest explorations into fertility and consumption in consumer research. A key concept in their analysis on the economic, sociological and social-psychological models of fertility consumption was role theory – the pattern of relationships defined by norms linking individuals to prescribed social positions, as well as defining the specific privileges, duties and obligations within those positions (Bagozzi and Van Loo 1978). This theoretical approach incorporates sex and gender norms as they are integrated in early childhood development as the mechanism that shapes an individual's social role and positioning in adulthood (Bagozzi and Van Loo 1978). Role theory is used to explain how fertility management behaviours in women are impacted by socially- and culturally-sanctioned expectations of their role as child-bearers and nurturers in family units (Bagozzi and Van Loo 1978). While role theory in this study is defined in its explanations of fertility consumption in heterosexual marriages (Bagozzi and Van Loo 1978), it can be argued that it encompasses more than simply gendered and heteronormative expectations limited to partnerships. Women today take on many different roles over their life course that may include such roles as student, working professional, political representative or caregiver to parents, among others.

Consumer culture theory takes both role theory and social identity theory further by incorporating both into a holistic appraisal of the relationships between consumers, culture and the market (Arnould and Thompson 2005). Marketing is not simply a unidirectional process of industry defining and producing goods that are subsequently consumed by individuals; rather, consumption practices are shaped by experiential and social phenomena and in how individuals construct and interpret their immediate world (Arnould and Thompson 2005). Consumer culture theory builds on the view of consumer goods as vessels of cultural meaning that extends both from the culturally-constituted world and individual consumers as proposed by Grant McCracken (1986). Culture is not only the lens by which the consumer views their world but is also the mechanism that shapes their actions and behaviours (McCracken 1986). In this sense, consumer culture theory describes a symbiotic relationship between markets, consumers and culture and attempts to understand how this relationship contextualizes consumption experiences and practices. Consumer culture theory is relevant to consumer identity and contraceptive marketing because researchers want to better understand how (female) consumers construct their

contraceptive use, how they interpret the marketing and advertising media promoting contraceptive use and how they shape their identities around their contraceptive method choices.

Viewed through an economic lens, contraceptive marketing and contraceptive use incorporates a process of exchange, a phenomenon widely considered to be the theoretical foundation of marketing scholarship (Bagozzi 1975). With exchanges, two or more parties engage in a reciprocal relationship that is based on shared interests and outcomes (Bagozzi 1975). Contraceptive marketing incorporates different levels of transactions or exchanges among three primary parties: the pharmaceutical company (or industry), healthcare providers and consumers. In what Bagozzi (1975) terms a complex circular exchange, consumers seek contraception to help manage their reproductive capacities, which they must acquire from a physician as a prescription and from pharmacists as the contraceptive product itself. Doctors and pharmacists receive monetary and other tangible benefits from promoting the products of certain pharmaceutical companies, as well as revenue to clinics from each patient consultation. The pharmaceutical companies advertise their product to healthcare providers and consumers simultaneously and receive revenue from the units prescribed out of health clinics and pharmacies. Consumers subsequently are exposed to the advertising campaigns of the company and are prompted by a call to action to a) consider their reproductive health management by incorporating the advertised product into their health practices, and b) to speak with their healthcare provider for more information and access to the product, continuing the cycle of exchange.

Much of the existing research focuses on these chains of exchange separately: in existing marketing literature, the focus is on pharmaceutical DTC advertising to providers and to consumers. In public health and other social science literature, the focus is on patient-provider relationships and consumer experiences with contraceptive use. There is an opportunity for marketing research to build on the work of public health to examine the intersections between marketing messages, consumers, and providers and how contraceptive knowledge is transformed at these intersections.

Current research focuses on the tangible elements of contraceptive marketing and consumption: when, which, how and in what ways contraceptive methods are used. Exchange, however, can incorporate both utilitarian and symbolic elements, or the transfer of "psychological, social or other intangible entities" (Bagozzi 1975, p. 36). The symbolic aspects of contraceptive advertising and use have been explored within the arenas of feminist and gender studies but have been lacking in marketing literature. In the context of a clinical setting, providers and patients engage in a series of transactions that involve not only exchange of a prescription, but exchanges of knowledge, experiences (shared or otherwise), and implicit/explicit social and cultural norms and scripts. This perspective is worth exploring in greater depth, as understanding both the tangible and intangible elements that inform whether a consumer will adopt a particular contraceptive method will directly impact how receptive that consumer will be to a particular marketing strategy. Viewing both healthcare providers and consumers as mutual stakeholders combining their individual knowledge and experiences on contraception places this exchange in the camp of service-dominant logic (SDL), proposed by Vargo and Lusch (2010).

Contraceptive use differs from other gendered consumer products in that it is more closely aligned to consumer identity and self to the extent that it is physically internalized. Because of

this, female contraceptive use requires individual knowledge and awareness of her body and her menstrual cycles that is both unique and critical to decisions regarding contraceptive uptake. This means that consumers bring to clinics a breadth of knowledge and experience that merges with the knowledge and experience of a healthcare provider in determining a course of action with contraceptive use. Viewed this way, patients become key parties to health service exchanges and not merely recipients of a product (or prescription). Service dominant logic (SDL) views marketing exchanges as not simply an exchange of goods but an exchange of knowledge, and shifts the role of consumers from recipients to co-creators and collaborators of this knowledge (Vargo and Lusch 2010). SDL recognizes that value in a product or service is determined by the beneficiary – the 'value-in-context' (p. 227) in contraceptive use is derived from consumers themselves, which in turn dictates how and in what ways contraceptives are communicated and exchanged in other settings (Vargo and Lusch 2010).

While contraception may be considered a more personalized object of consumption compared to other products like fashion (McCracken 1986), it is similarly embedded with social and cultural meanings that guide its use. Examining theories of identity (social identity theory, role theory), culture (consumer culture theory) and marketing (exchange theory, service dominant-logic) are necessary to establish a theoretical framework for contraceptive marketing, and can serve to guide further research in the discipline. There is opportunity to shift the role of contraceptive marketing beyond the narrow scope of DTC prescription drug advertising and into settings that align with public health initiatives and improving social welfare (Hastings and Saren 2003). Understanding how individual identities, values and behaviours, and the role of healthcare providers and other social and cultural informants drive contraceptive use may help to guide marketing and healthcare research and strategy to improve communications, transparency and accessibility of contraceptive technology.

2.2 Contraception Marketing Conceptual Framework

Figure 1 below (on next page) outlines a guiding framework of the key concepts of contraceptive marketing discerned from current literature, and outlines how existing marketing messages construct the identity of users, product use, and the role of risk impacting each of these attributes. These concepts will be explored in turn.

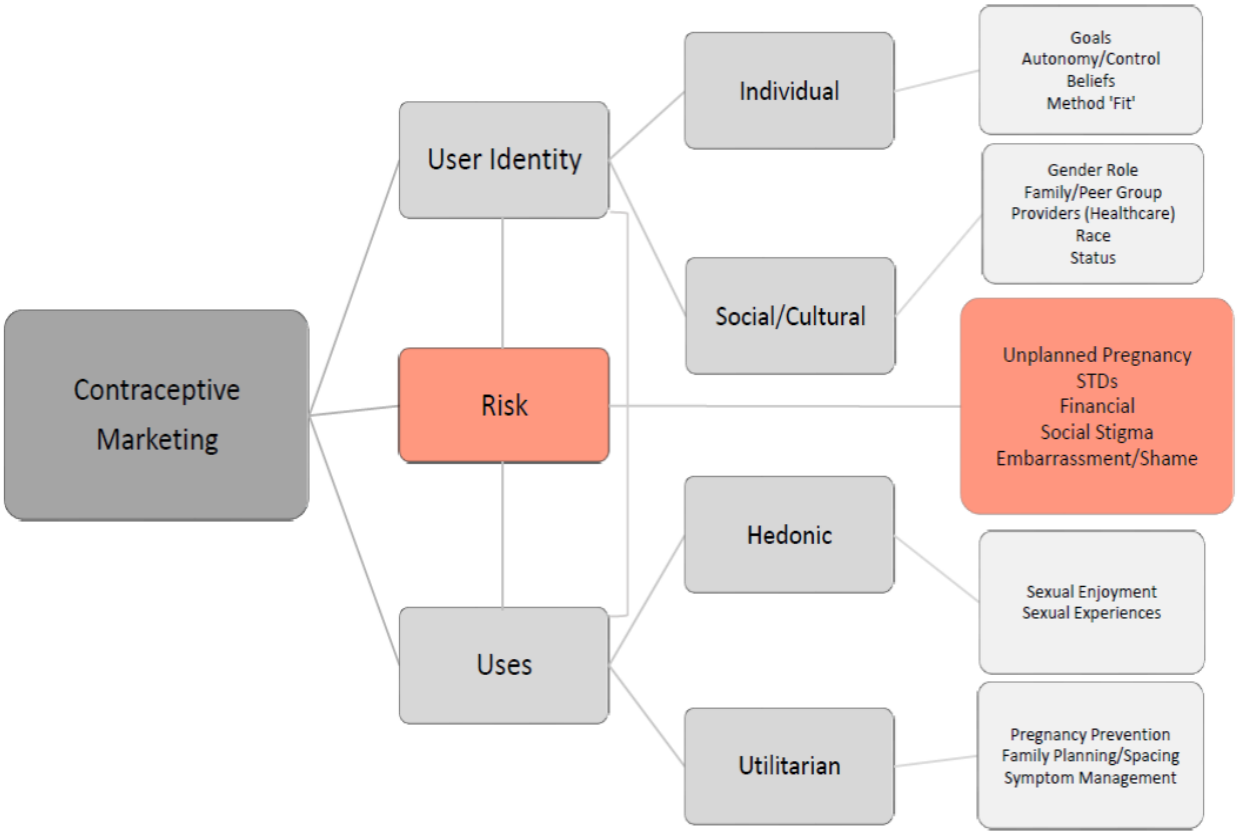

Figure 2.1 – Contraceptive Marketing Conceptual Framework

2.3 Contraception Types, Trends and Use

The most recent national publication on contraceptive use among Canadian women dates to 2015, suggesting a large gap in knowledge on current contraceptive rates (Statistics Canada 2015). The results of the Canadian Health Measures Survey (CHMS) from 2007-2011 indicated 16% of women ages 15-49 used an oral contraceptive (OC) method for reproductive health management; however, limitations in the scope of contraceptive methods (only OCs were assessed) and sampling parameters (the survey did not include women in remote locations or those living on reserves or First Nations settlements) provide little in the way of comprehensive Canadian demographic data that reflect current trends in contraceptive technology and uptake like LARCs (Rotermann, Dunn and Black 2015). Alternatively, U.S national health publications may provide a more detailed assessment of contraceptive use patterns among American women. From 2015-2017, approximately 65% of American women within the same age range were using a method of contraception, where contraceptive use increased concurrently with age and where sterilization, OCs, LARCs (including the IUD and implant) and condoms were reported as the most frequently used contraceptive methods (Daniels and Abma 2018). Similar trends have been found in European and Australian studies with the inclusion of ‘withdrawal’ reported as one of the most common contraceptive methods (Baharadwaj et al. 2012; De Irala et al. 2011; Wigginton 2016; United Nations 2019). While useful for a population level of analysis, the findings from both Canadian and U.S national health databases provide only a snapshot of contraceptive usage patterns limited to the survey administration period and, like other health

research, are constrained to the recall abilities and reporting accuracy of participants. The numerical data on consumer demographic variables such as race, education level and economic background in government publications provide limited context into how each of these variables impacts contraceptive use.

Despite the recent spike in IUD uptake, oral contraceptives continue to be cited as the most common method among users (Antonishak, Kaye and Swiader 2015 Bharadwaj et al. 2012; DeMaria et al. 2019; Rocca and Harper 2012; Sanabria 2014; Sundstrom, Billings & Zenger 2016; Sundstrom et al. 2015). By and large, contraceptive marketing has been promoted primarily for its use in preventing unplanned pregnancies. However, pharmacological advances in contraceptive technology have resulted in additional benefits in their use that include curing acne, controlling moods, reducing cramping and heavy periods, or mitigation of other medical conditions like endometriosis or recurring migraines (Ebeling 2011; Judge et al. 2017; Watkins 2012). That contraceptive use could offer multi-symptomatic solutions was the impetus for the advertising push to market contraceptives as 'lifestyle drugs', and a prioritization towards synthetic contraceptive types by providers and consumers (Watkins 2012). It is unsurprising then that non-hormonal methods – with the exception of condoms - like withdrawal or natural family and cycle tracking methods have received little marketing attention. Instead, most research continues to focus on more modern synthetic methods such as the IUD and implant (DeMaria et al. 2019; Higgins, Kramer & Ryder, 2016; Mann & Grzanka 2018; Sundstrom et al. 2016; Sundstrom et al. 2015), emergency contraception (Colarossi, Billowitz & Breitbart 2010; Johnson et al. 2010), and the vaginal ring (Antonishak et al. 2015; Meier et al. 2019).

Individuals consume products based on two main objectives – for utilitarian reasons, whereby the product or service satisfies a particular need, use or function, and where practicality is the main benefit; or for hedonic reasons, where the goal of consumption is immediate gratification, satisfaction or pleasurable experiences (Botti and McGill, 2011; Holbrook and Hirschman 1982). Within these objective guidelines, promoting contraception as a solutions-focused product for pregnancy prevention as well as for secondary symptom management frames it as utilitarian in its purpose (Botti and McGill 2011; Holbrook and Hirschman 1982; Ledford 2009; Watkins 2012). For non-hormonal contraceptive methods like condoms, the utilitarian aspects include not only pregnancy prevention but STD protection as well (Chiang, Chan and Milan 2018).

These ideas are substantiated in the literature: the majority of contraceptive research focused on contraceptive use for its utilitarian functions, where participant reasons for use included efficacy in pregnancy prevention (Bharadwaj et al. 2012; Sanabria 2014; Sundstrom et al. 2015; Sundstrom, Billings and Zenger 2016), protection from STDs (Baradwaj et al. 2012), birth spacing (Sundstrom et al. 2018), and secondary symptom management (De Irala et al. 2011; Wigginton et al. 2016). Financial cost and benefit, while not directly attributable to the physical goals of contraceptive use, did factor in as a consideration for uptake (Colarossi et al. 2010; Daley 2014; Johnson et al. 2010; Sanabria 2014; Wigginton et al. 2016). While most participants valued the efficacy and physical benefits that come with uptake of a contraceptive method, the degree to which their economic freedom allowed them flexibility of choice significantly impacted their weighing of the balance between benefits and costs.

Few studies investigated participant experiences of contraceptive use for hedonic goals, or sexual experiences and enjoyment. This may be due to the fact that most of the contraceptive

marketing and advertising continues to frame contraception for its practical, solutions-based function (Ledford 2009; Mann and Grzanka 2018; Sundstrom, Billings and Zenger 2016; Sundstrom et al. 2015). Condom advertising stands as the sole contraceptive method marketed both for its utilitarian (pregnancy and STD prevention) and hedonic (pleasure enhancement, positive and safe sexual experiences) aspects (Chiang et al. 2018; Medley-Rath and Simonds 2010). The degree to which contraceptive methods did or did not interfere with sexual experiences was often a lesser-cited reason for uptake by consumers (Baradwaj et al. 2012; Daley 2014; Higgins and Hirsch 2008). A study conducted by Higgins and Hirsch (2008) found effects on female sensation and well-being, effects on sexual spontaneity, desire for closeness, concern for partner's pleasure and perceived security (from unplanned pregnancy) were cited by participants both in and outside of monogamous partnerships as key attributes that influenced which method of contraception was used.

These studies make clear that contraceptive use among consumers involves more than simply reproductive risk management. Promoting synthetic contraceptives as a 'lifestyle drug' (Watkins 2012) has shifted the view of contraceptives as a unidimensional fertility solution to a product that can satisfy other physical, emotional or psychological needs in consumers. However, the majority of contraceptive marketing continues to reinforce the practicality and functionality of the methods while minimizing or omitting the hedonic, pleasurable benefits. Pleasure in use should not be restricted to a single method (condoms). Perhaps the hedonic elements of hormonal contraceptive uptake are implied, whereby regular contraceptive use helps to relieve pregnancy worries and control for other uncomfortable symptoms of menstruation, which opens individuals up to greater enjoyment in their personal and sexual lifestyles (Higgins and Hirsch 2008). As previous literature has shown, hedonic goals are not necessarily secondary or 'afterthoughts' for some consumers – it is a significant consideration in their contraceptive consumption behaviours. An area of opportunity for marketing research could involve expanding on the hedonic value of contraceptives and incorporating the 'pleasure principles' of contraceptive use into promotional strategies.

2.4 User Identity and Contraceptive Marketing

2.4.1 Individual - Goals:

To what extent contraceptive methods are incorporated into consumer health practices involves many overlapping contexts. Individual goals and values will shape how consumers negotiate the suite of contraceptive methods available to them. Contraception ads frequently incorporate goal-relevant imagery into their promotional strategies by featuring models in various settings or activities like engaging in fitness, bonding with peers or partners, or prioritizing hobbies like music (Kissling 2013; Mann and Grzanka 2018; Watkins 2012). In this way, contraceptive ads promote an ideal self – a user that can attain her desired goals by consuming the product – or an identity-relevant self by featuring imagery that align with the demographic of interest (Reed et al. 2012).

Of the studies reviewed, unplanned pregnancy prevention was the most common and primary goal among consumers for contraceptive uptake (Bhattacharjee, Berger and Menon 2014; Marston, Renado and Nyaaba 2018; Rocca and Harper 2012; Sundstrom, Billings and Zenger 2016; Sundstrom, Szabo and Dempsey 2018; Williamson et al. 2009). Other goals such as completing school and developing their careers were cited by participants as additional incentives for contraceptive uptake (Marston et al. 2018), although any alternative goals outside

of pregnancy prevention were infrequent in the literature. It is interesting that many of the studies focused on contraceptive use among adolescent (Daley 2014) or college-age (DeMaria et al. 2018; Higgins et al. 2016; Sundstrom et al. 2016; Wigginton et al. 2016) consumers but did not incorporate specific goal-related questions regarding contraceptive use outside of mitigating unplanned pregnancy. There is an opportunity for marketing research to expand on what other individual goals inform contraceptive use. For example, there is room to extend understanding on consumer financial and environmental goals tied to contraceptive consumption (Bagozzi and Van Loo 1978). The link between consumer goals and role theory is an important consideration for consumer behaviour research in contraceptive marketing. Goal-related contraceptive consumption is likely to differ depending on the life stage of the individual; students and young adults will have different short- and long-term goals compared to older or married adults that will differentially impact the degree of contraceptive uptake.

2.4.2 Autonomy and Control:

Contraceptive marketing is predicated on efficacy – the belief that a product will function the way it is promoted – and especially on self-efficacy – an individual's belief in their capacity to perform a behaviour to attain a desired outcome (Rosenstock, Strecher and Becker 1988). When women believe that they can successfully control their reproductive capabilities through consumption of a contraceptive method, they will be more inclined to do so. Consumer-perceived control and autonomy in consumption decisions have been reproduced in other studies involving explicit identity-targeted products and experiences (Bhattarjee et al. 2014; Botti and McGill 2011). Consumer self-efficacy emerged as a consistent theme in the contraceptive literature, with autonomy and control cited as one the main considerations for contraceptive method uptake (DeMaria et al. 2019; Marston et al. 2018; Sanabria 2014; Sundstrom et al. 2016; Sundstrom et al. 2015; Sundstrom et al. 2018). This narrative has been identified in the marketing strategies for contraception as well: while ads may cycle through different terms – empowerment, independence, control – the implied message of self-reliant fertility management endures over different brands, methods and organizations (Kissling 2013; Mann and Grzanka 2018; Medley-Rath and Simonds 2010; Watkins 2012; Woods 2013).

'Control' was defined by participants in the reviewed studies as the individual capacity to manage somatic functions tied to menstrual cycles (Marston et al 2018; Sundstrom et al. 2018). Control was also cited as a factor in individual-held experiences regarding the scope of choice in contraceptive method options, where the degree of perceived agency was greater for users that had access to multiple (more than 2) contraceptive options versus fewer (2 or less) (Daley 2014; Higgins, Kramer and Ryder 2016; Johnson et al. 2010; Sanabria 2014). At a deeper level, consumer-perceived control impacts the specific type of contraceptive used, where methods like condoms and oral contraceptives provide users a more 'hands-on' approach to fertility management compared to other methods like injections, IUDs and subdermal implants (DeMaria et al. 2019; Higgins et al 2016; Wigginton et al. 2016). Contraceptive consumption, then, is a practice not only of physical, bodily control by consumers but of psychological control, the degree of which will differ among individuals.

2.4.3 Beliefs and Values:

Control and contraceptive use are deeply tied to perceptions of individual responsibility. Most participants in previous studies were explicit about how contraceptive use contributed to

beliefs about responsible behaviour (DeMaria et al. 2019; Fennell 2011; Sanabria 2014; Sundstrom et al. 2018). User beliefs in the adoption of a specific contraceptive method or the degree of efficacy of certain methods contributed towards a positive self-concept as a responsible individual, romantic/sexual partner and citizen (DeMaria et al. 2019; Reed 2002; Solomon et al. 2011). Individual beliefs regarding the significance of menstrual cycles and female fertility in relation to contraceptive consumption was common area of tension among participants and their intentions towards contraceptive method uptake (Malefyt and McCabe 2016; Marston et al 2018; Sundstrom et al. 2018; Williamson et al. 2009)

While methods such as LARCs are promoted to lessen menstrual symptoms and even stop cyclical bleeding altogether (Dusenbery 2019; Watkins 2012), this benefit was not wholly embraced by consumers. Many women believed that monthly periods were important and expressed concerns that the methods would negatively impact fertility (Bharadwaj et al. 2012; Daley 2014; Payne, Sundstrom and DeMaria 2016; Sundstrom et al. 2016; Sundstrom et al. 2018; Williamson et al. 2009). While fertility fears and contraceptive use were primarily expressed regarding IUDs and implants, this was extended to other methods like the oral contraceptives (pill) and emergency contraception (Colarossi et al. 2010; Marston et al. 2018; Sanabria 2014; Williamson et al. 2009). While absent in much of the literature, religiosity may explain the significance that some users accord their menstrual cycles and can be a critical determinant of contraceptive use (Kusunoki et al. 2016; Ronis and LeBouthillier 2013). As previous studies have shown, responsibility, fertility and menstrual cycle 'naturalness' have been identified as key constructs in the self-concepts of contraceptive users. Consuming specific contraceptive methods contributes to a positive view of individuals as capable and responsible for their bodies and larger social impact while also maintaining balance in the physical and psychological aspects of their reproductive health.

2.4.4 Method 'Fit':

Consumer-held beliefs about fertility and contraceptive use informed the perceived 'fit' of a particular contraceptive method as a reason for differential method uptake among consumers (Malefyt and McCabe 2016; Sanabria 2014; Wigginton et al. 2016). Contraceptive 'fit' for consumers was defined as the optimal physical comfort associated with using a method as well as the minimization or absence of any secondary effects such as bloating, bleeding, cramping and weight gain (Higgins and Hirsch 2008; Sanabria 2014; Sundstrom et al. 2016; Wigginton et al. 2016; Williamson et al 2009). Consumers cited a sense of 'knowing' whether a contraceptive method was 'working with or against their body' (Wigginton et al. 2016, 260). This knowing was tied to perceptions of the physical and pharmacological properties of a contraceptive type. Despite all hormonal contraceptive methods sharing the same pharmacological properties (Watkins 2012), consumers differentially associated methods as congruent or incongruent with their self-identity based on their method of hormone delivery (Sanabria 2014; Sundstrom et al. 2016).

LARC methods like the IUD and implant involve a more invasive, physician-administered incorporation into the body compared to self-administered methods like oral contraceptives. For this reason, consumers perceived of LARC methods as 'foreign' and incongruent with their embodied views of themselves and their prescribed method of fertility management (Payne et al. 2016; Sundstrom et al. 2016). Alternatively, other users likened the 'set-it-and-forget-it' (Dusenbery 2019) aspects of IUDs to a freedom from the constant manual hormonal

management that comes with using the pill, Nuvaring or hormonal patch (Sanabria 2014). In this way, consumer-held beliefs on contraceptive 'fit' are also informed by identity-related elements of control and autonomy that individuals wish to have over their fertility management and reproductive decisions. In summary, consumer identity incorporates both physical and ideological attributes in assessments of contraceptive method 'fit' and consumption.

2.4.5 Social/Cultural Consumer Identities – Gender Role:

Without question, individual goals, beliefs, autonomy and perceptions of method 'fit' with their body altogether are informed by social and cultural factors. Identity-relevant beliefs about contraceptive method use among individuals are informed by their external self – how they perceive of themselves in their respective social environment (Reed 2002; Solomon et al. 2011). The external self can assume many levels of abstraction and importance, spanning from individual identities as partners, family members, as part of a peer group, and extending to members of a community, nation or race (Arnould and Thompson 2005; Reed 2002). This extension of social/cultural identity in consumer contraceptive use was demonstrated in the literature. Contraceptive marketing is observed as overwhelmingly targeted toward female consumers (Fennell 2011; James-Hawkins, Dalessandro and Sennott 2019; Kissling 2013; Mann and Grzanka 2018; Medley-Rath and Simonds 2010; Watkins 2012). This is made obvious (and expected) in advertisements for contraceptives for female use like the pill, IUDs, implants, the hormone shot, emergency contraception and vaginal rings, while condom advertising is generally targeted to men and women (Chiang et al. 2018; James-Hawkins et al. 2019). In this sense, gender role identity is a key social construct in contraceptive consumption (Bagozzi and Van Loo 1978).

This gendered targeting may be why women in the studies reported beliefs of personal responsibility for contraceptive use. User-reported marital or relationship status did not change perceptions of responsibility in contraceptive uptake and management (Fennell 2011; DeMaria et al 2019; Higgins and Hirsch 2008; Marston et al. 2018; Wigginton et al. 2016; Williamson et al, 2009). Only three of the reviewed studies incorporated both male and female perspectives on contraception use. Male views were generally supportive of receiving more information on different contraceptive options outside of condoms, discussing contraceptive use in partnerships, and of assuming personal responsibility in using gendered contraception like condoms (Fennell 2011; Higgins and Hirsch 2008; James-Hawkins et al. 2019). These studies demonstrate the implications that identity-salience and identity-congruence strategies in contraceptive marketing have on consumer identity and reproductive behaviour. As most contraceptive types are targeted towards females, males are often not primed nor encouraged to learn more about different methods for fertility management outside of condoms despite being key stakeholders in their successful use (Fennell 2011; Forehand, Deshpandé and Reed 2002; Reed et al. 2012).

In addition to assuming personal responsibility for contraceptive use in partnerships, women also reported a vested interest in the impacts of contraception on their partners' preferences and experiences (Higgins and Hirsch 2008; Marston et al 2018; Williamson et al. 2009). Partner requests or reports of interference of a contraceptive method were the most common reasons for women in relationships to change or discontinue a contraceptive method (DeMaria et al. 2019; Higgins and Hirsch 2008; Williamson et al. 2009). In this way, female responsibility incorporated not only her own vested interests in contraceptive use, but that of her partner. This self-identified responsibility of women to manage contraceptive use was echoed in

male perspectives as well regardless of male-reported relationship status (Fennell 2012; James-Hawkins et al. 2019). Males also described personal conflicts with their degree of involvement in contraceptive use, acknowledging their desire to assume more responsibility in reproductive decision-making while also respecting the autonomy of women in managing their fertility needs (Fennell 2012; James-Hawkins et al. 2019). Female participants in the studies consistently oscillated between their individual and relationship identities, both of which informed their decisions regarding contraceptive method use or non-use. Women had to balance their individual goals with the relationship goals of satisfaction and trust to guide in their contraceptive uptake (Daley 2014). This balance becomes more significant when family and peer group identities are also incorporated.

2.4.6 Families and Peer Groups:

Exclusive of marital partnerships, users reported the degree to which membership in their biological and marital families impacted their identities as contraceptive users (Daley 2014; Marston et al. 2018; Williamson et al. 2009). Adolescents cited the influence of family as resources for fertility and contraceptive information and how the presence or absence of this information impacted constructions of themselves as contraceptive users (Daley 2014). The role of female matriarchs were reported as a valued resource for individual self-concepts around femaleness, fertility and responsible sexual behaviours (Daley 2014). Family attitudes toward contraceptive use were cited as a key factor in whether women adopted a synthetic method of contraception specifically or used any contraceptive method generally (Johnson et al. 2010; Marston et al. 2018.; Williamson et al. 2009). Familial role also impacted the degree to which female consumers perceived of their held responsibility for the continuity of bloodlines; this perception would extend to their perceived membership in extended families like in-laws (Marston et al. 2018; Williamson et al. 2009). This identity conflict determined the extent to which women would adopt certain contraceptive methods or other alternatives for fertility management.

Peer groups were reported as a primary resource for contraceptive information as well as barometers by which individual female identity was measured (Daley 2014; Johnson et al. 2010; Malefyt and McCabe 2016; Sundstrom et al. 2016; Sundstrom et al. 2015). In the absence of or as an alternative to parental guidance, peers can act as a support network for contraceptive access and use, particularly if the type or access method elicits anxiety or embarrassment like condom purchases (Ronis and Lebouthillier 2013) or requesting emergency contraception (Fallon 2010; Johnson et al. 2010). Often reported as a first point-of-reference before family, healthcare providers or other resources, peer groups and external peer influencers serve as sources of positive identity-shapers for contraceptive method uptake (Daley 2014; Sundstrom et al. 2016; Sundstrom et al. 2015) as well as negative identity-shapers to dissuade a particular method (Johnson et al. 2010). Research focused on promoting newer contraceptive methods like the IUD and implant (Sundstrom et al. 2016; Sundstrom et al. 2015) explored the use of young influencers and friends as identity-salient measures to encourage new user uptake. In this context, social identity theory (Reed 2002) and role theory (Bagozzi and Van Loo 1978) can explain how individual-perceived roles in family units as well as membership in peer groups shape contraceptive uptake or switching among contraceptive methods. A related area worth exploring would entail the effects of peer group polarization towards a specific contraceptive method and how users negotiate between the ideal versus actual identities in their contraceptive method uptake.

2.4.7 Healthcare Providers:

More than all other providers, the physician-patient relationship is the most significant from a consumer behaviour and contraceptive marketing standpoint. While direct-to-consumer (DTC) advertising has helped to promote consumer autonomy and empowerment by reducing physician reliance as another resource for contraceptive information (Watkins 2012), physicians continue to occupy a key role in consumer reproductive decision-making, specifically with contraceptive use. Since most contraception available today requires a prescription or clinical administration, physicians assume a triangulate partnership with industry and with patients in a contraceptive marketing framework. In the physician-provider relational context trust is paramount, and has been cited in multiple studies as a key determinant in contraceptive uptake among consumers (Adams et al. 2019; De Irala et al. 2011; Sundstrom, Szabo and Dempsey 2018). Individuals want to trust that physicians will be well-versed in all contraceptive methods and will be able to advise on a best fit (DeMaria et al. 2019; Higgins et al. 2016; Sundstrom et al. 2016). Trust is also tied to the belief that physicians will communicate with transparency and honesty in consultations and will always have the bests interests of their patients at heart (Sundstrom et al. 2018). In many cases, individuals will prioritize the recommendations of physicians over partner input in decisions regarding uptake of hormonal contraceptive methods (De Irala et al. 2011; Sundstrom et al. 2018; Zimmerman 2018).

Much like the relational closeness of friends versus acquaintances, the nature of the relationship between the physician and consumer is also important – interactions will be significantly different if a patient as a long-established family physician compared to transient physician visits in hospitals or walk-in clinic settings. The degree of physician influence on individual consumption decisions can serve as a source of empowerment for consumer health identities (Sundstrom et al. 2018) or a source of conflict in cases where prioritization of contraceptive attributes differ between physicians and patients (Higgins et al. 2016; Meier et al. 2019; Payne et al. 2016; Sundstrom et al. 2016; Weisberg et al. 2013). Physician biases towards specific products or methods along with larger systemic healthcare biases towards specific groups or economic brackets can have significant impacts on consumer agency and autonomy in accessing a contraceptive method that meets her individual health needs and goals (Higgins et al. 2016; Meier et al. 2019). For Black, Indigenous and Latina women especially, the remnants of historical government practices of population control and forced sterilization continue to fuel distrust of healthcare bodies and implicate decisions regarding their reproductive identities (Colarossi et al. 2010; Higgins et al. 2016; Meier et al. 2019). What happens when there is a disconnect between consumers and physicians? To what extent do consumers engage in supplemental contraceptive education and resource-seeking outside of clinical settings? In what circumstances do they seek other healthcare providers for contraceptive information, such as pharmacists or nurse practitioners?

Recent FDA changes to contraceptive drug access have given pharmacists a larger scope in prescribing and dispensing of contraceptives, making them key stakeholders in reproductive healthcare and information conduit for consumers seeking contraception (Maderas, Landeau and Taylor-McGee 2008; Colarossi et al. 2010). Pharmacists may also be considered a more approachable, less threatening healthcare provider and a preferred first point-of-contact for consumers as an alternative to seeing a physician (Colarossi et al. 2010). In cases where geographic location like small towns or settlements restrict consumers from accessing a physician, pharmacists may assume a central health role in contraceptive administration and

counsel (Faris et al. 2010). Like physicians, however, pharmacists can also be subject to biases in communication and product provision (Sanabria 2014), and in rare circumstances can be barriers to consumer access to contraception by refusing to prescribe some contraceptive types (Maderas et al. 2008).

2.4.8 Race and Culture:

Gender role identity, religiosity and contraceptive use align closely to individual racial and cultural identities (Higgins et al. 2016; Marston et al. 2018; Williamson et al. 2009). This is most prevalent in studies of contraceptive use in developing countries (Marston et al. 2018; Williamson et al. 2009). Female participants in countries including Ghana, South Africa, Tanzania, Mali, Nigeria and Vietnam described contraceptive use as conflicting with their individual, marital and social identities (Marston et al. 2018; Williamson et al. 2009). Maintaining their identity as 'good wives' as well as managing expectations as child-bearers in marriages influenced the extent to which women adopted certain contraceptive measures (Marston et al. 2018). Males in these countries assumed a larger role in contraceptive decision-making and would often delegate the extent of contraceptive use and the type of method used (Williamson et al. 2009). Geographical differences in contraceptive method accessibility also restricted female autonomy of choice. Limitations existed by brand and by method; generally, women would have access to some version of oral contraceptive, emergency contraception and condoms (Marston et al. 2018; Sanabria 2014). Where one of these methods is predominantly in the control of men, women were left to choose between synthetic methods or less efficacious methods like 'withdrawal' (Marston et al. 2018).

Historical events involving the nefarious use of contraception must also be considered as it impacts racial and cultural identity. Government-funded measures to enforce population control in Indigenous, Black, Puerto Rican and other minority or economically-disadvantaged groups has left decades of trauma and distrust towards healthcare systems and the promotion of certain contraceptive methods among non-White users (Higgins et al. 2016; Kusunoki et al. 2016; Meier et al. 2019; Rocca and Harper 2012). This is especially prevalent in user attitudes toward LARCs and IUDs in particular (Higgins et al. 2016, Meier et al. 2019). Understanding the ways in which reproductive technology intended to liberate women was instead used against them based on the colour of their skin or their culture is critical for studies on sexual health and reproductive behaviours. That these perspectives endure today among minority groups is problematic; a contraceptive method that has significant medical and social benefits to female livelihood has been tainted and left out of consideration for some women. Future studies must consider how these historical contexts continue to shape minority opinions on contraceptive attitudes and use, and should incorporate these perspectives as guiding frameworks for future marketing and reproductive health campaigns that are culturally-inclusive and informed.

Cultural differences in perceptions of pharmaceutical method use have been demonstrated in previous studies, whereby cultured views on health management often involved rejection of pharmaceutical treatments in favour of complementary and alternative medicines (CAMs) (Adams et al. 2019). Aside from critiques of contraceptive marketing on the gender-skewed promotional strategies, incongruence in identity-salient advertising of contraceptive methods may explain some of the racial differences in contraceptive method uptake (Higgins et al. 2016; Williamson et al. 2009). The cautioned view on pharmaceutical and synthetic treatments was demonstrated in the current studies on consumer identity research and contraceptive use in non-

Western countries (Marston et al, 2018; Williamson et al. 2009). Culturally-informed individual beliefs on the significance of fertility and menstruation and the perceived risk of synthetic contraceptive use on fertility drove many women to consider other socially-accepted options like condoms (Rocca and Harper 2012), or 'natural' methods like withdrawal (described earlier), abstinence periods or traditional herbs and treatments (Marston et al. 2018; Williamson et al. 2009). For consumers in non-Western countries, culture and custom significantly determines how contraception is used and how it is linked to identity. Cultural influence in Western countries like the U.S. was incorporated in some of the studies (Colarossi et al. 2010; Higgins et al. 2016), however there is an opportunity to explore this in more detail, especially in Canadian contexts that incorporate multi-ethnic and Indigenous identities.

2.4.9 Status:

Fertility, described earlier, not only informed individual identity in developing countries but also to defined individual status (Marston et al. 2018; Williamson et al. 2009). Female social status in certain cultures directly implicated whether she used a particular contraceptive method, especially those that required pharmacist access (Marston et al. 2018; Williamson et al. 2009). Extramarital sex and unplanned pregnancy were viewed as a violation of social norms in some countries, much like the failure to produce (many, and in a timely manner) children in a marriage was another blight to cultural norms and expectations (Marston et al. 2018; Williamson et al. 2009). In these scenarios, female consumers engaged in identity conflict management with their contraceptive use to satisfy their individual goals and fertility needs while maintaining the expectations that defined their social role (Marston et al. 2018; Reed et al 2012; Williams et al. 2009). In this way, fertility is viewed as a form of currency for women – to be able to conceive is to guarantee their social rank and financial safeguards within marriages (Williamson et al. 2009). Subjective views of social status also informed what ***types*** of contraception were acceptable and not acceptable for use; for example, OCs require a larger financial investment over time and are normalized as daily method of reproductive health management, much like taking a daily multivitamin for general health benefits. Based on these factors, OC use is predominantly associated as a middle- to high-income method of contraception. Other method use may act as a blight to social status, which will be discussed in later sections.

While the relationship between identity status and contraceptive use was explicitly demonstrated in studies in African and Asian countries, it is worthwhile to consider how women in North America also tie their contraceptive use to a particular social status. Like some developed countries, financial wealth and security in North America are a metric of social status; it can be assumed that a female's socioeconomic status will determine a) the suite of contraceptive methods that are accessible to her, and b) the amount of children she may choose to have and the flexibility of the timeframe with which to do so. Where those in a higher socioeconomic bracket may invest in more children versus those in lower socioeconomic levels, the inverse may also be true: where high socioeconomic status is tied to having less children compared to lower socioeconomic status, with a corresponding linearity between financial security and contraceptive accessibility. There is opportunity for this to be explored in more detail in future studies, especially in cities with a diversity of social wealth and income brackets.

2.5 Contraceptive Marketing and Consumer Risk

Depending on the particular identity and identity-congruent beliefs and values, individuals will view 'risk' in different ways (Mandel 2003). In a study on identity and consumer risk-taking, Mandel (2003) demonstrated that the degree to which an individual would take a financial or social risk depended on whether they were primed with independent or interdependent cues. Those primed with independent cues were more likely to take a social risk versus a financial risk, whereas those primed with an interdependent cue reported the opposite (Mandel 2003). In this way, the degree to which a consumer allocates importance to a particular identity in their working self-concept will inform how they approach risk as well as the types of risk they will take (Mandel 2003). Within the existing contraceptive marketing literature, risk linked both user identity as well as the use outcomes for consumers. Contraceptive marketing frames risk in different ways: where private (commercial) ads focus mostly on female autonomy and empowerment and on risk avoidance indirectly, public health-related contraceptive ads are more explicit about individual risks (Mann and Grzanka 2018). However, consumer perceptions of individual versus social risks to contraceptive use can differ by geographic location. Of the studies conducted in North America and Europe, consumers prioritized risk in contraceptive use/non-use at an individual level. In African and Asian countries, consumers prioritized risk with contraceptive use at a social level (Marston et al .2018; Williamson et al. 2009).

Using the findings from North American studies, Figure 2.2 outlines the consumer stratification of risk with contraceptive use beginning at the individual level and expanding outward to a larger social contexts:

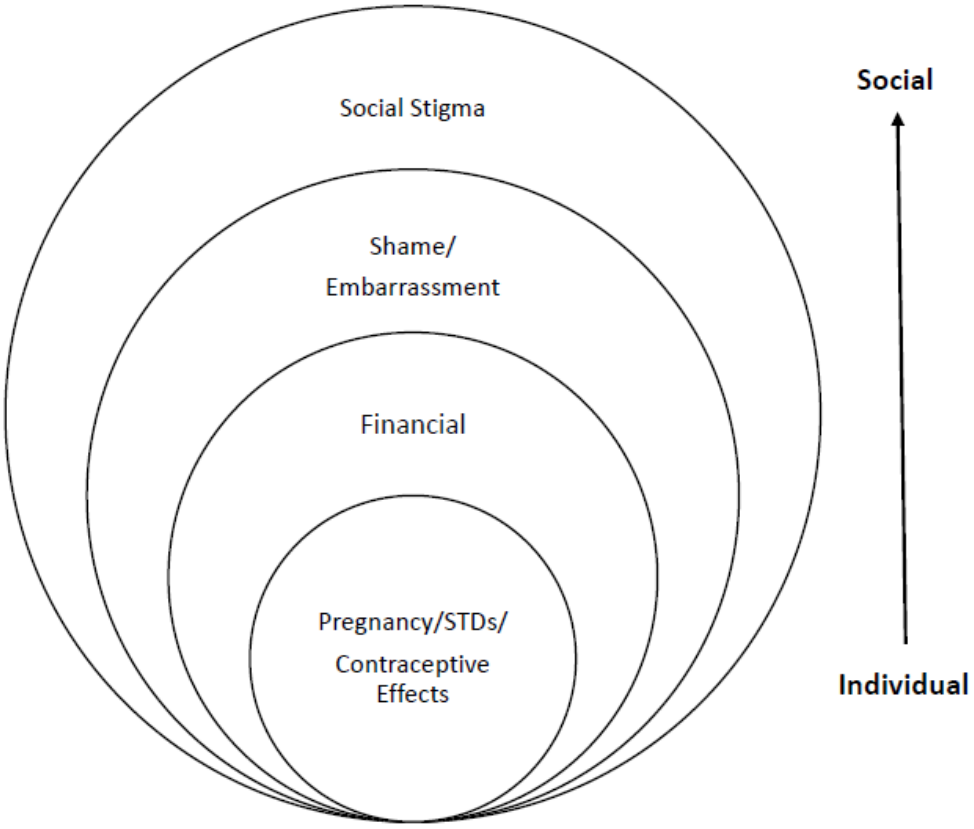

Figure 2.2 – Consumer Stratification of Risk

For nearly all consumers, avoidance of unintended pregnancy and STDs were cited as both individual outcomes (aligned with their goals) and risks to mitigate by using contraception. Unexpected contraceptive side effects were cited as a risk ***with*** contraceptive use by participants in studies and a primary reason for method changes or discontinuation (Sundstrom et al. 2018; Wigginton et al. 2016). Individual perceptions of contraceptive side effects were formed as a result of their experiences with certain contraceptive methods, and generally were not found to be clearly communicated in advance of their uptake (Ledford 2009; Mann and Grzanka 2018). Unintended pregnancies specifically were linked to financial risk (Colarossi et al. 2010; Daley 2014; Mann and Grzanka 2018; Williamson et al. 2009) especially among consumers outside of stable partnerships and in low-income or income precarious circumstances. Even within partnerships as with consumers in developing countries, hormonal contraceptive use in and of itself was considered a greater financial risk based on its perceived implications to fertility and potential consequences to the marriage, a key determinant of economic security (Marston et al. 2018; Williamson et al. 2009). Feelings of shame and embarrassment were linked as a consequence of unintended pregnancies and STDs as well as financial windfalls tied to contraceptive use or misuse, and are classified as a standalone risk (Daley 2014; Williamson et al. 2009). Shame and embarrassment also impacted the identity-salience of contraceptive consumption whereby some women would avoid purchase of a particular type altogether as was often the case with emergency contraception (Colarossi et al. 2010; Johnson et al. 2010; Williamson et al. 2009). Unintended side effects like weight gain, acne, mood changes and irregular bleeding/cramping exacerbated perceptions of shame and embarrassment, impacting individual identities and often extending into personal relationships (Daley 2014; Wigginton et al. 2016).

Finally, risk of social stigma was an overarching consequence linking consumer identity and contraceptive use. As described previously, socially-responsible women were perceived as those that adopted any regularized method of contraceptive use compared to women who used no methods; however the method of use also dictated which users were ‘more’ responsible based on social and cultural norms (Mann and Grzanka 2018; DeMaria et al. 2019). Using a more effective, long-acting method like the IUD or implant may promote greater identity-relevant perceptions of responsibility and reproductive control compared to using one-time methods like emergency contraception or ‘natural methods’ like withdrawal and cycle tracking (Mann and Grzanka 2018; Sundstrom et al. 2015; Sundstrom et al. 2016). Alternatively, in cultures with more traditional gender roles and norms, modern contraceptive use was tied to a negative social stigma and a rejection of female identity as chaste (outside of marriage) and obedient partners and child-bearers (Marston et al. 2018; Williamson et al. 2009).

Contraceptive use and consumer identity is at once an individual and social risk, however risk mitigation in one identity can appear to satisfy some of the risks of the other. Risk perception appears to be culturally linked, where individuals in collectivist countries will prioritize risk based on social identity compared to those from individualist countries who prioritize risk at an individual level. There is an opportunity to extend understanding on the social stigma linked to particular contraceptive methods and how this impacts contraceptive uptake. For social marketers, repairing the stigma of contraceptive types and endorsing an equal promotion of all contraceptive options in an “anything that works” as opposed to an “anything

but" rhetoric of contraceptive uptake can help to promote healthy reproductive decisions and behaviours among a greater population rather than a select group.

In summary, the existing literature demonstrates that contraception marketing involves more than simply product and brand promotion. It comprises three primary elements centered around user identities, product use and risk. User identities involve both individual (goals, autonomy/control, beliefs, method 'fit') and social/cultural factors (gender roles, peers and family, providers, race, status) that, singly and in combination, inform how contraception is perceived and consumed within user self-concepts. Contraceptive use has evolved beyond its initial purpose of preventing unplanned pregnancy and is consumed for other utilitarian reasons such as family spacing, menstrual symptom management or cessation, or as a treatment option for medical conditions. Alternatively, contraceptive consumption can also be used for hedonic purposes, to enhance sexual experiences and enjoyment. Finally, risk determines the extent to which individuals will or will not use particular contraceptives, or contraceptives generally. Risk assumes different outcomes, ranging from unplanned pregnancy, STDs or contraceptive side effects, financial windfalls, embarrassment/shame and stigma. Each of these elements of identity, use and risk are fluid in the context of individual consumption patterns and will assume different degrees of importance over the course of a consumer's reproductive life.

CHAPTER 3: METHODS

3.1 Methodological Approach

Taken together, the conceptual frameworks described earlier are grounded in a constructivist paradigm that views meaning and experience as constructed by individuals and informed by social and cultural contexts (Braun and Clark 2013). The current study seeks to understand the ways in which identity drives contraception uptake, the contexts for changes to contraceptive use and how contraceptive advertising informs this practice of private consumption. Understanding these aspects involves incorporating the narratives of individuals as well as healthcare providers to understand the origins and nuances in individual attitudes and experiences with contraceptive use, and to understand the patterns of contraception that have implications from a marketing and public health standpoint. While quantitative analyses can tell us about the numbers and rates of contraceptive use that may be useful from a marketing analytics standpoint, only qualitative analyses can provide a richer understanding of the complexity and meaning behind individual contraceptive use. Unlike other mass-produced products like phones and TVs, fashion, cars or food, contraception use is not a 'one-size-fits-all' product. The fact that contraception is advertised as such may be problematic for prospective users with complex medical histories and health needs. Medical science has provided a portfolio of different synthetic contraceptive options for women in addition to other non-pharmacological options like condoms and natural family planning, and understanding how these options are incorporated into individual health decisions requires a deeper understanding than statistics alone can provide.

In this context, this study followed a qualitative method of inquiry to explore how identity frames and informs consumer uptake of contraception, how contraceptive marketing ads construct user identities, and the ways that healthcare providers impact consumer health identities and contraceptive use. Grounded theory is a well-established systematic approach to qualitative research and a best practice to understand a phenomenon through the lens and experience of individuals (Charmaz 2006). It was originally constructed as a response to criticisms regarding the validity and rigour of qualitative research compared to quantitative studies (Charmaz 2006). The outcome of a grounded theoretical approach is a theoretical model that is the result of a deep and immersive assessment of the data; theory 'emergent' from the data (Charmaz 2008). As there exists little research into the complexity of identity and consumption in marketing research, grounded theory is an ideal approach to understanding the complexities of this personal practice of healthcare consumption.

The emergent nature of a grounded theory methodology entails that an inductive approach is applied when designing a study (Charmaz 2008). Specifically, researchers approach analysis without any pre-established themes or concepts; rather, they engage in the data with an open-ended approach and allow for themes and concepts to reveal themselves using techniques like close readings and constant comparisons of the data (Charmaz 2006). This level of analytical rigour, along with the processes of theoretical sampling and memoing are what makes grounded theory a reliable and valid qualitative approach. A common point of contention among researchers is ***whose*** grounded theory that a study adopts (Charmaz 2008). Much like the systematic nature of the method, the process of identifying which theorists' – Glaser and Strauss (1967), Corbin and Strauss (1990) or Charmaz (2006) – version of grounded theory was applied is another process by which researchers must attend to ensure reliability and reproducibility of

their research (Charmaz 2008). Each version of grounded theory shares the same overarching principles of data-driven theoretical development; however each differ in the degree of flexibility of application and the involvement of the researcher.

Glaser and Strauss (1967) intended grounded theory as a defined method of data collection and dissemination where the rigour was based in the process, while Charmaz (2006) has expanded this to include the researcher's own epistemological assumptions and experiences as part of the data analysis. In this way, the researcher is not an impartial, objective audience to the research – rather, they bring their individual understanding and experience to the phenomenon of interest, as well as ideas and assumptions that inform how they interact with participants, frame questions, and determine the data of interest during analysis (Charmaz 2006). For this study, I chose to adopt Charmaz's (2006) grounded theory for two reasons: first, how contraception is viewed and consumed is unique to every individual user, and is informed by a web of overlapping biological, social, political, environmental and structural contexts that shape each individual's use; and second, I approach this study as a long-time contraceptive user. My interest in contraception is personal and social – it is a tool not only for health management but also for meeting certain individual and social goals or milestones. It is a critical tool for individuals to write their own life narratives that are no longer solely determined by their biological anatomies or 'clocks'. The personal investment in this area of research allows me to adopt the lens of an 'insider' – one that has insights and perspectives that may lend themselves to a more intuitive approach to contraceptive marketing research, to guiding the areas of inquiry within the research area, and building connection and rapport with participants.

3.2 SCPOR and Patient Partners

This study was undertaken in partnership with the Saskatchewan Centre for Patient Oriented Research (SCPOR), a research organization led by the Canadian Institute of Health Research (CIHR). SCPOR operates under the vision of research that brings the patient experience to the fore. In this way, SCPOR helps to provide research funding and support for trainees in undertaking research that is patient-oriented in methodology and outcomes. The benefits of patient-oriented research are twofold: the systems of health research knowledge are no longer relegated to the authorities of researchers and academics alone but are expanded to include the 'researched'; and the dissemination of the research is intended to be 'by patients, for patients' in a language that is inclusive and with outcomes that are realistic and directly implementable to patient groups. To help guide these research pursuits, patients themselves are involved as partners and members of the research team for all aspects of study development, as was the case with the current study.

My patient partner is a current student pursuing her Doctor of Pharmacy (Pharm.D.) at the University of Saskatchewan. She brings a unique lens the current study by occupying two worlds: as a pre-professional healthcare specialist with experience in the pharmacological and dispensation of pharmaceutical products like contraceptives, and as a consumer of contraception for many years. My partner was instrumental in the preparatory stages of research and assisted with recruitment of both patient participants as well as healthcare providers. She had valuable insights with the development and refinement of the interview guides as interviews progressed and was a key partner in data coding and analysis. Her perspectives were critical in unpacking the interview data of both patients and providers and helped to lay the connections between these stakeholders that informed development of the model.

3.3 Content Assessment

To get a sense of how contraception is currently promoted to consumers and providers, a preliminary content assessment was conducted. I undertook an examination of popular consumer magazines to examine how contraception was currently being advertised. Based on the target female demographic, available readership data yielded Vogue, Cosmopolitan, Elle, Women's Health, In Style, Vanity Fair and Harpers Bazaar as the most popular women's lifestyle magazines based on print and digital circulation (Alliance for Audited Media 2020). Cosmopolitan and Vogue were determined to be the most reliable print source for contraception advertisements per monthly issue, and all ads were examined for DTC contraception advertisements over a one-month period. The sample included 12 issues in total between May 2019 and May 2020 for Vogue and 10 issues total between May 2019 and May 2020 for Cosmopolitan, as I was unable to locate two issues. The contraceptive ads were assessed by determining the contraceptive method being promoted, and the pictorial and verbal components were assessed to determine how user identities were portrayed. Key findings from this analysis found an exclusivity of contraceptive methods promoted in Vogue, where ads for the subdermal implant Nexplanon and emergency contraception Plan B were the only contraceptive products that were included in the sample.

Cosmopolitan demonstrated a wider variety of contraceptive ads for the non-hormonal IUD Paragard, the hormonal IUD brand Kyleena, Nexplanon and Lo Loestrine FE, an oral contraceptive brand. Paragard was featured significantly more per issue than the other methods. These results are bolstered by the DTC ad spend trends for contraceptive advertising as found by Wu and colleagues (2016). Only the Nexplanon ads featured models from different racial backgrounds; the majority of the models were young, white, and attractive, in keeping with findings from previous literature. The verbal components of the ads predominantly described features of the product itself, although older ad runs of Nexplanon found in the content assessment featured language framing user identity in predominantly positive and empowering contexts. These ads were used to guide interview questions and as supporting documents in participant data collection methods. The final ads that were selected for use in the interviews included a Nexplanon ad featuring actress Vanessa Hudgens, and a Plan B ad featuring a non-celebrity model. In addition to the print ads, a Youtube link for the most current Paragard TV commercial campaign was selected for participants to review prior to the interviews. The ads were chosen because they were the most current campaign ads for the contraceptive products as well as the most commonly occurring contraceptive ads in both Vogue and Cosmopolitan. Both print ads and a digital commercial ad were used to ensure diversity of products and advertising media, and to account for the different instances of ad exposure that consumers may encounter.

3.4 Setting and Participants

Ethics approval for the study was granted in October 2020 by the Behavioural Research Ethics Board at the University of Saskatchewan. Due to the ongoing COVID-19 pandemic, all recruitment and data collection were conducted under the University's pandemic protocols. This entailed conducting the patient partner meetings, recruitment initiatives and data collection remotely. Participant recruitment proceeded in November 2020 after consultation and planning meetings with the patient partner. The population of interest for this study included women between the ages of 18 and 45 that were a) English-speaking; b) currently taking a or had taken a method of contraception within the previous six months; and c) currently sexually active or had

been sexually active within the previous six months. Applicable methods of contraception included oral contraceptives, IUDs or subdermal implant, the vaginal ring (Nuvaring), hormone shots (Depo Provera), IUDs, emergency contraception (Plan B), the patch, condoms (male or female) or natural cycle tracking. Healthcare providers were also included as a population of interest for this study as they act as key agents for contraceptive resources and administration for patients whose roles are also integral to patient health identities. Eligible healthcare providers were a) English speaking female practitioners; b) that were actively licensed and practicing family physicians, OBGYNS, pharmacists or nurse practitioners; c) with experience in contraceptive counselling and prescribing within the last 3 months. Female practitioners specifically were chosen for recruitment due to the likelihood that they may also have personal experience with contraceptive use separate from their professional practice, which may be informed or influenced by their work. This 'shared' experience with contraceptive use among practitioners and patients may act to implicitly bridge social and occupational gaps within medical consultations.

3.5 Recruitment

Recruitment for patient consumers and healthcare providers took place from November 2020 through January 2021. Patient consumers were recruited using purposive techniques similar to previous studies (Marston et al. 2018) until theoretical saturation was reached. Theoretical saturation is a key metric for grounded theoretical approaches wherein sample data is assessed simultaneously with data collection measures (Charmaz 2006). Active and immediate data analysis following collection acts as a guide for additional sampling until no new themes or concepts emerge (Charmaz 2006). Recruitment measures for consumer participants incorporated participants from different life stages such as student samples and adult women based in the community. Recruitment outreach was exclusively digital due to the unique timeframe of conducting research during the COVD-19 pandemic and to ensure the safety of the participants and researchers. Consumer patient participants were recruited using digital bulletins and email outreach at the University of Saskatchewan through select campus health locations including the Student Wellness Centre and University of Saskatchewan Students' Union (USSU) groups including the Childcare Centre and Women's Centre. Off-campus digital recruitment included public health clinics such as Positive Passions, Saskatoon Community Clinic, Saskatoon Sexual Health Centre and the Sexual Health Clinic. A total of 18 patient consumer participants were confirmed for interviews, however the final number was amended to 17 after one participant missed the interview after submitting consent forms and did not elect to reschedule.

Recruitment for healthcare providers involved email circulation through the University of Saskatchewan's College of Pharmacy, Department of Family Medicine, Department of Obstetrics and Gynecology, as well as through private clinics such as the Campus Medicine Shoppe, Wall Street Obstetrics and Gynecology, Broadway Obstetrics and Gynecology and provincial organizations including the Pharmacy Association of Saskatchewan. A total of 5 healthcare providers consented to the interviews – this included 3 pharmacists and 2 family physicians.

No prospective participants were contacted directly by the primary researcher to ensure confidentiality of information and freedom of choice. Interested participants were given contact details in the email bulletins and Facebook posts to contact the primary researcher, at which point they were given additional screening questions to confirm they met the eligibility criteria.

Once eligibility was determined, participants were invited to schedule an interview date and time of their choosing. All participants were given the option of receiving a $20 Indigo or Amazon e-gift card of their choosing in appreciation for their time which was sent to their contact email used for booking the interview or to an alternative email they provided the primary researcher.

3.6 Interview Structure/Data Collection

Data was collected using semi-structured interviews where patient consumer participants were asked about their experiences learning about and using contraception, their resources for finding contraceptive information and their perspectives on different contraceptive methods. Interview questions were guided by previous literature and incorporated areas previously identified as gaps in the research, including the circumstances that led individuals to begin contraceptive use and how that use has changed over time. Copies of ads from the content assessments as well as a Youtube link to the current Paragard ad campaign were emailed to the participants prior to the participant meetings with instructions to simply review the content for discussion during the interview. Participants were asked during the interview for their perspectives and feedback on the ads. Healthcare participants, in addition to the questions asked of consumers above, were asked to provide insight into the trends in contraceptive use they have seen through their profession as well as the common contraception questions they fielded in their work.

Participants were given the option to have an interview conducted over the phone or through Webex videoconferencing platform. Two mock interviews were conducted prior to the participant interviews, one with a close friend of the researcher and the other with the patient partner, to get a sense of the flow of the conversation and to fine-tune any questions for the interview guide. While the interview guide was pre-set, the flexibility of the interview structure allowed for participants to guide the flow of discussion and allow for probing into particular topics or areas of interest that were tangential to the areas of questioning included in the guide. The interviews included an opportunity for participants to add any additional points of clarification outside of the questions that may be of relevance or importance to the topic. A copy of the interview guide can be found in Appendices E and F; copies of the contraception ads can be found in Appendix G.

Prior to the interviews, participants were emailed the consent forms as well as the contraception ads described above with at least a week in advance of their interview dates in most cases to allow time for participants to review the details of the form and ads, and to allow for any questions or clarifications to be addressed. The interviews were conducted using the Webex toll-free call-in numbers for phone interviews and with added video for videoconference interviews. Both phone and videoconference interviews were recorded using the Webex recording feature, and with the recording feature of the primary researcher's iPhone as a backup copy. All interview recordings and transcriptions were saved and stored in a password-protected university Cabinet account.

All participants were briefed at the start of the meeting regarding the expected duration of the interview, and reminded that they did not have to answer any questions that they were not comfortable with. All participants were made aware that the interviews would be recorded and the specific start and stop times for the recordings. Periodic check-ins throughout the interviews were done to ensure the participants were comfortable. Options for pseudonyms (researcher or participant-generated) or complete identity confidentiality were given in the consent form, as

well as the option for participants to request a copy of their transcript of the interview. In most cases, participants consented to the researcher selecting a pseudonym on their behalf. Where requested, participant-generated pseudonyms were used. Two participants elected to remain entirely confidential; in these cases, titles such as ‘Respondent’ or ‘Family Physician’ were used.

The interviews were completed over the months of December 2020 and January 2021. All but two interviews were conducted over the phone. Each interview lasted approximately 45 minutes with the range of interview lengths being as short as 30 minutes and as long as 1.25 hours. All interviews started with a general discussion to build rapport before prior to the starting of the recordings. Interestingly, the two interviews that were conducted over Webex yielded a longer on-average discussion and a faster rapport compared to interviews conducted over the phone. This was surprising, given the fact that phone interviews can afford more privacy and discretion when discussing a topic area as personal as contraceptive consumption, and therefore could result in greater comfortability in disclosing personal experiences. Before the close of the interviews, participants were invited to share any other comments or questions they had before the interview was wrapped up and confirmation on their gift card delivery was confirmed. All participant email correspondence as well as email addresses used for delivery of the e-gift cards were stored in a separate folder form the transcripts in the password protected University Cabinet account.

3.7 Transcription and Coding

3.7.1 Data Transcription

Interview data was transcribed using the transcription feature of the University of Saskatchewan Webex account. Additional manual transcribing was completed by the primary researcher to improve any transcribing gaps and add clarity to the Webex-generated transcripts. Transcribing occurred immediately after an interview, in following the process of the theoretical saturation (Charmaz 2006). Transcripts were downloaded from the researcher’s University Webex account to their campus Cabinet drive and edited using the Notepad application. Transcribing between interviews allowed for an informal analysis of the interview data and provided an opportunity to make minor amendments to interview questions that were points of confusion or required additional clarification during participant interviews. Minor amendments included re-wording particular questions to allow for clearer delivery, and to add additional prompts to questions based on concepts that emerged from prior interviews. All interviews were transcribed exactly as recorded, including pauses, colloquialisms, and filler words (all, umm). Interruptions in conversations were also noted. In some cases where the official interview questions were completed and the remainder of the interview involved general discussions, this content was cut out from the final transcript and indicated in the transcript copy. Where requested, transcripts were converted to word documents to be sent to participants requested copies.

3.7.2 Coding

The interview data was consolidated and analyzed using NVIVO software. Data analysis began with a preliminary read-through of the completed transcripts in order to gain familiarization with the data and to note any broad trends or themes. As a complement to the initial transcript review and to help parse out content based on the interview questions, copies of each transcript were made in Microsoft Word and arranged by inserting ‘headings’ of the

interview questions. Arranging the transcript layouts by headings allowed for NVIVO to autocode the data by these headings and consolidate the responses from each of the participants under each heading query for easier analysis and to aid in constant comparison across the texts (Charmaz 2006). Following the preliminary read-though of the original and heading-organized transcripts, initial coding began with a close read of the data (Charmaz 2006). Initial coding followed the first step of grounded theory analysis, where the intent is to follow as closely to what appears in the data (Charmaz 2006). I achieved this by using line-by-line coding, and coding my data using gerunds, or 'action words' to tie the codes to the events exactly as described in the data chunks I was analyzing.

With line-by-line analysis, I coded the data by each sentence or thought stream in the transcript, and sometimes incorporating an entire paragraph under a single code. Initial coding allows for a methodical way to immerse into the data and move outwards from a literal (or semantic) interpretation of the data towards a more conceptual (latent) interpretation as categories and themes begin to emerge in consecutive rounds of analysis (Braun and Clarke 2013). It allows for the researcher to get a better sense of the worldviews of the participants and the processes at work in their accounts (Charmaz 2006). We first 'ground' ourselves in what the data is telling us so that we do not get misled in attaching any abstract or theoretical assumptions prematurely.

The initial data coding yielded over 200 unique codes. Based on the content of the interview questions, some very broad categories emerged from the initial coding, such as codes related explicitly to the ads ('Ads') that participants were asked to comment on, to the role of partners ('Partners') and doctors ('Healthcare Providers') in their experiences with contraceptive use. Many passages in the transcripts were initially categorized under multiple codes. This was done so that they could be more closely reviewed in consequent rounds of coding and refined into a best fit. Most of the codes, however, did not immediately fall into a broad category.

In the second round of analysis, focused coding was employed to closely assess each generated code and to begin grouping codes together under emerging categories. Codes and excerpts were reviewed and either amalgamated together under an existing code or were re-coded to add clarity to the texts. The initial categories that emerged were based on repeated concepts or terms that were reproduced over the interviews and guided by the interview questions. Refinement and grouping of the codes was aided by recursive analysis of the transcripts to ensure the codes and categories were authentic to the contexts of the individual accounts. In both the initial and second round of coding, constant comparison across the texts was used to ensure thoroughness of the analysis and to aid in refinement of the categories and codes. Both processes of focused coding and constant comparison allowed for new references and codes to emerge to add 'meat' and nuance to the established categories.

The final round of analysis involved theoretical coding. With theoretical coding, the existing codes and categories are assessed alongside each other to determine the relationships and overlapping contexts (Charmaz 2006). In this round, analysis moves beyond the literal extrapolation of the participant accounts to the more latent and conceptual meanings behind their narratives. Where participants made reference to their bodies 'adapting' to the different contraception formulas, their systems implicitly 'knowing' when to menstruate or their understanding of the inner workings of their bodies, these codes merged into the theme of "Knowing Bodies", a refined concept that helped to explain the repeated accounts of implicit and explicit somatic knowledge that emerged as a result of contraceptive use. Theoretical coding

helps us to answer the question "what does this *really* mean?" in individual narratives of their contraceptive experiences. The result of theoretical coding entails a selection of key categories or concepts that were repeatedly produced in the participant accounts that relate to one another and explain the ways in which contraceptive use and identity play out in individual and social contexts.

3.7.3 Memoing

Memo writing is a key hallmark of grounded theory research. Memo writing allows researchers to document their process and ideas that emerge from their study development, data collection and analysis, and can serve as a point of reference and analytical text for data coding purposes (Charmaz 2008). Memoing helps to contextualize the reflexiveness and position of the researcher in their work and can act as a guidepost for any emerging concepts in the study (Charmaz 2006). Throughout the process of my study from development through to analysis, I kept a written journal of my observations and reflection on the process. I memoed why I made the decisions I did in the development of the research questions, how I determined my population of interest and the inclusion/exclusion criteria, as well as my observations on the recruitment process. In addition to the Webex recordings, memos were taken during the participant interviews (without any identifying data recorded) both for recall later in the interviews, as well as to flag any questions that needed reworking or key topics that could be incorporated into later interviews.

Memoing was indispensable as an aid to my data analysis and allowed me to track every iteration of data analysis by date. I was able to use memoing to record my initial findings and thoughts on the data, to ask questions of myself or flag codes for a closer review. Memoing also allowed me to identify any gaps in the data or areas for future analysis that fell beyond the scope of my study. Memo-writing ultimately served as a journal of sorts to help me understand qualitative research and my role in it as observer and participant. Due to the added complexity and restrictions of conducting a qualitative study during the COVID pandemic, my memo writing was an important methodological tool that repeatedly referred to during data analysis alongside the interview transcripts. It helped to formulate and refine categories, to critique and analyze the scope and content of the categories, and to explicate the different ways of explaining the categories and their relationships. Incorporating the process of initial, focused and theoretical coding in conjunction with memo writing, I was able to develop a framework out of the data to explain how identity and contraceptive use are placed in the larger social and cultural arenas.

CHAPTER 4: FINDINGS

4.1 Theoretical Framework

This section begins with an overview of the emergent framework that contextualizes the relationship between consumer identity and contraceptive use. The framework outlined in Figure 4.1 aims to explicate the different factors that inform consumer identities and consequently shape how contraceptives are or are not consumed. Incorporating accounts from interviews with seventeen patient consumers and five healthcare providers, the resulting framework describes the key social agents and the identity narratives that are reproduced within these social agents that directly inform consumer health identities, beliefs, and contraceptive use.

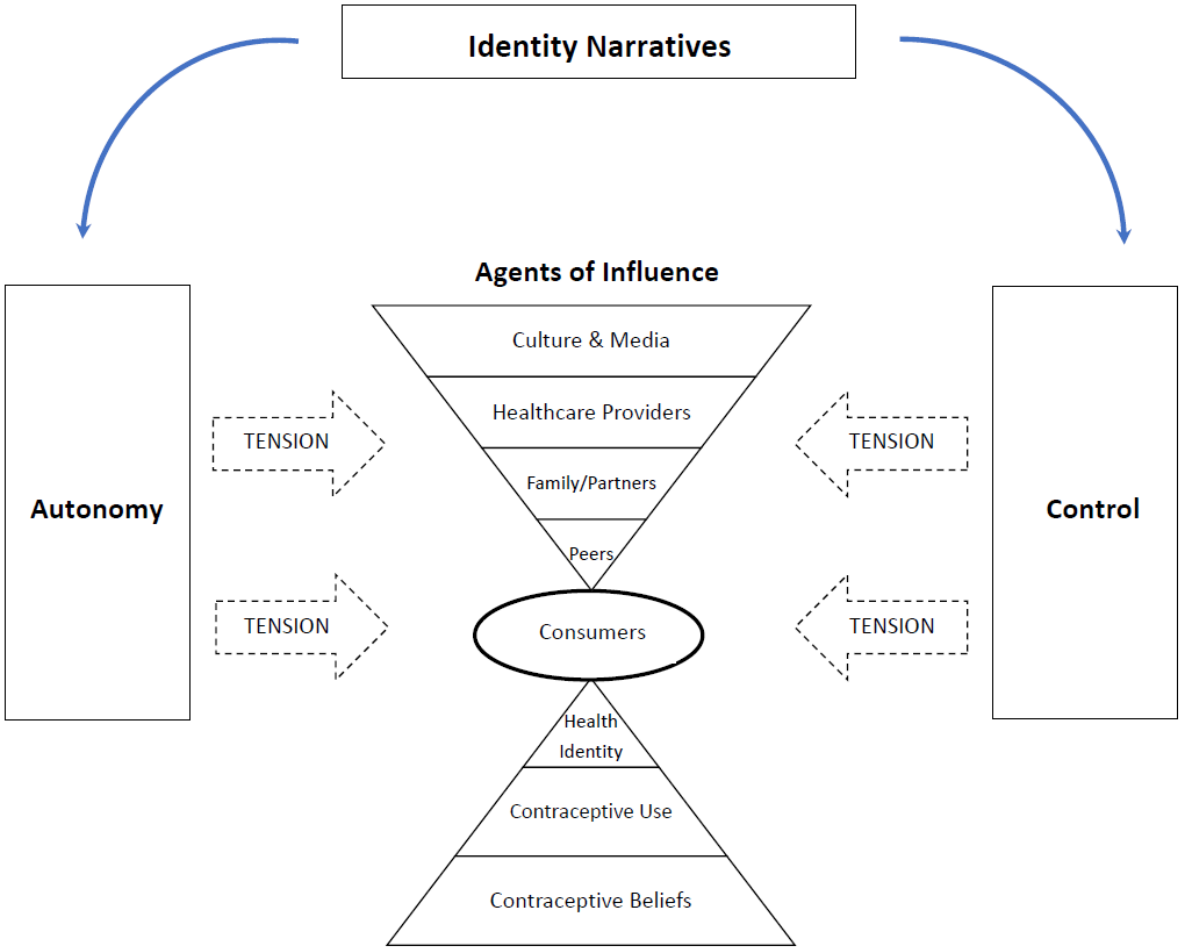

Figure 4.1 – Factors of Influence of Consumer Identity that Impact Contraceptive Uptake

The order of the agents is important; they are listed in ascending order based on their level of closeness to the immediate social environment of the individuals. Where cultural and media sources impact consumer identity on a macro level, their effects are less immediate to the consumer's self-concept; the role of peers and healthcare providers were the most commonly cited social agents whose roles directly informed consumer identities and contraceptive uptake at

a micro level. Interestingly, the roles of peers and providers as contraceptive guides and resources were identified as more important to individual self-concept than the role of parents *or* partners. These findings will be expanded upon in later sections.

The concepts of 'Autonomy' and 'Control' repeatedly surfaced in the discussions with consumers and providers. Not only were these terms used directly by nearly all participants when describing contraception and its use, but they also fed implicit assumptions about the female experience and her relationship with contraception. Taken together, these concepts form the primary identity narratives that frame contraceptive use among consumers. The concepts of autonomy and control emerged in participant accounts as *diametric*, or oppositional narratives identified as overlapping contexts within the different social agents. The reproductions of these didactic identity narratives in social contexts results in a tension at the individual level. The process by which an individual negotiates these competing narratives within their respective social frameworks consequently informs how they will perceive their reproductive health identity and beliefs about contraception and contraceptive use. Table 4.1 below provides more detail on the ways in which these identity narratives are reproduced within the different social agents of influence. These conflicting narratives will be discussed at the level of each social agent.

		Identity Narrative	
		Autonomy	**Control**
Agents of Influence	**Peers**	Key contraceptive resources Method Influencers	Method Deterrents Cautionary Contraceptive Lore
	Providers	Trusted health partners Patient and Public Health Advocacy Unbiased and Ethical Consultations	Biasing Methods Discomfort and Distrust Gatekeeping Accessibility
	Family & Partners	Communication and Collaboration with Contraceptive Use Supporting Sexual Health Decisions Trust is key	Controlling Health Behaviours Conflict and Misalignment Discretionary Disinvolvement
	Culture & Media	Normalizing Contraceptive Use and Access Proactive and Productive Women 'Knowing' Bodies	The Feminine Contract Menstrual Body as Problematic Sole Sexual Responsibility

Table 4.1 - Conceptual Framework of Consumer Identity and Contraceptive Use

4.2 Peers

4.2.1 Peers as Key Resources and Method Influencers

Peers were cited by nearly all participants as key first points-of-contact regarding contraceptive information and counsel. Peers served as a channel to fill in the gaps with the limited early sexual education participants received in elementary schools, or as alternative resources to parent figures. Many participants described a comfortability and trust in discussing topics like contraception with their friends:

"Yeah, I would say talking with peers feel- felt like; feels like the most safe space, uh, to discuss contraception methods. Um, being with people your age who are really accepting, you can kind of just talk about anything with them." (Respondent A)

Participants regularly relied on the experiences of their friends' contraceptive use to guide their decisions on initial contraceptive method starts or method changes. The power of peer-to-peer resource sharing was also recognized by healthcare providers. Charlene, a family physician, would often incorporate this into her patient counselling by prompting patients to reflect on what they already know about contraceptive methods through patient social circles:

"And I think it's just easier, you know, you do what your friends are on; and that's usually what I ask girls, and they come in and I say 'Well what have you heard of? What do you know about?'" (Charlene, family physician)

The comfortability with using peers as referents for contraceptive information may explain patterns of contraceptive uptake among specific demographics and communities. Out of the 17 participants interviewed, 15 mentioned oral contraceptives (OCP, or 'the pill') as either their initial or current method of contraception, with condoms (12) and IUDs (3) as the second and third most cited methods used, respectively. In cases where participants started hormonal contraceptives at a later age (ages 16 and later), many described beginning a method similar to their friends or using their friends' experiences to guide their contraceptive choices. A common scenario involved participants expressing interest in shifting away from pill or condom use to IUDs. Even before consulting with doctors, participants would refer to their friends' positive experiences with the IUD as an incentive to explore the method further, echoing Sundstrom, et al's. (2016) findings on the effects of peer influencers and LARC uptake. The degree to which friend groups factor into contraceptive uptake may explain the reluctance by some in using newer contraceptive technology like IUDs. Product familiarity and acceptability among participants was always explained in the context of *who* they already knew that used the methods:

"But overall, just because I know a lot of people take the pill; I would rather do the pill." (Michelle)

"…I guess, like talk to, like, my friends; uh, a lot of my friends are [sexually] active and I think probably half of them are on the pill and use condoms and half just use condoms so like, it seems like a good choice." (Allison)

The accounts of Allison and Michelle describe how the experiences of their friends using specific contraceptive methods empowered them to consider the same method for their own sexual health needs. Reliance on existing and available contraceptive knowledge among peers is worth considering when promoting newer products like the LARC Nexplanon, which was

recently introduced to Canadian markets. When asked to provide their impressions on the Nexplanon print ad featuring actress Vanessa Hudgens, sentiments were overwhelmingly negative not only because of its content, but because of its 'foreignness':

"Um, I don't think- just amongst my friend group – I've heard of, like, the arm implant, but I didn't really know anything about it. And I don't really know anybody who does that." (Adrianne)

When prompted to confirm if she had previously heard of the contraceptives in the ads, Adrianne automatically framed her understanding in the context of her friend groups. These findings place the potential for contraceptive uptake to tilt more heavily in favour of experience over information or novelty. Despite the creative license taken by advertisers to frame a product in a favourable light (celebrity spokespersons, popping text and colour), word-of-mouth was shown to be stronger in determining individual perceptions toward a product. Viewed another way, peer groups served to polarize beliefs about the acceptability and use of specific contraceptives; individuals would adopt this dominant contraceptive discourse into their own beliefs about contraceptive types as well as the methods they would and would not consider using.

More than simply method influencers, peers were described as a source of support in their shared experience as women and as contraceptive users. Peers were cited as a sounding board for commiserating over the less desirable realities of contraception consumption. In cases where participants had to grapple with unpleasant side effects associated with their contraception, they turned to their friends for advice. A few months after getting a Kyleena hormonal IUD inserted, one participant disclosed that she began to experience significant dips in her moods and dissociative states. She began to question whether the depressive episodes may be due to the new method of contraception, and it was not until a friend mentioned experiencing a similar phenomenon with her contraceptive method that her suspicions were confirmed:

"…my roommate at the time, she had been going through a similar experience and, like, brought it up that, like, she felt that what I was experiencing was similar to hers; where she just felt like really emotional, like the world was ending and shared that same, like, kind of dissociative-like…trying her best to do things that made her feel grounded but, like, just couldn't get a hold on it…and yeah, so kind of, from that conversation was like what led me to take mine out." (Respondent A)

Perceptions of comfort and security in discussing personal topics like mental health in the scope of contraceptive use with peers was a recurring sentiment among participants. When women felt seen, heard and validated by their peers, this would feed into individual perceptions of autonomy and self-determination in decisions to start or discontinue methods, as experienced by the participant above. Comfortability with sensitive topics among friends appeared to increase with age and life circumstance – most participants over the age of 30 explained how their ease with discussions related to reproductive health and contraceptives increased among peers with the onset of major life milestones like marriage or having children.

Conversely, those participants who began using contraception at an earlier age (ages 10-15 years) served as a referent for their peers for contraceptive expectations. Adrianne, a current university student, drew on her early contraceptive education from her parents and her use of the pill for acne control to educate her friends once they began using contraceptives at later ages. As both contraceptive resources and influencers, peers provide a channel that individuals can draw

on to inform themselves about the fit of a contraceptive method in their reproductive plans. Peers can serve as strong motivators for the adoption or rejection of a particular contraceptive method. They provide for women an authentic account of the lived experience as a contraceptive user outside of the artifice of a pharmaceutical ad or physician's office. Drawing on the guidance and experiences of peers can be a stronger determinant of individual agency regarding contraceptive use outside of healthcare contexts. If a woman has many friends within her group that are using a contraceptive, she is more than likely to engage in a similar act, even going as far as to frame her expectations of contraceptive use to align with those of her peers. This process of alignment of individual attitudes towards contraceptives as well as shared patterns of contraceptive uptake in the manner of an individual's social group lends support to social identity theory (Reed 2002) that describes how individuals will adopt cognitive and behavioural strategies to frame their self-concept in reference to a particular group membership.

4.2.2 Peers as Deterrents and Cautionary Contraceptive Lore

Peers and peer experiences were also cited as a reason for deterring participants from certain contraceptive methods. With IUDs in particular, many participants shared secondhand 'horror' stories from friends about negative experiences that predominantly involved the IUD insertion process or an IUD failure. Friends' accounts of the pain and discomfort with having an IUD inserted were enough to deter participants from ever considering it as a contraceptive option, despite wanting to change their existing method for something more cost-effective and less user-intensive. Michelle, a student and childcare worker, shared how her friend had an IUD inserted and was "down for the count for, like, 2-3 days…throwing up constantly"; while Kay, a website developer, described her friends' IUDs as 'shifting' and causing them internal pain. Adrianne recounted how her friend's mother was using an IUD at the time that she became pregnant with her friend. It is likely that the IUDs of that time were far different from the modern options available to women today, yet Adrianne remained cautious around considering IUDs as a potential contraceptive option. Jenn, another university student, shared a story heard through her friends of an IUD getting embedded in the ovaries of its user, resulting in their removal and subsequent infertility.

Two participants recalled the Yaz oral contraceptive controversy as a specific brand to avoid. Dawn, a stay-at-home mother of two, shared how her friend's use of the Nuvaring resulted in her experiencing a psychotic episode that abated once she stopped using it. Narratives circulated among peer groups were seen to be more powerful discourses to control the perceptions of specific contraceptive methods or brands than even ads; in many cases these stories were enough to colour participant perceptions of those methods and remove them from consideration in their reproductive plans. Other participants shared general cautionary tales about the consequences of contraceptive misuse. Tia, an environmental service worker, recounted instances of friends and associates who contracted sexually transmitted diseases (STDs) from contraceptive non-use, while another friend experienced an unplanned pregnancy at 16 and dropped out of school. In her view, she reasoned that the lingering stigma around contraceptives and accessibility issues prevented many of her friends from taking or maintaining consistent contraceptive practices and made a point to avail herself to friends in similar circumstances to get the contraceptive resources they needed. In this context, peer experiences with contraceptive non- or misuse actually served to reinforce participant beliefs about proper and responsible contraceptive use:

"I always preach, um, health and wellness to anyone that I can because it is my passion and, you know, I talked to people that I know when I say, 'Well, do you need a contraceptive? Are you safe? Do you use a condom?' And kids now don't want to use condoms! …But I know people who have had intercourse and then wanted Plan B and felt too uncomfortable to go. Of course, I went for them because I'm a good person but- I think the stigma around it is debilitating to people." (*Tia)*

Just as their positive experiences shape individual attitudes and intent towards contraceptive use, so too do the negative experiences of peers. To a greater extent, negative peer contraceptive experiences were a stronger predictor of identity disassociation and a controlling force in dictating contraceptive method use and behaviours among participants. Despite the higher efficacy, lower long-term cost and, in the case of the copper IUD, reduced risk of hormonal side effects, many of the participants were unwilling to consider an LARC as a viable contraceptive option in part due to the attitudes toward and experiences of the methods among their friends. In this way, peer perceptions served as mechanisms of control over both the likelihood that a woman would use a contraceptive method as well as the type of contraceptive used. In many of these cases, participants often integrate the experiences of their friends into their own rationalization for contraceptive use, assuming they will have similar if not the same experiences as their peers:

"[speaking about negative contraceptive effects among friends] Yeah, I think if I took birth control now, like if I hadn't been on it before but I started taking it now, it's something that I would maybe even expect to feel just because [of] how common it seems amongst my friends." (Jenn)

Rory, a childcare worker, was encouraged by a *male* friend to take the pill for the first time in adulthood, due to her recent shift into a long-term relationship:

"And then, when I have my first serious relationship, is that I have a close guy friends; and then he was telling me this:'You know, my girlfriend [is]actually using those birth control. The long term birth control, maybe you should consider to doing now because, uh, you have a stable relationship.'" (Rory)

Not only was Rory directed away from non-hormonal contraceptive use (condoms) towards a hormonal method, but she was also driven to use this method simply because of a change in her relationship status. She attributed her hormonal contraceptive use as a socially-conditioned response to her peers, *"Because all my girlfriends who has[sic], like, boyfriend…they will like, take this."* While it stands that a new relationship may be the impetus for adoption of a contraceptive method as some participants described, many of the women in this study turned towards contraceptive use for individual health-related reasons. For many, contraceptive uptake was a health decision made in consultation with their healthcare providers.

4.3 Healthcare Providers

4.3.1 Providers as Trusted, Unbiased Advocators of Patient Health

In addition to peers, healthcare providers were cited as the primary resource for contraceptive information by participants, supporting similar findings in previous studies (De Irala et al. 2011; Sundstrom, Szabo and Dempsey 2018). In some cases, doctors were the *only*

resource that consumers relied on for contraceptive information and access, adding further support to the key partnership that doctors play in contraceptive marketing contexts (Dehlendorf, et al. 2017; Sundstrom, Szabo and Demsey 2018). In these circumstances, 'trust' and provider 'openness' to exploring treatment options emerged as key attributes in contraceptive consultations with healthcare providers:

"I'd probably just call my family doctor because I don't really trust, like, looking at stuff online, just because I know that pharmaceutical companies can sort of, you know, pay to have things come up on Google as, like, an ad." (Jenn)

"[On discussing the Depo Provera shot with her doctor] He was- he's a fantastic doctor; so he, he agreed. He said 'Yes, this is the best option. Here's why'. Cause [sic] he's really open to trying new things. So if I would've said 'I want to do this', he would have, but because I was hesitant with, like, an IUD or anything, he agreed that this was the best option for me." (Wendy)

When women like Wendy and Jenn felt they could trust in their provider and share their health questions and concerns in an open exchange, they felt more empowered and in control of their health outcomes. Interestingly, these attributes were only mentioned in cases where participants had an established family doctor. Where participants started contraception as a treatment for medical conditions such as polycystic ovarian syndrome (PCOS) or other significant hormonal imbalances, reliability and trust in their doctor was tantamount to their adoption of a contraceptive method. In situations where many of the participants started contraception at a young age, trust in their healthcare provider was implicit, expected and reaffirmed by parent figures.

Despite the expansion of provincial regulations on prescribing authority for Saskatchewan pharmacists to include all contraceptive options with the exception of IUDs and the subdermal implant, pharmacists were observed to be an underutilized resource for participants. This may be due in part to the newness of their prescribing authority, but may also be due to the fact that physicians are perceived as having a more comprehensive understanding of patient health backgrounds and experiences. In this context, participant trust may be tied to the credentials of the healthcare provider, where doctors are perceived culturally as the formative resource for health-related matters. Yet the pharmacists in this study indicated an equally similar comprehensive understanding of prescription treatment regimens in their experiences with patient consultations.

While the pharmacists that were interviewed described the bulk of their contraceptive-related patient interactions as predominantly renewals or refills of existing prescriptions, they affirmed the value of patient engagement and consultations as foremost in their professions, despite consumer perceptions of their work as simply 'pill pushers':

"So to me, it discounts the value of our professions - whether you're a pharmacist or pharmacy intern, or physician or nurse practitioner or nurse, or whoever you are, a sexual health counsellor - providing information that should go along with this[contraceptive] drug product and simply, it just makes it a transaction of a product. Like, there's the piece missing here."(Lisa, pharmacist)

While Lisa's comment is in reference to the wording in the Plan B ad stating its availability over the counter in the family planning aisle, her perspective can be extrapolated to describe the role

of healthcare providers foremost as consultative agents and partners with patients in patient-centred healthcare settings.

In addition to consulting and prescribing treatments, the healthcare providers in this study expressed an openness to improving patient and public health advocacy. Nearly all providers described a need for improving sex education in schools and in encouraging patient autonomy in seeking contraceptive resources outside of medical consultations. Improving sexual education in elementary and secondary schools was shared among participants as well. Where most described limited or absent sexual education discussions in their schooling, Tia credited the visiting public health nurses that would put on presentations at her high school for supplementing her early contraceptive knowledge:

"…[describing the circumstances when she showed up to high school instead of skipping classes] I don't know how I got them, but it would always be when there was some presenter or some public health nurse, someone who I didn't want to see there presenting something. And thank God they did, because I always learned so much because I was the only kid that actually listened; and the public health nurses coming out and explaining contraceptives, how they work, what's in them. I retain a lot of information from that…I learn from hands-on, talking, communicating back and forth." (Tia)

Tia's account encapsulates the nuances of individual learning and education around topics like sexual health and contraceptive use. Where some individuals gain more value from written resources like books and pamphlets, others learn best from hands-on experience or in-person discourse. With patients, healthcare providers can utilize both approaches in their consultations as a best practice for priming contraceptive awareness and uptake.

In addition to their contraceptive consultations, two of the providers directed patients to local health organizations including Out Saskatoon and Saskatoon Sexual Health as well as public health sites like the Society of Obstetricians and Gynaecologists of Canada (SOGC). Encouraging patient agency in health-seeking behaviours is a hallmark of patient-centered care (Dehlendorf et al. 2017; Merz, Czerwinski and Merz 2013) and allows for providers to extend their professional resources to further benefit patient health and wellness. Endorsing external resources such as the SOGC allows providers to help dispel contraceptive health misinformation by guiding patients towards information that is evidence-based and reliable. Using evidence-based research and judgement as a foundation for an unbiased and ethical standard of practice was cited among all practitioners in this study. As female healthcare providers with a professional acumen on contraceptive knowledge and having had personal experience with contraceptive use, the providers were clear in communicating that their professional training did not allow for personal biases in their consultations. Rather, their individual journeys in educating themselves on contraceptives were drawn upon in guiding patients on contraceptive resources. This manifested in guidance towards external resources like the SOGC and local health organizations, working with patients to determine their health goals, and dispelling patient concerns regarding contraceptive effects and use.

4.3.2 Provider Distrust, Bias and Barrier-Making

Of the participant accounts of experiences with healthcare providers (doctors and pharmacists), many of the interactions were described as neutral or negative. While the providers in this study described the ways in which they leveraged their knowledge and resources to work

with patients to arrive at a method to suit their needs, over half of the participants indicated that it was the doctors who determined the contraceptive formula for patients with limited guidance or discussion on expectations or alternatives. In all of these cases, providers assigned the oral contraceptive to patients as a preliminary treatment option or as different formulations in follow-up consultations. The automaticity towards the oral contraceptive as a first option for participants was reaffirmed among healthcare providers in the context of the method's popularity in the general public; however, providers also indicated a bias towards prescribing methods based on previous prescribing experience:

"It's something they've been using for decades, right? So a lot of prescribers are just comfortable…We know how to use those medications. We know what the long-term effects are, and we can educate people about that. There's a little bit less unknown." (Lisa, pharmacist)

As with consumers, providers relied on the pill as a primary contraceptive treatment option, but framed their preference as based on existing health scholarship as well as their years of prescribing experience. The 'unknown' in Lisa's account was in reference to newer contraceptive technology like LARCs as a potential explanation for its slow uptake among women of reproductive age. Charlene's explanation regarding pill preference among providers and patients may be more telling:

"…I think that's very, very popular just because it was the first one, so it's comfortable. As we're experiencing now with the vaccine and stuff for COVID, people prefer things that have been around a long time and feel safer with that." (Charlene, family physician)

Perceived provider bias was apparent with other contraceptive methods including the IUDs. One participant recounted an experience with a provider where she expressed an interest in the copper IUD but was instead persuaded towards the hormonal version:

"But then the doctor I went to was trying to steer me away from the copper IUD, and she wasn't really making it clear why. Just saying, like, 'I don't like them. Like, the hormonal ones are such a low dosage. Like, you don't need to worry about it.' And, like, I just didn't really know what to do in that situation. I felt like I should trust this health care practitioner, so I chose a hormonal one." (Respondent A)

Similar instances of participant discomfort with provider consultations regarding contraception were noted. Participants preferred to discuss contraceptive options with general physicians with whom they had no prior medical relationship instead of their family physician to avoid awkwardness in broaching the subject with a provider that treated them through adolescence and with close ties to their family. In this instance, both discomfort and distrust that their physicians would communicate with their families drove participants to seek alternative providers. Participant experiences with accessing Plan B were cited as awkward, uncomfortable, and interrogatory with pharmacists:

"So it was only $20 to buy it but then it was also $20 to have a consultation with the pharmacist who then, like, grilled me on, you know, 'Do you know what all of your options are for safe sex and contraception?' Like, 'Were you using condoms-?' Like, none of your business! Not your business! You're a pharmacist, and not even my regular one, I'm not fucking telling you. But like, that's what they have to do, they have to have a consult with you to kind of make you, like shame you a little bit." (Rae)

While the pharmacists interviewed felt that the consultation requirement for getting Plan B was an important and valued opportunity to discuss patient health concerns and safety with its use, participants perceived of the consultations as embarrassing, patronizing and a deterrent from considering the method again in the future.

The process of accessing Plan B is an example of what many participants described as an instance of gatekeeping of contraceptive access by providers. While the Plan B ad referenced in the study directed prospective users to 'find it in the family planning aisle', this is not actually the case in some Canadian provinces, and in Saskatchewan in particular. In one extreme case, a participant shared an instance in 2005 where she had to visit multiple Saskatoon pharmacies to inquire about Plan B before finally accessing it due to the fact that many didn't stock it, and in one location was turned away for requesting Plan B because the pharmacist refused to dispense it. In these instances, control of product availability and consumer access contributed to participant perceptions of embarrassment and frustration with contraceptive use. Plan B consultations, to participants, were more a means to push a dialogue on proper versus improper sexual behaviours by pharmacists more than as a conversation about the product itself. Other examples of controlled accessibility involve pharmacy inventories of brand name and generic formulations of contraceptives for consumers. While the pharmacists in this study described that these decisions were made at a corporate level, it did impact what they were able to fill for patients as well as the incurred cost to patients.

Implicit provider bias, distrust and discomfort in provider consultations, and impediments to contraceptive access were recurring examples of attempts to control the choices for women. Limits to communication in consultative settings meant that women had to accept the decision of the provider on a contraceptive route or seek an alternative opinion. As many participants cited providers as their primary resource for contraceptive information, this put them in a position of vulnerability to the inherent power structures of the patient-provider relationship. Regardless of provider experience, preference, or bias, this meant that women would settle for a method that may not have been a best fit for their health needs, goals, and agency as contraceptive users. As some of the participants experienced, incongruencies with some contraceptives led not only to feelings of distrust towards their provider, but negatively impacted health identity-related perceptions, like Kay's investigation into her sudden amenorrhea involving multiple pill brand changes and a biopsy:

"And then I, because I wasn't having a period, I was like, 'What the hell's going on? Help me; am I dying?' Like what's going on?... But I will say Oh, sweet Jesus, that I had a terrible experience with the gynecologist who was like, 'Okay, well, I'll just do a biopsy.' And it was so painful, because I don't know if she was just in a bad mood but she made me bleed and it was terrible…So I don't know what the hell's going on still, because I'm scared to go back to her, because I don't want her to break my vagina." (Kay)

Or another participant's worries about herself as a contraceptive user:

"So yeah, it does definitely make me concerned whether there is an option for me or, like, should I try this copper IUD? Like, just after this doctor being like, 'Oh, I don't like it' and stuff. So it makes me wonder like, are there negative side effects that I don't want to bring on?" (Respondent A)

In these examples, participant perceptions of their bodies as 'healthy' bodies were linked to contraceptive use. When a misalignment with a contraceptive regimen occurred, some participants would not only question the interests of the provider but would question their own bodies when side effects arose. This can have the effect of overvaluing the belief of medical interventions like hormonal contraceptives as the only viable option for reproductive health management.

4.4 Families and Partners

4.4.1 Communication, Collaboration and Support in Families and Partnerships

Parent figures and partners played important roles in consumer health identities and contraceptive use, albeit at different milestones in women's reproductive ages. For some participants, parents were credited as supportive and involved in their early contraceptive education and use. Mothers assumed a primary role in early intervention and facilitating discussions on contraceptive options and scenarios for its use, and as intermediaries in medical consultations with healthcare providers. One participant had the benefit of a father who took the initiative in educating her on sexual health matters and her contraceptive options. In this case, both she and her father shared a medical experience with Accutane use, which for women in particular requires simultaneous use of a contraceptive due to the severe fetal development risks in the event of an unplanned pregnancy.

Family support was demonstrated in other ways that were tangential to or took the place of direct and open discussion. Participants recalled how their parent figures provided them with resources like books as a first point of reference:

"...And then more in depth, with a bit more scientific of a lens, my mom gave me, um, a much larger book. It was like, 500 pages called 'Sexy Users Guide', which sounds intimidating at that age, but like I learned best by reading and it also removed a lot of the 'Oh my God, my parents talking to me about sex'; where I could just like, read it and come to her if something didn't make sense." (Megan)

Engaging with adolescents in ways that encourage them to explore their bodies and sexual health on their own terms is a valued tool to build autonomy and self-advocacy at an early age (Daley 2014). For participants, providing secondary resources was their parents' way of demonstrating support and engagement in a significant life change as adolescents, but also as a placeholder where parent-child discussions about sex and contraceptives were otherwise awkward to facilitate. Where there existed a family history of reproductive or menstrual-related health matters, participants like Tia could draw on a wealth of experience from the women figures in her family that helped her to understand her own reproductive and hormone-related issues. In addition to parent figures, participants also relied on extended family members like cousins for contraceptive support. Cousins were perceived of as a safer and trusted option for contraceptive-related questions and provided a buffer from involving immediate family. The benefits of familial involvement with contraceptive education had the effect of priming positive health-seeking behaviours and autonomy in participants as well as a comfortability in asking questions of their bodies and health needs in spaces that were safe and supportive.

Where participants began to be sexually active and engaging in relationships, partners assumed a greater level of involvement in contraceptive decisions and use. In a few participant

cases, a new relationship was the prerequisite for contraceptive use at all, a divergence from most participant circumstances where contraceptive uptake occurred outside of the scope of sexual partnerships and primarily for the purposes of personal health management. For participants, open discussion with sexual partners about contraceptive use or non-use was pivotal for strengthening the relational connection and for redistributing the responsibility associated with healthy sexual behaviours. Expectations surrounding communication and transparency did not differ regardless of whether the sexual encounter was transactional (a one-night stand) or established as a long-term relationship; however, the level of communication was considered more robust within stable partnerships compared to one-time sexual encounters. Partner roles in relationships assumed different levels of involvement depending on the maturity of the couple and the partnership. In marital partnerships, males shared responsibility in determining contraceptive type or took full responsibility by electing for permanent contraception (a vasectomy) after family planning had completed.

The extent to which partners engaged in open discussions around sexual health and contraceptive use coincided with the perception of trust that participants had in their partners and in their shared contraceptive use. Many participants described how they would 'double up' on methods (using a hormonal contraceptive as well as a condom) in transactional or early relationships as a best practice for avoiding STDs as well as the perception of added security and comfort afforded from using two methods. Only in cases where trust was established in a partnership did participants feel comfortable in discontinuing condom use. The significance of removing the 'barrier' tied to condom use is twofold: women themselves felt empowered within and as a result of their partnerships to forego a method of contraception; and in addition, they felt a greater connection and improved sexual experiences while still being protected through hormonal contraceptive use. Condom use notwithstanding, hormonal contraceptive use was not observed to have a noticeable physical difference in sexual experiences for participants. Rather, participants opined the psychological benefit with regularized use of a hormonal contraceptive may have a cascading effect on women's increased presence and engagement in sexual encounters (Higgins and Hirsch 2008). Words like 'protection', 'security', 'freedom' and 'comfort' were most often cited among participants when describing their experiences with hormonal contraceptive use in sexual encounters. When women felt they had ownership and control over their reproductive outcomes, they allowed themselves to enjoy sexual experiences more than using no methods outside of situations where women were actively engaged in trying to get pregnant.

4.4.2 Parent/Partner Control, Conflict and Disinvolvement with Contraceptive Use

An interesting finding centred on the level of ***non-involvement*** of parent figures in comparison to the depth of involvement of providers and peers among most participants. 'Discomfort' was often mentioned as a contributing factor to both participant and parent non-engagement in conversations about sexual health generally and contraceptive use specifically. Participants preferred to explore contraceptives on their own terms or through other channels of information before they would consider involving their parents. According to participants, parent figures jointly avoided any conversations with their children around sex and contraceptives in an act of 'discretionary disinvolvement'. Alternatively, the responsibility was shifted into the hands of the parent considered more 'hands-on' in their child's health matters. Culture played an important role in the acceptability of family discussions on topics of sexual health. Participants who identified as Chinese, Middle Eastern and Filipina described any dialogue regarding sex and

contraceptive use as strictly off-limits with parent figures. Sexuality outside the parameters of marriage was neither acknowledged nor accepted. Rory credited her move to Canada as the first time she was exposed to contraceptives and their widespread use among women outside of her family home:

"Like, birth control is not really that common in China, so I only heard about [it] in movies. But like, yeah, when I was age 18, when I was actually in Canada and I was like 'Oh, okay. Actually it's normal for a lady to take this.'" (Rory)

In some circumstances, parent figures employed controlling behaviours around participants' health as adolescents. Jenn described how her mother made the decision for her to begin contraception at 14 years old. Despite the fact that she was neither dating nor sexually active, Jenn perceived her mother's involvement with her contraceptive use as both a preemptive measure in anticipation of her eventual foray into relationships as well as the generational trickle-down effect of the sexual health freedoms gained during her mother's youth. With Rae, a social worker and new mother, it was her parent's religious background that drove their reactionary measures to start her on contraceptives at age 15. For her family, the social consequences of an unplanned teenage pregnancy were more deleterious than the health effects associated with contraceptive use:

"Um, and then eventually when I started menstruating, I got 'the talk' because now, like, contraception matters or contraceptives matter all of a sudden to my parents. So, yeah, they're obviously more concerned about pregnancy than STIs… Yeah, so I grew up in like a Presbyterian household so, like, the encouragement was like, 'We don't have sex until we are married'-people; and so not really any discussion around, like sex or contraceptives or like, safety until like, I like- literally the day I started menstruating. So, [it] was much more of like a reactionary- like a reactive thing, as opposed to being like a preventative thing." (Rae)

For participants like Rae and Jenn, their initial contraceptive exposure was more consequential to the onset of womanhood. Contraceptive use was not interpreted as a mechanism of empowerment over their changing bodies; rather, it was viewed as a mechanism of control.

Partner interests would conflict with participant interests regarding prophylactic use. Most participants admitted to stopping condom use soon into an established relationship as much as for partner comfort as for their own preference. However, some participants described partner pressure as a reason for stopping condoms or starting a hormonal contraceptive:

"I don't know, like, actually the reason I got it, an IUD, is because like my boyfriend at the time- he wasn't a great boyfriend- he was like, 'You have to be on birth control' and so I was like, 'Okay, yeah, I can do that.' And I think that's fair, like, especially because they don't really have any other control other than using condoms, like, and those aren't really exactly foolproof, so.." (Denise)

"Umm, I think mainly is because in Grade 12 I started dating my current boyfriend and we were more interested in sex and, umm, then I think it was mainly he was the one who told me that I should do it just so it would be less stress and be safer. So, I think it was moreso encouragement from him." (Michelle)

Partner pressure involved, in cases like Denise's, explicit requests from partners to start or discontinue a contraceptive and/or the implicit responsibility over the comfort level of their partner. The perceived responsibility for contraceptive use in partnerships extends further: Denise and Michelle *validated* their partners' expectations for them to begin contraceptives by *dismissing* the legitimacy of condoms as a safe method of contraception. Denise opined that condoms weren't exactly 'foolproof', which is not wrong in scenarios where condoms can be used incorrectly; however, this same logic can be applied to all methods of contraceptives regardless of pharmacological properties. Like other participants, she simply accepted the responsibility of contraceptive use within the partnership.

Anti-condom sentiment and distrust was a common theme among participants, and not solely limited to the attitudes of their sexual partners. In the same vein, many participants expressed a desire for more male contraceptive options both as an initiative for males to take on more responsibility in partnerships and to 'level the playing field' experientially for males to understand the secondary effects with taking a hormonal contraceptive. Given the prompt of a hypothetical scenario where more male contraceptive options were to exist, there was unanimous agreement among participants that males would be no more likely to take alternative methods to condoms:

"And I think that if- I mean, it's kind of like toxic masculinity as a guy; if a guy's friends find out that the guy is taking a pill, how do you think that they're gonna be treated? Or how do you think their friends group is going to react? I mean, they want to look all tough and macho and everything and, I mean, taking a pill, they're gonna be treated like 'Oh, like, are you some kind of woman?'; like something along those lines." (Dawn)

These perspectives may be better understood as an outcome of the gendered narratives reinforced in larger community and cultural spheres.

4.5 Culture and Media

4.5.1 Empowering and Equipping Women Through Normalizing Contraceptive Use and Access

How women internalize messages about sexual health and contraceptive use through social circles, healthcare bodies, families and partners are all fed by larger cultural scripts and enacted through media and advertising. Contraceptive technology advances in North America mean that most women can have multiple options at their disposal to manage the nuances of their reproductive experiences. All participants in the study had the benefit of knowing someone with experience in one or more contraceptive methods that supplemented their own individual contraceptive knowledge. No participants described scenarios where they were unable to access any contraceptives (hormonal and non-hormonal), and almost all participants cited experience with more than one type of contraceptive. Cultural acceptance of contraceptives assumed multiple lenses among study participants: as a channel for women to advocate for their bodies, health needs and goals; as a metric for personal responsibility for their health decisions; and as a tool for understanding their own bodily experiences.

Many women felt that their experiences with contraceptive use led to them developing a deeper understanding of their bodies and their menstrual experiences. Where certain contraceptives produced unwanted side effects that prompted a switch, women like Dawn, Rae

and Denise credited their experience with contraceptives for an increased awareness of their bodies in relation to hormone-triggered fluctuations:

"When I went off of it, it was just like, profound. I felt like I can feel myself again; like, I was connected, my mind and my body were connected, and I lost probably 30 pounds, like fairly quickly, like just it's crazy. Yeah, and I just felt so much better." (Denise)

Similar anecdotes among participants tying their somatic responses to their contraceptive use lend support to the idea of 'knowing bodies'. Women explained that their body would 'know' when to menstruate when they were taking contraceptives, to stop contraceptives because their body 'needed a break', and to give hormonal contraceptive use time for their 'system to balance itself out'. In this way, contraceptive use engages a deeper wholistic awareness and understanding about women's somatic selves compared to other consumer products (Watkins 2012; Wigginton et al. 2016).

Contraceptives, by their very existence, have normalized conversations regarding female wellness and sexual health management. Where discussions around periods or pregnancy prevention and contraceptive use were formerly relegated to the examination rooms of doctors' offices, the normalcy with which these conversations occur in modern social and public arenas has removed any former 'taboo' associated with the topic in Western cultures (Tone 2006; Watkins 2012). The emergence of longer-acting oral contraceptives and IUDs has also upended accepted beliefs about the menstruating body:

"We're seeing more of a trend, I would say, towards continuous use contraceptives…and that's because a lot of women have realized now – and we know as a medical community - that it's safe to do so." (Lisa, pharmacist)

This understanding of periods as optional and not necessary was shared both by healthcare providers as well as participants:

"I think that girls figured out that, like, if you just keep taking your birth control and you don't stop like- if you don't take that week of sugar pills, and you just go into the next one, then you won't get your period. So I think they [pharmaceutical companies] kind of figured out that girls were maybe just doing that anyways, so they just made a type of pill to adapt to it." (Jenn)

That contraceptives provide an opportunity for women to unshackle themselves from the discomforts associated with a monthly period allow for women to choose how they want to calibrate their menstrual experiences. Where participants wanted to automate the occurrence of their periods, decrease the volume and duration of their periods, or eliminate them entirely, they were able to find a contraceptive to satisfy these health goals.

Contraceptive advertising has historically promoted narratives of empowerment and autonomy to prospective users (Kissling 2013; Watkins 2012). However, this study found that ideas about autonomy and empowerment were reflected less in the pictorial content of the ads and more in the written content. The comprehensive explanation about the Nexplanon implant in the ad, while regarded as 'wordy', instilled confidence in some participants that they were fully informed about the product and its potential effects. Similar explanations were given for the Plan B ad: despite being described as simple in appearance, participants appreciated that it explained clearly what the product would do, which may help to reframe concerns about emergency

contraception being an abortifacient (Colarossi et al. 2010). In particular, the messaging in the Paragard commercial promoting the 'hormone-free' benefits of the IUD is reflective of a new social movement towards wellness-focused consumption. Paragard's messaging was well-received more for its non-pharmacological script than the dramatized freedom and independence of the actress in the commercial, according to participants. For women with health-related limitations for synthetic contraceptives or those that choose to incorporate drug-free contraceptive alternatives like Jenn, who by trial-and-error found she experienced significant negative physiological effects from synthetic hormones, copper IUDs are being framed as an effective and health-conscious alternative to traditional contraceptives.

4.5.2 The Feminine Contract: How Culture Problematizes the Menstrual Body and Assigns Reproductive Responsibility

For the majority of participants and providers, the contraceptive ads included in the study neither promoted a realistic account of contraceptive use, nor were they considered incentivizing as future contraceptive method options. Like Adrianne's reference to not knowing anyone using Nexplanon as a reason for her lack of familiarity with the product, other participants drew from social references in their analysis of the Paragard copper IUD commercial. Dawn expressed concern that ads like the Paragard commercial were starkly unrealistic to the realities of using contraceptives:

"And then you have this girl on here that's like 'I got a copper IUD!'; and yes, it is; it has no – like – um, hormones in it, but still; like, I know I have friends that have taken IUDs and they're like 'It was a horrible experience'." (Dawn)

Within the same vein, the Paragard commercial was criticized for framing their product as inherently 'better' than hormonal methods while discounting its effects to menstrual cramping and bleeding with use:

"The Paragard was kind of cute, but they did talk about some of the side effects, which I thought was good, but the one thing they didn't mention is that it can increase menstrual flow in some women and I feel like that's a really important one to highlight with the copper IUD; and I was actually really surprised that that didn't even come up." (Megan)

"I feel like a drug ad sort of, well in this case, literally danced around the actual issue…I almost never have women who want- they all want lighter periods, or control of their period time or no period. Rather than a potentially heavier, potentially more crampy one, the potentially additional benefits of having hormones always seem to outweigh the [caveats]-" (Charlene, family physician)

Responses towards the Nexplanon ad were predominantly negative, with the majority of references criticizing the volume of information and listed side effects as deterring. Healthcare providers expressed similar reservations to the message framing of the Nexplanon ad as a dissuader for prospective consumers:

"…there was a lot going on. I was like 'holy smokes'. I don't know how anyone's going to read this and understand what it's about. Like, I can barely read it and understand what it's about." (Charlene, family physician)

While the Plan B ad objectively contained the most explicit references to consumer empowerment and agency, some participants took issue with its indirect referencing to female responsibility for mitigating unsafe sexual encounters:

"So the Plan B, I think that one is kind of weird because, you know, it takes two to tango…So it's like, you know, it's like the woman's responsibility to take care of that. Which I think is kind of strange…I think it's- they're very directed towards females, and females have to take care of their own problems. If they get pregnant by another man, you know, it's their issue." (Yolanda)

Plan B's dialogue of assigned responsibility speaks to a larger cultural issue around contraceptives as a whole: that, at the end of the day, contraceptive use is a 'woman's issue':

"Even though I am really good about taking my pill, um, if I forget, the entire burden is on me. And there's also been like; sometimes my partner has been a little bit like 'Did you remember to take your pill today? Did you remember? Did you forget? You can't forget! You have to take it!' I don't really appreciate that, like, this implication that I would be like forgetting; because I've been on it for so long, that I don't really like that it's an opportunity for like another person to kind of pressure me." (Jenn)

"I, I think what ultimately is most important is that everyone- or, that everyone feels the most comfortable; like you shouldn't be persuaded to use a form that you're not comfortable with and I guess in that case mostly with women, like, because it's pretty much all on us." (Respondent A)

Regardless of relationship status, participants described that they felt solely responsible for their reproductive fates.

Male responsibility was constrained to condom use in the case of transactional or short-term relationships and would reduce even further once long-term relationships were established. Naturally, participants framed this responsibility in the context the larger biological investment required of women: their capacity to carry and bear children, compared to a man's biological investment. That contraceptives have become so deeply gendered may explain this imbalance in use among the sexes – as Dawn indicated in an earlier quote, men would be wont to avoid anything that could 'threaten' their masculinity. A better explanation may be that men would avoid anything that could threaten their virility; never mind the fact that women must regularly battle the side effects of hormonal contraceptive use, which can also impact their perceptions and experiences around femininity and womanhood.

The trade-offs that contraceptive users experience with taking a method of contraception drive an underlying belief of the menstrual body as problematic. Most participants expressed that their initial contraceptive use was strictly for health matters and not for use in sexual encounters. Common reasons for contraceptive uptake or changes included acne control, reducing cramping, regulating periods and lightening periods. Whether expressed or implicit, control was the driving impetus over contraceptive use. With the exception of participants exclusively using condoms, all other participants using hormonal contraceptives did so with the intention of managing some perceived negative aspect around their menstrual systems. Most troublingly, this idea of control and management began at the onset of puberty for some participants, like Jenn and Rae. Instead of having the opportunity to experience and understand the nuances of her changing body, Jenn was primed to perceive her menstruating body as problematic where no problems yet existed:

"Because I think that my period wasn't that bad at the time; um, I think that I didn't need it that badly at the time, although I appreciated what my mom was trying to do for me, I think that I would have told- Because I didn't have sex till I was 18, so I would have said, like, 'Don't worry about this until you're actually like, 17, and you actually understand how your body works. Like, how do you actually feel? Is your period actually that bad or is it just new?' So, I think I would have maybe just told myself to hold off a little bit?" (Jenn)

With Rae's experiences with her family's religious beliefs, a fertile body was a dangerous body, because it could mean embarrassment for her family within their community if it was used outside of the parameters of religious doctrine.

Perceptions of responsibility and control over their menstrual experiences fed into a larger understanding defined as the 'feminine code of conduct' – all the ways in which the female biological or menstrual experience is enacted and reproduced culturally that women continuously negotiate from the onset of puberty and throughout their reproductive lives and beyond. Conversations around menstruation are almost never spoken of as a neutral experience but as dichotomized – women either have great periods or they have bad periods. Starting contraceptives at a young age was akin to a 'rite of passage' for women as they moved from childhood into young adulthood. Under this code of conduct, contraception is consistently framed as 'good', 'right' or 'necessary' in larger social and health arenas for women to use to improve their reproductive functions (Woods 2013). If menstruating bodies are perceived as 'messy', 'problematic' or 'unmanageable', then promoting the 'goodness' of contraceptives means framing it as antonym using words and meanings like 'empowerment', 'security' and 'control' (Kissing 2012; Woods 2013). By consistently reaffirming the value of contraceptives to 'improve' menstrual bodies, women will continue to consume contraceptives even though their experiences of their bodies on contraceptives are frequently beset by the same side effects they were encouraged to control in the first place. As part of the feminine code of conduct, women endure the effects of synthetic hormones on their body out of a duty of responsibility as reproductive citizens and because contraceptive-related side effects come at a lower societal cost than that of unmitigated natural female hormones (Mann and Grzanka 2008).

CHAPTER 5: DISCUSSION

5.1 General Discussion

The emergent findings of this study revealed recurring instances of identity-driven narratives of autonomy and control woven throughout individual contraceptive experiences and use shared by participants and providers. At the same time, key social agents were identified as having a direct impact on a woman's identity within the context of contraceptive use. Peers and peer groups were observed to have the most direct influence on participant perceptions toward and use of contraceptives, while healthcare providers occupied an equally prominent role as agents within health systems in helping women to make sense of their health experiences and contraceptive uptake. Parents and partners were identified as primary agents of influence, albeit at different stages in a participant's reproductive life. Parents served as an early source for sexual health education and acted as intermediaries between their children and doctors, while partners assumed a greater role in contraceptive use and healthy sexual behaviours in early and later adulthood. Identity dynamics occurring within these social networks are consequently fed by larger cultural narratives about gender, sexual health and responsibility that are then enacted through media and advertising in a trickle-down approach through each of the channels of providers, parents, partners, peers, and to contraceptive users themselves.

This study was undertaken to answer the research question on the ways in which consumer identity informs contraceptive use. The findings and resulting theoretical framework address this question by describing the process of identity conflict that women engage in with contraceptive use. This conflict involves navigating the didactic narratives of autonomy and control as they are reproduced in overlapping and tension-creating scenarios within the interpersonal and intrapersonal spaces for women. As a result of this conflict, women develop perspectives and practices that inform their self-concepts around their health which then dictate their contraceptive use and larger contraceptive beliefs. The following sections will examine these concepts of identity narratives within the areas of media and advertising, within clinical spaces in provider-patient exchanges, and describe the practical and theoretical contributions of the study to advance contraceptive consumer research.

5.1 Contraceptive Advertising and Identity Politics

This study examined how identity is framed in contraceptive advertising and how this impacts consumers. Many of the criticisms towards DTC contraceptive advertising have centred on its unrealistic portrayals of models or spokespersons as well as the message-framing of contraceptives as 'cure-alls' for the modern ills of womanhood (Kissling 2013; Watkins 2012). This study has found that these messages continue to be reproduced in current campaigns, and that women are no longer as amenable to the agential smoke and mirrors tactics of pharmaceutical advertisers. In the case of the Paragard commercial seizing on the current wellness movement in consumer culture, many participants were not convinced of its marketed 'superiority' over hormonal methods. Targeted promotion of niche contraceptive products like the hormone-free IUD may have the effect of deterring more prospective users based on its explicit identity marketing (Bhattacharjee, Berger and Menon 2014). While having a hormone-free contraceptive alternative to condoms is advantageous to users, especially those with pre-existing health concerns that would otherwise be restricted for contraceptive options, framing

Paragard as the only method congruent with consumers of the health-minded, ‘organic’ milieu discredits the actual health benefits that can be gained from using hormonal contraceptives.

As Charlene, one of the family physician participants explained, many women start contraceptives for the express purpose of mitigating problematic symptoms of their menstrual cycles. When she communicated in her patient consultations the main side effect of Paragard as increasing cramping and menstrual bleeding, most would opt out of the copper IUD for the hormonal version instead. Ads like Paragard and earlier generation campaigns of Seasonique (Kissling 2013) and Yaz (Singer 2009; Watkins 2012) can be faulted for their tailored messaging – for women looking to ‘free’ themselves from synthetic irritants (Paragard), their premenstrual symptoms (Yaz) or their cycles at all (Seasonique) - that either minimizes or omits information incongruent to their prospective audience. Contraceptive advertising demonstrates the significance of corporate social responsibility (CSR) on the part of pharmaceutical organizations in promoting products in ways that are transparent and ethical (Hastings and Saren 2003), and yet even current campaigns like the Paragard continue to fall into the grey area of fact versus fallacy in their IUD promotion (U.S. Food & Drug Administration 2019) Decisions on the part of pharmaceutical advertisers on striking a balance between marketing and health education remain problematic within contraceptive advertising (Ledford 2009), and the Nexplanon and Paragard ads in the current study reinforce the precarity of this dynamic.

Nexplanon was criticized primarily for its volume of patient data listing the potential contraindications and side effects; this had the effect of being perceived as information overload and a scare tactics measure for most participants. However, some appreciated the thoroughness of the brand’s explanation, reinforcing the continued dilemma of advertisers in ensuring an ad’s ‘persuasiveness’ as well as the duty to inform consumers of all reasonable risks with a product’s consumption (Ledford 2009). In cases where ads fail to provide enough information for women to make an informed decision on uptake of a contraceptive method, they are tasked with educating themselves on their reproductive choices or, as all ads mandate, to ‘speak with their doctor’. To what end, then, are contraceptive ads ‘empowering’ women to consume their product when they direct them to physicians, another agent acting as both gatekeeper of particular contraceptive methods and intermediary of contraceptive advertising?

Ironically, contraceptive advertising frames its users as 'independent' and 'in control' of their bodies and reproductive cycles yet on an implicit level perpetuate the obligation of women to 'reign' in problematic features of their biological experience (Kissling 2012; Mann and Grzanka 2018). Their menstrual cycles and associated symptoms are viewed as issues instead of as a natural variation in their ‘biological homeostasis’, described by pharmacist Lisa, inasmuch as cases like scoliosis, allergies or seasonal affective disorder are seen as common health aberrations in individuals. This is not to say that those health nuances don't need treatment - in many cases they do. Rather, women's menstrual cycles are unilaterally marketed as in need of constant control and management, in which case pharmaceuticals are framed as a first and primary treatment option. How can a woman, as participant Jenn mentioned, truly be able to understand her body as whole when she is immediately referred to contraceptives at first menarche?

Contraceptive marketing further clouds this embodied understanding by normalizing the continuous long-term consumption of its product as a way to tie women to a medicalized view of their body, and to discourage them from stopping their method due to the ‘unknown’ of what their body is like without synthetic contraceptives. An interesting finding tied the participants’

aversion to the Paragard and Nexplanon due to their invasive nature. Most commentaries on participant perspectives of LARCs were framed specifically towards their installation and removals. The requirement of clinical intervention with LARC may for some women mean that their autonomy *is* being impeded – they have to rely on other agents to ensure their method is administered properly, and they must trust the work of the providers to ensure the efficacy of the method.

Hormonal contraceptive advertising, unlike condom advertising, routinely promotes its product as problem- or risk-mitigating: preventing unplanned pregnancy, reducing menstrual cycle occurrences, decreasing PMS; and with LARCs, eliminating daily administration of pills and the risk of missing doses. For prospective consumers – especially those primed under the expectation to manage their reproductive symptoms - contraceptive advertising promulgates a value proposition to control these aspects of their life so they can be better versions of themselves, more productive, more engaged in their work and social lives, or more present in relationships (Payne, Frow and Eggert 2017). In the ads of for this study, this value proposition was reinforced through their use of models and spokespersons. Many of the participants described a disconnect between the presence of the spokespersons in the each of the Plan B, Nexplanon and Paragard ads. The extent to which the women connected their own experiences and knowledge to the ads suggests that typical advertising formulas that utilize 'flash', jingles or even celebrity ambassadors lack the persuasive power to promote contraceptive uptake.

The findings in this study would suggest that contraceptive advertising re-evaluate the role of the spokesperson at all in contraceptive campaigns. Informational content within the ads, however extensive or minimal, was demonstrated to be the most beneficial for participant agency in evaluating prospective methods, and has been shown in previous studies as a better indicator of consumer uptake (Antonishak et al. 2018; Colarossi et al 2010). There is an opportunity to re-evaluate the medium of contraceptive advertising holistically. Participants shared that they did not engage in print magazines or cable TV as media sources, which may explain the disconnect and ambivalence towards the ads used in the study. Rather, peer influence and word-of-mouth occupies a higher role in women's health perceptions and decision-making and may be better indicators of their contraceptive uptake (Daley 2014; Sundstrom et al. 2016). Contraceptive marketing would be better served by engaging in channels more aligned to the ways in which women receive their information by focusing on social platforms like Instagram or TikTok, both of which are known for their vast community of social influencers.

Incorporating influencers has been demonstrated to be a more realistic and engaging approach to marketing contraceptive consumption and puts more agency in the hands of prospective consumers as an external resource for information-gathering outside of clinical contexts (Sundstrom et al. 2016). Reliance on influencers, however, does entail risks that can include spreading misinformation and polarizing of products. Like the physical ads and commercials used in this study, social media faces similar criticisms regarding the unrealistic portrayals of its users; influencers in particular can produce more harm than benefit when their content is heavily edited and reconstructed into images that perpetuate unattainable social 'ideals'. Issues of representation can also arise when involving influencers. Relying on influencers that fall within the gender binary diminishes visibility and invalidates the experiences of individuals that identify as non-binary or gender fluid. As some participants remarked, the explicit gender scripts used in contraceptive marketing becomes problematic when considering users that do not subscribe to traditional symbols associated with femininity – examples of this

would include ad models wearing dresses, makeup, etc. For these reasons, care and intention towards aligning with influencers that are sex- and body-positive can help to mitigate some of the risks of online promotion and dissemination of contraceptive marketing resources using lay-friendly language and platforms that are more accessible to prospective users and the public.

5.2 Provider-Patient Exchanges in Health Marketing Contexts

This study explored the ways in which healthcare providers influenced consumer health identities and contraceptive use. The findings have shown that the provider-patient relationship was a significant indicator of contraceptive uptake at all among women. Physicians were described to occupy a more significant relationship to participant health identities than parents or partners. The depth of provider involvement in participant decisions surrounding contraceptive uptake supports what has been found in previous studies (De Irala et al. 2011; Sundstrom et al. 2018), however the findings have shown that perceptions regarding the nature of this involvement differed among participants and providers. Most participants described their exchanges with healthcare agents as one-sided, where the provider determined the contraceptive regimen. However, providers described patient consultations as a more open discussion with a prioritization towards patient goals and interests in their prescribing practices. These findings suggest that there may be a disconnect between consumer patients and providers in perceptions of consumer agency in contraceptive consultations.

One explanation for this may point to the fact that many of the participants started contraceptives in early adolescence. In some participant cases where early sex education was absent in school settings or through parent figures, providers served as the first point of exposure to contraceptives. Naturally, adolescents would defer to the experience and knowledge of a physician for most health matters, including sexual health education. This early priming to ‘trust’ in healthcare providers would be the product of social conditioning as well as positive reinforcement by parent figures that were involved in their child’s health. Conversely, trusting provider decisions may have occurred as a result of parental non-involvement in adolescent sexual health decisions, and may have served as placeholder for a dependable adult resource (Daley 2014).

The risk with physician-led consultations and patient dependency is revealed in perceived biases on the part of the provider that result in impediments to communication and collaboration with patient consumers on a best fit for their reproductive goals. Provider bias in this study emerged as a result of prescribing experience, product knowledge, and patient-centred biases. Provider deference to a particular formulation like oral contraceptives was described as a reflex of sorts, based on previous prescribing experience as well as comfort in product familiarity. This familiarity is inevitably reproduced socially in a woman’s interpersonal relationships by way of family members and friends using similar methods, and then within women themselves. The risk here lies in effective reproducibility of patient outcomes by providers based on a bedrock of evidence-based research and occupational experience, however the patient’s experience of the consultation and the product are misaligned to that of the provider’s. They trust in the recommendation of their provider and are disappointed when their contraceptives result in unwelcome side effects that overshadow the communicated benefits of the product. Provider perceptions of patient knowledge can also introduce bias and impact the efficacy of their consultations. When patients are perceived as unfamiliar with contraceptives, providers will

adjust the depth and volume of information they communicate or fall back on reliable scripts, just as one of family physician mentioned, “I kind of run through the same spiel every time”.

One of the dominant critiques among women was the perceived lack of additional guidance and resources from their providers in clinical settings. This absence of additional resources and support produced perceptions of an ‘information poverty’ among participants. Reliance on clinical formalities and scripts can be helpful in ensuring a balanced level of care among patient interactions, but this can create gaps in understanding of unique patient motivations and patient-held knowledge around sexual health supports. In circumstances where patient backgrounds involve different geographical or cultural upbringing as some of the participants in this study shared, this adds additional complexity to the knowledge-transfer in provider-patient relationships and increases the risk of power imbalance in this relational context (Adams et al. 2019; Colarossi et al. 2010; Higgins et al. 2016; Meier et al 2019). Additional roadblocks may present in clinical consultations where physicians use language or resources framed in a heteronormative discourse. Where patients may not identify within the gender binary, framing contraceptive discussions within the parameters of ‘female effects’ or experiences can result in a disconnect between stakeholders and create conflict in finding a solution that fits the patient-specific goals and needs for their reproductive health.

It is when this misalignment of outcomes occur that women describe their encounters with healthcare providers with ambivalence or distrust (Higgins et al. 2016). If women like the participants in this study place a significant value in providers as shared decision-makers in their reproductive health goals, it should stand that women would occupy a shared stake in contraceptive consultations. When viewed through a marketing lens, providers act as intermediaries for patient consumers to unpack social and cultural messaging surrounding health and wellness (Adams et al. 2019; Higgins 2016). They exchange more than prescriptions, but also ideas about what it means to be healthy and how to embody and enact culturally relevant health rituals (McCracken 1986; Vargo and Lusch 2008). This piece – exchanging ideas – in provider-patient relationships appeared to be missing within many participant accounts in this study. Participant perceptions of agency in physician-patient relationships were tied to the belief that they felt seen, heard, validated and supported in consultative settings around contraceptive use. When perceptions of patient-held agency were absent, women resigned to the recommendations of the provider or changed providers. Cooperation is replaced by acquiescence, and acquiescence results in dissatisfaction with a contraceptive method and discontinuation in use.

One consideration for the information poverty experienced among participants include the fact that many of the participants did not see their family physician or even a specialist OBGYN for contraceptive counselling. Patient embarrassment and distrust deterred some participants from approaching their own family physician based on their relationship to the participant’s family. The risk to patients in seeking an alternative provider for contraception instead of their family doctor may be a consultation that lacks the depth of the patient’s health history that their family clinic would have; this may subsequently impact the suitability of the contraceptive method that is prescribed. Patient reliance on general physicians for contraceptive resources may also impact patient agency and the quality of consultation. The depth of patient concerns and inquiry into contraceptive options may extend beyond the time constraints of a typical clinical appointment.

Positive provider experiences were affirmed in participant contexts involving a dedicated family doctor or provider with close ties to their family, or in clinics specializing in sexual health and wellness. Family provider relationships served as clear examples of the value in patient-centered healthcare in the context of contraceptive uptake. Hallmarks of patient-centred care involve open communication between patients and providers, collaboration on health goals, and support and empowerment for patient-led decisions (Dehlendorf et al. 2017; Merz et al. 2013). Compared to more serious health conditions like cancers or heart disease, reproductive health management should be considered the one health topic of which patients are their own experts. Contraceptive counselling involves one of the few instances where patients have even a basic understanding of their somatic experiences to inform its uptake. Contraceptive use, by extension, is one of the best opportunities to extend patient-centered care within a marketing framework of service-dominant logic (Merz et al. 2013; Vargo and Lusch 2008).

Provider involvement in consumer health identities can extend beyond their prescribing capacity to a resource-based capacity where information is prioritized as the first level in a multi-tiered approach to reproductive health management. Physician and pharmacist roles are predicated on improving the human condition using a framework of diagnostic applications to identify health problems and generate solutions incorporating (predominantly) pharmacological intervention. Improving individual perceptions towards and consumption of contraceptives could be redirected away from symptomatizing women's menstrual experiences and instead educating women about the variability of their menstrual biology as a first response by providers. Encouraging a space of exploration instead of diagnostic and risk mitigation strategies could have the effect of a proactive shift in female perspectives about their reproductive identities and accountability towards their health versus current reactive approaches. The findings support an opportunity to re-calibrate patient consultations by adding more tools to encourage patient agency and confidence in discussing their reproductive needs (Dehlendorf et al. 2017; Merz et al. 2013). The providers in this study expressed an openness to facilitating patient and public health agency by directing patients to local sexual health organizations and equipping patients with external evidence-based resources including lay-friendly contraceptive pamphlets and government-based public health sites like the SOGC. Leveraging knowledge resources in a collaborative context with patients shifts the role of providers as purveyors of a good (prescriptions and treatments) to purveyors of a service (knowledge transfer, promoting local supports and agency-building) (Vargo and Lusch 2008).

This study found that pharmacists were objectively underutilized as contraceptive resources, except strictly as accesspoints for contraceptive products. Pharmacists were rarely cited as a supportive agent in participant experiences with contraceptive access so much as they were impediments to contraceptives, as has been found in previous studies (Johnson et al. 2010; Sanabria 2014). This under-reliance was tied to access protocols for emergency contraceptives as well as participant misconceptions about the value of pharmacists in the medical care cycle. Pharmacists have been shown to be key agents for contraceptive knowledge and supplemental prescribing bodies in other jurisdictions (Farris et al. 2015; Maderas et al. 2008; Sanabria 2014), and yet many participants in this study were not aware of or convinced of their legitimacy as alternative health partners.

Intervention methods like the counselling requirement for Plan B in Saskatchewan pharmacies are often perceived as patronizing on the part of pharmacists in advising patients on healthy sexual practices. Where the value is intended on connecting with and educating patients

on contraceptive methods as the pharmacists in this study have described, women may find that this consultation is an 'overstep' by pharmacists as infringing on patient confidentiality, where it is more accepted in physician clinics. Pharmaceutical barriers do remain an issue among contraceptive users, but more in the context of limitations to specific brands or generic formulations (Sanabria 2014). While the pharmacists in this study have described the inventory decisions occurring at a corporate level, this does raise potential issues to consumers in terms of *ease* of accessibility for preferred brands. In scenarios where clinics and pharmacies are joined, there is an opportunity for business to bleed even further into contraceptive consultations where clinicians and pharmacy managers may collaborate to drive purchase trends towards specific methods (Padamsee 2011). At present, no literature is known that has explored this phenomenon in Canadian contexts; however the risk to patient consumers in further commodifying sexual and menstrual regulation may have consequences to social initiatives for encouraging healthy reproductive behaviours (Hastings and Saren 2003).

Women may also be unaware of the recent expansion in prescribing authority for Saskatchewan pharmacists to include contraceptives. Pharmacists can help to bridge the informational gap that women experience in physician consultations. Including pharmacists in patient-centred care frameworks enhances consumer agency by providing another reputable channel to seek contraceptive resources and products. Pharmacists can also continue the medical service model by extending the knowledge-transfer of physicians as well as reorienting patients towards evidence-based resources (Maderas et al. 2008). In cases where women do not have a dedicated family doctor or experience barriers in securing physician appointments, pharmacists can serve as a more accessible and less intimidating healthcare agent that can help women to arrive at a best fit method or provide them with a temporary solution while they wait to meet with a physician. Contraceptive marketing research would gain value from exploring the relationship between physicians and pharmacists as healthcare partners in promoting contraceptive uptake as a larger public health initiative.

5.4 Contributions

This study contributes to advancing an agenda for contraceptive marketing that is transformed from a commodity framework to a public health framework. The findings have shown that women begin, end or change contraceptives for uniquely individual reasons that are at the same time socially motivated. Contraceptive marketing involves a complex dynamic of interpersonal and intrapersonal factors that inform the very essence of what it is to be biologically child-bearing. Consuming contraceptives is an act of intention to improve or advance one's health. The social consequences of contraceptive uptake, good and bad, are too significant to relegate to simply a medicine cabinet product in the eyes of marketers. This research can lay the foundation for a social marketing agenda that can marry the promotional incentives of a marketing strategy with the policy initiatives of a public health infrastructure.

Contraceptive use is not solely a 'woman's problem'; its existence and use impacts men and women; communities and cultures. A first step would be to re-evaluate contraceptive ads to refrain from isolating promotion in gendered ways and increasing the transparency of contraceptive information. Public health organizations have done the work of framing communications to reach wider audiences and to make health issues a peoples' issue instead of any single group issue. Redistributing the responsibility of reproductive health decisions can help to remove the reproductive burden placed on women from the time they begin menstruating until

they reach menopause. Understanding the ways in which women are interpreting marketing messages around contraception will better equip healthcare providers to approach patient consultations with a better sensitivity to the unique motivations and needs of prospective users. Involving pharmacists and local sexual health organizations helps to broaden the scope of reputable resources for contraceptive information and increase consumer agency in decisions around their reproductive health and consumption habits.

Practical contributions could involve overhauling contraceptive advertising away from traditional formulas and towards social marketing mixes that incorporate gender neutral language and more transparency in product information. References for consumers to 'speak with their doctor' should be expanded to 'healthcare provider'. As this study and others have shown, there is often more than one agent involved in reproductive-health related decisions; and opening the resource channels to more than one healthcare provider empowers consumers to make their own decisions on whom they wish to involve and entrust with their health choices. The findings can be useful in clinical settings in the form of a patient support guide that can place contraceptive use in realistic social contexts as a companion piece to medical reference documents. Helping women to understand that their contraceptive choices may be fed by more than one source may encourage reflection on the meanings behind their reasons to start a contraceptive regimen. Alternatively, this text could be valuable for parents and educators as support tool to enhance discussions around contraceptive use with adolescents.

Theoretical contributions could involve advancing the work of Vargo and Lusch (2008) in promoting a service-dominant logic marketing framework by placing contraceptive promotion into an informational, resource-centred context instead of an end-user transactional process. Accessing and consuming contraceptives involves more than simply an exchange of goods, and incorporates an overlapping network of shared knowledge, attitudes, and ideas surrounding what it means to use contraception. It is a consumption method that requires an exchange of experience and perspective from providers and consumers, and this process of knowledge exchange continues in a cyclical process back into research, resources and development of the product. To put it succinctly: contraceptive use ***does*** take two to tango, and this involves more than just sexual partners. The embodied experiences and perceptions of users are critical to advancing its uptake among larger populations; in this context, a service-dominant logic involving consumers as primary stakeholders is a realistic strategy for contraceptive marketing and engages communities in meaningful ways to drive change in empowering large-scale healthy sexual behaviours and decisions in populations.

5.4 Limitations

The COVID-19 pandemic caused some time-delays in receiving ethics approval for this research, which had the effect of shortening the timelines to complete participant recruitment, data collection and data analysis. Due to the social-distancing measures in effect, recruitment and data collection had to be restricted to remote settings only. Thankfully, this did not appear to impact recruitment interest for patient participants, but it did limit participant interviews to phone or videoconferencing options only. As previous studies have demonstrated, exploring a decidedly personal and intimate phenomenon like contraceptive consumption has a paradoxical effect of bringing women together to connect on tales and trials on their respective contraceptive experiences.

Healthcare providers were more difficult to recruit, which may have also been due to the increased volume and burden on healthcare infrastructure due to the ongoing pandemic. In spite of this difficulty with recruitment, this research was strengthened by incorporating the perspectives of both patient consumers and providers in a marketing context to better understand contraceptive consumption where previous studies limited their focus to one of these populations. While phone interviews had the benefit of allowing participants increased comfort in sharing their experiences from the safety of their homes, not having the opportunity to develop an in-person rapport may have impacted the richness in detail of the personal accounts volunteered by participants. Where participants elected to a videoconference interview, however, the participant-researcher connection was quicker to coalesce, and conversational flow and detail was successful in spite of the lack of in-person settings.

This research project is specific to the contraceptive experiences of this sample of participants. The patient participants were a largely homogenous sample – they were fairly similar in age ranges and education levels. The healthcare providers in this study were very similar in age and years of experience in their respective fields, where all but one described themselves as fairly new to their professions with approximately two years' experience on average. While this is advantageous to understand the perspectives of next generation providers with regard to patient-centered healthcare, these perspectives may differ from providers with many years of experience with different contraceptive formulations.

This study was intentional in its focus on women and the female experience; as a result, the findings are not generalizable to the broader population. However, this research has demonstrated an opportunity to re-evaluate contraceptive marketing and advertising by incorporating messaging that is gender-inclusive, similar to the approach of public health campaigns. This research can also be used an opportunity to further research into male-administered contraceptives so that the burden of responsible healthy behaviours can be balanced among sexual partners. Finally, this research was undertaken with the purpose of exploring the ways in which consumer identity informs contraceptive use, how this is enacted through advertising, and how social agents influence identity-congruent contraceptive use. This research was specifically focused within the context of individual experiences and accounts that impacted contraceptive use. The findings have demonstrated that this exploration has been fruitful, and that there are takeaways that can inform both healthcare and marketing contexts within the realm of reproductive health and pharmaceutical consumption.

5.5 Future Research

This proposed framework has the potential to be incorporated into future marketing strategies in both health and general consumer contexts. While it was developed within the discipline of consumer behaviour and pharmaceutical marketing, this framework can be used to identify the overlapping interpersonal and intrapersonal dynamics that inform individual beliefs and intentions around different health consumption practices. The significance of peer influence on contraceptive use bears exploring in channels that are more congruent to peer-to-peer (P2P) commerce, such as online communities and social media platforms like Instagram, YouTube and TikTok. Exploring how influencers promote health identities by way of products like contraceptives will broaden understanding of the different social environments in which a social marketing approach for contraceptive uptake could be advanced.

While beyond the scope of this current research, there is a critical need to explore contraceptive use through an Indigenous lens. The level of care and sensitivity required to engage with Indigenous communities to understand contraceptive meanings and use requires a dedicated study. Nor was it perceived of as appropriate for a white middle-class woman researcher to assume the role as keeper and disseminator of Indigenous narratives tied to sexual health and reproductive identities without considering the historical and enduring systemic and discriminatory health practices that continue to affect Indigenous women. It is important to understand how Indigenous women perceive of and engage in contraceptive use, especially as LARCs continue to be advanced as the next promising generation of contraceptive technology considering their bloodied history with the Dalkon Shield and similiar sterilization measures on minority and disenfranchised groups.

CHAPTER 6: CONCLUSION

Contraceptive use is a unique consumer product in that it is framed as an individual and private method of consumption yet continues to be marketed as a mass consumer product using traditional advertising formulas. Having evolved from its formative pharmaceutical use as a tool for preventing unplanned pregnancies, women now use contraception for reasons other than simply fertility management – for aesthetics, menstrual regulation, mood and hormonal management, or as part of a treatment regimen for medical conditions like PCOS or endometriosis. Individual decisions to use contraception do not occur in a vacuum; they are fed by overlapping social dynamics. Contraceptive uptake is impacted by political, environmental and cultural phenomena; and inversely, contraceptive use in and of itself can have larger medical, economic, environmental, social and cultural impacts (Hill 2019; Tone 2006). This means that discussions around contraceptive marketing, access and use must be approached as an ethical consideration beyond simply as a consumer product. Understanding how individuals perceive of contraceptives and why they make the decisions they do around contraceptive uptake can help to reorient contraceptive marketing from a traditional advertising mix to a public health approach.

This study was undertaken to explore the relationship between consumer identity and contraceptive use; how user identities are constructed in contraceptive advertising and this impacts consumers; and the ways in which social agents like healthcare providers influence consumer health identities and contraceptive uptake. Semi-structured interviews were conducted with seventeen community-based participants and five healthcare providers to gain a better understanding of the intrapersonal and interpersonal dynamics that impact consumer perceptions of contraceptives and decisions to incorporate contraceptives into their reproductive plans. Using a grounded theoretical approach, the findings resulted in a theoretical framework that outline the key social agents and identity narratives that are reproduced within these social agents that directly inform consumer health identities, beliefs, and contraceptive use.

Peers, healthcare providers, parents and partners were identified as primary social agents that informed consumer health identities and contraceptive use; each of these social agent groups are fed by larger cultural scripts that are enacted through media and advertising. The concepts of autonomy and control emerged in participant accounts as oppositional identity narratives that are reproduced within the levels of each social agent and result in a conflict that women must negotiate. As a result of this conflict, women develop perspectives and practices that inform their self-concepts around their health which then dictate their contraceptive use and larger contraceptive beliefs. The findings present an agenda to pivot contraceptive marketing away from traditional advertising strategies to a social marketing approach that incorporates stakeholders including healthcare providers and public health bodies in promoting transparency, ethicality, and consumer agency in contraceptive use.

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APPENDICES

Appendix A: Ethics Approval Certificate

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB) 17/Nov/2020

Certificate of Approval

Application ID: 2234

Principal Investigator: Marjorie Delbaere

Department: Department of Management and Marketing

Locations Where Research Activities are Conducted: Saskatchewan, Canada

Student(s): Tara Lucyshyn

Funder(s): Saskatchewan Centre for Patient-Oriented Research

Sponsor: University of Saskatchewan

Title: Birth Control Embodied: How Marketing and Consumer Identity Drive Contraceptive Use

Approved On: 17/Nov/2020

Expiry Date: 17/Nov/2021

Approval Of: Behavioural Research Ethics Application

Interview Guide

Consent Form

Recruitment Materials (poster, online bulletin, email)

Acknowledgment Of: TCPS2 Core Certificate (Lucyshyn)

Review Type: Delegated Review

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TPCS 2 2018). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the following website for further instructions: https://vpresearch.usask.ca/researchers/forms.php.

Digitally Approved by Patricia Simonson
Vice-Chair, Behavioural Research Ethics Board
University of Saskatchewan

Appendix B: Participant Recruitment Memo

Department of Management & Marketing

University of Saskatchewan

PARTICIPANTS NEEDED FOR RESEARCH IN CONTRACEPTION MARKETING

We are looking for female volunteers to take part in a study on contraceptive marketing and contraceptive use.

As a participant in this study, you would be asked to participate in an individual interview to discuss your knowledge and experiences with contraceptive options and contraception use.

Your participation would involve a one-time session that will run approximately 60 minutes (1 hour) in length.

In appreciation for your time, you will receive an e-gift card of your choice for Amazon or Indigo Books.

For more information about this study, or to volunteer for this study, please contact:

Tara Lucyshyn
Department of Management & Marketing
Edwards School of Business

at
306-966-7138 or
Email: tara.lucyshyn@usask.ca

This study has been approved by the University of Saskatchewan Behavioural Research Ethics Board

UNIVERSITY OF SASKATCHEWAN | usask.ca

Appendix C: Healthcare Provider Recruitment Memo

Participants Needed: Birth Control Marketing Study

Good Afternoon,

I am an MSc. Marketing student interested in exploring contraceptive use, trends and patterns. As most contraceptive consumption involves medical intervention, my study intends to include not only consumer perspectives but also the knowledge and perspectives of healthcare providers.

In addition to consumer perspectives, we are also looking for providers such as doctors, OBGYNs, pharmacists or nurse practitioners to take part in in the study as key intermediaries for contraceptive resources and access.

As a participant in this study, you would be asked to take part in a telephone or video interview session of approximately 60 minutes to describe your knowledge and experiences with contraception resources, contraceptive methods and access and how these elements inform your patient consultations.

In appreciation for your time, you will receive your choice of an Amazon or Indigo Books e-gift card for your contribution.

To be eligible to participate you need to be female, a licensed family physician, OBGYN, nurse practitioner or pharmacist with experience in contraceptive counselling and prescribing within the last 3 months.

If interested, please contact:

Tara Lucyshyn, MSc Candidate, Edwards School of Business

tara.lucyshyn@usask.ca; (306) 966-7138

Appendix D: Participant Consent Form

UNIVERSITY OF SASKATCHEWAN

Participant Consent Form

You are invited to participate in a research study entitled: Birth Control Embodied: How Identity Drives Contraceptive Use

Student Researcher(s): Tara Lucyshyn, Graduate Student, Department of Marketing & Management, Edwards School of Business, University of Saskatchewan; phone: (306) 966-7138; email: tara.lucyshyn@usask.ca

Principal Investigator/Supervisor: Dr. Marjorie Delbaere, PhD., Associate Dean Research and Faculty Relations, Edwards School of Business, University of Saskatchewan; phone: (306) 966-5916; email: marjorie.delbaere@usask.ca

Purpose and Objective of the Research:

- To understand what reasons and factors go into choosing and using a contraceptive method (the pill, the IUD, condoms, etc.)
- To explore how individual and social factors impact contraceptive method use or non-use.
- To examine what attributes individuals value when making decisions on using a method of contraception

Procedures:

- Data will be collected from individual interviews
- Interviews are expected to run approximately 1 hour in length
- Interviews will be conducted remotely via Webex videoconferencing or over the phone
- All interviews will be audio/video recorded (video recording will be done only in the case of Webex interviews); participants may request that the recorder be turned off at any time without giving a reason
- Interview recordings will be transcribed by the student researcher
- Please feel free to ask any questions regarding the procedures and goals of the study or your role.
- Participants will have an opportunity to view and make revisions to their transcripts, which will be made available within 7 days of the interview date. Participants will have until **February 28, 2021** to submit any revisions to their transcripts. If no revisions are received by February 28, 2021, the data will be used as it was initially transcribed.

Funded by: *Saskatchewan Centre for Patient-Oriented Research (SCPOR)*

Potential Risks:

- There are no known or anticipated risks to you by participating in this research.
- Participants will receive a copy of this form stating the goals of the study and all the relevant contact information for future inquires.

Potential Benefits:

- Expanded understanding on different contraceptive methods, technology and contraceptive benefits

Compensation:

- You will receive a $20 e-gift card of your choice of Amazon or Indigo Books for your participation in the study. The e-gift card will be sent to the email address you provided to the researcher.

Confidentiality:

- The data from this research project will be published and presented at conferences; however, your identity will be kept confidential. Although direct quotations may be reported from the interview, you will be given a pseudonym, and all identifying information (e.g. your workplace) will be removed from the report
- Results will be used in a summary report to the Student Wellness Centre to help enhance provider-patient consultations regarding contraception, however no participant identifying information will be included
- **No** contact information will be provided to anybody outside of the research team

Please put a check mark on the corresponding line(s) to grant or deny your permission:

I grant permission to be audio recorded	
I grant permission to be video recorded	

Please only select one option below:

I wish for my identity to be confidential but you may refer to me by a pseudonym. The pseudonym I choose for myself is: _____	
I would like you to choose a pseudonym for me.	

Storage of Data:

- Electronic data will be stored in a password-protected computer and (in the case of phone interviews) smartphone during analysis, but will be moved to a secured Cabinet system at the University of Saskatchewan for long-term storage

- Physical transcripts will be stored in a locked cabinet in a locked office
- Upon completion of the study and post-publication, data will be securely stored at the University of Saskatchewan for five years
- Following the five-year storage period, data will be destroyed beyond recovery
- Data that contain identifying information such as consent forms and participant lists will be stored separately from the data collected in a password protected computer, and will be destroyed once data collection is complete and the forms are no longer required

Right to Withdraw:

- Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort.
- Should you wish to withdraw, please contact the primary researcher, Tara Lucyshyn at tara.lucyshyn@usask.ca to request to withdraw your participation from the project. Your data will be fully deleted from the research project and destroyed in a secured setting at the University of Saskatchewan campus.
- Your right to withdraw data from the study will apply until March 31, 2021. After this time, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.

Follow up:

- To obtain results from the study, please email Tara Lucyshyn at tara.lucyshyn@usask.ca or Marjorie Delbaere at delbaere@edwards.usask.ca to receive a summary copy of the results of the study.

Questions or Concerns:

- Contact the researcher(s) using the information at the top of page 1.
- This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office: ethics.office@usask.ca; 306-966-2975; out of town participants may call toll free 1-888-966-2975.

Signed Consent (on next page):

Your signature below indicates that you have read and understand the description provided. I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project. A copy of this consent form has been given to me for my records.

Name of Participant	*Signature*	*Date*

Researcher's Signature	*Date*

Please sign and email a copy of this form to the researcher at tara.lucyshyn@usask.ca. Print or electronic signatures will suffice as authorization of your consent. You may keep a copy of this consent form for your records.

Appendix E: Consumer Participant Interview Guide

Patient/ Consumer Interview Questions:

1. Can you start with telling me a bit about yourself, like your first name and what you currently do (student, worker, stay-at-home parent, etc.)
2. Tell me about the first time you learned about contraception? How did you hear about it? Age?

a. From a person: Tell me about the person you learned this from?
b. From source: Tell me about the source, how you came upon it?

3. When did you begin to use contraception? [Prompt: How soon was this after you first learned about it?]

a. What method did you use?
b. How did you decide on that method?

4. What reasons did you start using contraception?
5. Tell me about the role your family or parents have played in your early experiences with contraception?
6. You were provided with two copies of print ads for contraception and a link to a Youtube link for an ad for Paragard prior to meeting. Tell me what your first thought/reaction was when you first saw these ads. Have you seen them before?

a. What's your overall impression of the ads?

7. Where would you go to find more information on contraception? [Prompt: web? Doctors? Friends? Family?]
8. Can you tell me about the last contraceptive method you used? Why did you switch/stop?
9. Tell me about the current method you use. What led you to decide on this method?

a. What do you like about your current method?
b. Consistent use? Any stops or breaks?
c. Is there anything you wish you could change about your current method?

10. What do you like about contraception in general?

a. Is there anywhere where contraception is missing the mark or could be improved?
b. What are your thoughts on the fact that there are so many different contraceptive methods available to women, but only one method for males?

11. What is your view on the role of partners in decisions regarding contraceptive use or choosing contraceptive methods in a relationship?
12. Can you describe for me any major myths or rumors you've heard about regarding contraception, or specific contraceptive types?
13. Some people have reported that birth control use has changed them/bodies/personalities that they've only noticed once they changed/went off hormonal contraception? Have there been any instances where you might have noticed changes like this in your own experiences?
14. Some people have found that birth control has made their sex lives better, while others have found that it's made it worse and others have found no effect? What are your thoughts on that?
15. Can you describe for me any challenges/issues that you've encountered in accessing contraceptives or information on birth control/contraceptives?
16. Knowing what you know now at this point in your life, if you had a chance to explain contraception to your younger self, what would you tell them?
17. Is anything else or any final thoughts you'd like to add?

Appendix F: Healthcare Provider Interview Guide

For Providers:

1. Can you start with telling me a bit about yourself, like your first name and how long you've been practicing as a healthcare provider?
2. Before you started in your profession, can you tell me about the first time you learned about contraception? How did you hear about it? Age?
3. In your current role, what are your primary resources for getting information on contraception?

a. Prompt: [Drug Reps? Online Sources? RX Files? Society of Obstetricians & Gynecologists?]

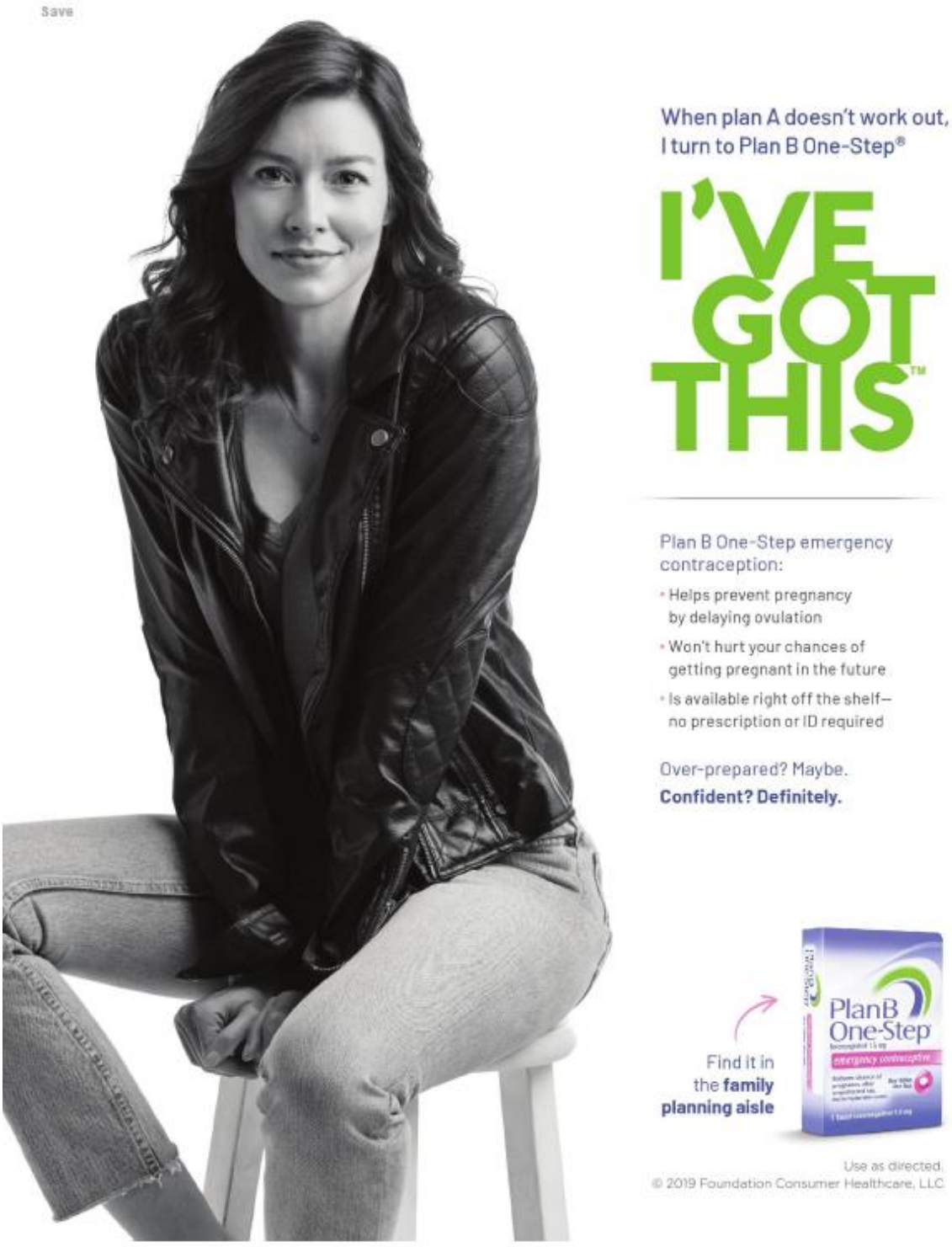
b. With new contraceptive technology and brands coming to market, how do you stay informed about these new products, as well as new information coming out about existing methods/brands?

c. What sources would you say you prioritize as a healthcare provider?

4. You were provided with copies of print ads and a YouTube link for a contraception ad prior to our meeting. Tell me what your thoughts were when you first saw these ads. Have you seen them before? What impressions do you get?
5. What are the top 3 most important things that you prioritize in a contraceptive method in your role as a provider? [Prompt: in your patient consultations]
6. What are the most common contraception trends/methods that you are noticing right now? Has this changed in the last year/5 years/10 years?
7. What are the most common questions patients come to you for regarding contraception?
8. What are the biggest myths/rumors you have heard about contraception from patients?
9. What would you recommend for additional resources for your patients when they want more information on birth control?
10. How have your personal experiences, if applicable, with contraception informed your interactions with your patients?

    Is there anything else or any final thoughts you'd like to add?

Appendix G: Sample Consumer Ads



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Save

learn about vanessa's birth control

highly effective:

- Prevents pregnancy for up to 3 years*
- Over 99% effective,† without a daily hassle

a small, discreet arm implant:

- Takes a few minutes to insert in a doctor's office
- If plans change, it can be removed at any time by a doctor

*NEXPLANON must be removed by the end of the third year. †Less than 1 pregnancy per 100 women who used NEXPLANON for 1 year.

NEXPLANON (etonogestrel implant) 68 mg is a prescription medication for the prevention of pregnancy in women.

important safety information

- You should not use NEXPLANON if you are pregnant or think you may be pregnant; have or have had blood clots; have liver disease or a liver tumor; have unexplained vaginal bleeding; have breast cancer or any other cancer that is sensitive to progestin (a female hormone), now or in the past; or are allergic to anything in NEXPLANON.
- Talk to your health care provider about using NEXPLANON if you have diabetes, high cholesterol or triglycerides, headaches, gallbladder or kidney problems, history of depressed mood, high blood pressure, allergy to numbing medicines (anesthetics) or medicines used to clean your skin (antiseptics). These medicines will be used when the implant is placed into or removed from your arm.
- **Immediately after the NEXPLANON implant has been placed, you and your health care provider should check that the implant is in your arm by feeling for it. If you cannot feel the NEXPLANON implant, contact your health care provider immediately and use a non-hormonal birth control method (such as condoms) until your health care provider confirms that the implant is in place.** You may need special tests to check that the implant is in place or to help find the implant when it is time to take it out.
- The implant may not be placed in your arm at all due to failed insertion. If this happens, you may become pregnant. Removal of the implant may be very difficult or impossible if the implant is not where it should be. Special procedures, including surgery in the hospital, may be needed to remove the implant. If the implant is not removed, then the effects of NEXPLANON will continue for a longer period of time. Other problems related to insertion and removal include pain, irritation, swelling, bruising, scarring, infection, injury to the nerves or blood vessels, and breaking of the implant. Additionally, the implant may come out by itself. You may become pregnant if the implant comes out by itself. Use a back up birth control method and call your health care provider right away if the implant comes out.
- The most common side effect of NEXPLANON is a change in your normal menstrual bleeding pattern. In studies, one out of ten women stopped using the implant because of an unfavorable change in their bleeding pattern. You may experience longer or shorter bleeding during your periods or have no bleeding at all. The time between periods may vary, and in between periods you may also have spotting.
- If you become pregnant while using NEXPLANON, you have a slightly higher chance that the pregnancy will be ectopic (occurring outside the womb) than do women who do not use birth control. Ectopic pregnancies can cause serious internal bleeding, infertility, and even death. Call your health care provider right away if you think you are pregnant or have unexplained lower stomach (abdominal) pain.
- The use of NEXPLANON may also increase your chance of serious blood clots, especially if you have other risk factors, such as smoking. If you smoke and want to use NEXPLANON, you should quit. Some examples of blood clots are deep vein thrombosis (legs), pulmonary embolism (lungs), retinal thrombosis (eyes), stroke (brain), and heart attack (heart). It is possible to die from a problem caused by a blood clot, such as a heart attack or stroke. Tell your doctor at least 4 weeks before if you are going to have surgery or will need to be on bed rest, because you have an increased chance of getting blood clots during surgery or bed rest.
- Cysts may develop on the ovaries and usually go away without treatment, but sometimes surgery is needed to remove them.
- Besides changes in menstrual bleeding patterns, other common side effects reported in women using NEXPLANON include: headaches; vaginitis (inflammation of the vagina); weight gain; acne; breast pain; viral infection such as sore throats or flu-like symptoms; stomach pain; painful periods; mood swings, nervousness, or depressed mood; back pain; nausea; dizziness; pain and pain at the site of insertion. Implants have been reported to be found in a blood vessel, including a blood vessel in the lung.
- Call your health care provider right away if you have pain in your lower leg that does not go away; severe chest pain or heaviness in the chest; sudden shortness of breath, sharp chest pain, or coughing blood; symptoms of a severe allergic reaction, such as swollen face, tongue or throat, trouble breathing or swallowing; sudden severe headaches unlike your usual headaches; weakness or numbness in your arm, leg, or trouble speaking; sudden partial or complete blindness; yellowing of your skin or whites of your eyes, especially with fever, tiredness, loss of appetite, dark-colored urine, or light-colored bowel movements; severe pain, swelling, or tenderness in the lower stomach (abdomen); lump in your breast; problems sleeping, lack of energy, tiredness, or you feel very sad; heavy menstrual bleeding; or if you feel that the implant may have broken or bent while in your arm.
- **NEXPLANON does not protect against HIV or other STDs.**

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Nexplanon
(etonogestrel implant) 68mg
Radiopaque

Please read the adjacent patient brief summary for NEXPLANON and discuss it with your doctor.

MERCK

NEXPLANON®
(etonogestrel implant) 68 mg
Radiopaque

You may be able to get NEXPLANON for free. Check with your insurance provider about coverage and cost.

Patient Brief Summary

Nexplanon®

(etonogestrel implant) 68mg

Radiopaque

Subdermal Use Only

NEXPLANON® does not protect against HIV infection (the virus that causes AIDS) or other sexually transmitted diseases. Read this Patient Brief Summary carefully before you decide if NEXPLANON is right for you. This information does not take the place of talking with your healthcare provider. If you have any questions about NEXPLANON, ask your healthcare provider.

What is NEXPLANON?

NEXPLANON is a hormone-releasing birth control implant for use by women to prevent pregnancy for up to 3 years. The implant is a flexible plastic rod about the size of a matchstick that contains a progestin hormone called etonogestrel. It contains a small amount of barium sulfate so that the implant can be seen by X-ray, and may also contain magnesium stearate. Your healthcare provider will insert the implant just under the skin of the inner side of your upper arm. You can use a single NEXPLANON implant for up to 3 years. NEXPLANON does not contain estrogen.

What if I need birth control for more than 3 years?

The NEXPLANON implant must be removed after 3 years. Your healthcare provider can insert a new implant under your skin after taking out the old one if you choose to continue using NEXPLANON for birth control.

What if I change my mind about birth control and want to stop using NEXPLANON before 3 years?

Your healthcare provider can remove the implant at any time. You may become pregnant as early as the first week after removal of the implant. If you do not want to get pregnant after your healthcare provider removes the NEXPLANON implant, you should start another birth control method right away.

How does NEXPLANON work?

NEXPLANON prevents pregnancy in several ways. The most important way is by stopping the release of an egg from your ovary. NEXPLANON also thickens the mucus in your cervix and this change may keep sperm from reaching the egg. NEXPLANON also changes the lining of your uterus.

How well does NEXPLANON work?

When the NEXPLANON implant is placed correctly, your chance of getting pregnant is very low (less than 1 pregnancy per 100 women who use NEXPLANON for 1 year). It is not known if NEXPLANON is as effective in very overweight women because studies did not include many overweight women.

Who should not use NEXPLANON?

Do not use NEXPLANON if you:

- Are pregnant or think you may be pregnant
- Have, or have had blood clots, such as blood clots in your legs (deep venous thrombosis), lungs (pulmonary embolism), eyes (total or partial blindness), heart (heart attack), or brain (stroke)
- Have liver disease or a liver tumor
- Have unexplained vaginal bleeding
- Have breast cancer or any other cancer that is sensitive to progestin (a female hormone), now or in the past
- Are allergic to anything in NEXPLANON

Tell your healthcare provider if you have or have had any of the conditions listed above. Your healthcare provider can suggest a different method of birth control.

In addition, talk to your healthcare provider about using NEXPLANON if you:

- Have diabetes
- Have high cholesterol or triglycerides
- Have headaches
- Have gallbladder or kidney problems
- Have a history of depressed mood
- Have high blood pressure
- Have an allergy to numbing medicines (anesthetics) or medicines used to clean your skin (antiseptics). These medicines will be used when the implant is placed into or removed from your arm.

Interaction with Other Medicines

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins and herbal supplements. Certain medicines may make NEXPLANON less effective, including:

- aprepitant
- barbiturates
- bosentan
- carbamazepine
- felbamate
- griseofulvin
- oxcarbazepine
- phenytoin
- rifampin
- St. John's wort
- topiramate
- HIV medicines
- Hepatitis C Virus medicines

Ask your healthcare provider if you are not sure if your medicine is one listed above.

If you are taking medicines or herbal products that might make NEXPLANON less effective, you and your doctor may decide to leave NEXPLANON in place; in that case, an additional non-hormonal contraceptive should be used. Because the effect of another medicine on NEXPLANON may last up to 28 days after stopping the medicine, it is necessary to use the additional non-hormonal contraceptive for that long.

When you are using NEXPLANON, tell all of your healthcare providers that you have NEXPLANON in place in your arm.

How is the NEXPLANON implant placed and removed?

Your healthcare provider will place and remove the NEXPLANON implant in a minor surgical procedure in his or her office. The implant is placed just under the skin on the inner side of your upper arm.

The timing of insertion is important. Your healthcare provider may:

- Perform a pregnancy test before inserting NEXPLANON
- Schedule the insertion at a specific time of your menstrual cycle (for example, within the first 5 days of your regular menstrual bleeding). If the implant is placed after the fifth day of menses, then you should use an additional contraceptive method (such as a condom) for the first 7 days after insertion.

Your healthcare provider will cover the site where NEXPLANON was placed with 2 bandages. Leave the top bandage on for 24 hours. Keep the smaller bandage clean, dry, and in place for 3 to 5 days.

Immediately after the NEXPLANON implant has been placed, you and your healthcare provider should check that the implant is in your arm by feeling for it.

If you cannot feel the implant immediately after insertion, the implant may not have been inserted, or it may have been inserted deeply. A deep insertion may cause problems with locating and removing the implant. Once the healthcare professional has located the implant, it should be removed.

If at any time you cannot feel the NEXPLANON implant, contact your healthcare provider immediately and use a non-hormonal birth control method (such as condoms) until your healthcare provider confirms that the implant is in place. You may need special tests to check that the implant is in place or to help find the implant when it is time to take it out. If the implant cannot be found in the arm after a thorough search, your healthcare professional may use x-rays or other imaging methods on your chest.

Depending on the exact position of the implant, removal may be difficult and may require surgery.

You will be asked to review and sign a consent form prior to inserting the NEXPLANON implant. You will also get a USER CARD to keep at home with your health records. Your healthcare provider will fill out the USER CARD with the date the implant was inserted and the date the implant is to be removed. Keep track of the date the implant is to be removed. Schedule an appointment with your healthcare provider to remove the implant on or before the removal date.

Be sure to have checkups as advised by your healthcare provider.

What are the most common side effects I can expect while using NEXPLANON?

- **Changes in Menstrual Bleeding Patterns (menstrual periods)**

The most common side effect of NEXPLANON is a change in your normal menstrual bleeding pattern. In studies, one out of ten women stopped using the implant because of an unfavorable change in their bleeding pattern. You may experience longer or shorter bleeding during your periods or have no bleeding at all. The time between periods may vary, and in between periods you may also have spotting.

Tell your healthcare provider right away if:

- You think you may be pregnant
- Your menstrual bleeding is heavy and prolonged

other frequent side effects that caused women to stop using the implant include:

- Mood swings
- Weight gain
- Headache
- Acne
- Depressed mood

Other common side effects include:

- Headache
- Vaginitis (inflammation of the vagina)
- Weight gain
- Acne
- Breast pain
- Viral infections such as sore throats or flu-like symptoms
- Stomach pain
- Painful periods
- Mood swings, nervousness, or depressed mood
- Back pain
- Nausea
- Dizziness
- Pain
- Pain at the site of insertion

Implants have been reported to be found in a blood vessel, including a blood vessel in the lung which can be associated with shortness of breath, cough and/or the coughing up of blood or blood-stained mucus.

This is not a complete list of possible side effects. For more information, ask your healthcare provider for advice about any side effects that concern you. You may report side effects to the FDA at 1-800-FDA-1088.

What are the possible risks of using NEXPLANON® (etonogestrel implant)?

- **Problems with Insertion and Removal**

The implant may not be placed in your arm at all due to a failed insertion. If this happens, you may become pregnant. Immediately after insertion, and with help from your healthcare provider, you should be able to feel the implant under your skin. If you can't feel the implant, tell your healthcare provider.

Location and removal of the implant may be difficult or impossible because the implant is not where it should be. Special procedures, including surgery in the hospital, may be needed to remove the implant. If the implant is not removed, then the effects of NEXPLANON will continue for a longer period of time.

Implants have been found in the pulmonary artery (a blood vessel in the lung). If the implant cannot be found in the arm, your healthcare professional may use x-rays or other imaging methods on the chest. If the implant is located in the chest, surgery may be needed.

Other problems related to insertion and removal are:

- Pain, irritation, swelling, or bruising at the insertion site
- Scarring, including a thick scar called a keloid around the insertion site
- Infection
- Scar tissue may form around the implant making it difficult to remove
- The implant may come out by itself. You may become pregnant if the implant comes out by itself. Use a back-up birth control method and call your healthcare provider right away if the implant comes out.
- remove the implant
- Injury to nerves or blood vessels in your arm
- The implant breaks making removal difficult

- **Ectopic Pregnancy**

If you become pregnant while using NEXPLANON, you have a slightly higher chance that the pregnancy will be ectopic (occurring outside the womb) than do women who do not use birth control. Unusual vaginal bleeding or lower stomach (abdominal) pain may be a sign of ectopic pregnancy. Ectopic pregnancy is a medical emergency that often requires surgery. Ectopic pregnancies can cause serious internal bleeding, infertility, and even death. Call your healthcare provider right away if you think you are pregnant or have unexplained lower stomach (abdominal) pain.

- **Ovarian Cysts**

Cysts may develop on the ovaries and usually go away without treatment but sometimes surgery is needed to remove them.

- **Breast Cancer**

It is not known whether NEXPLANON use changes a woman's risk for breast cancer. If you have breast cancer now, or have had it in the past, do not use NEXPLANON because some breast cancers are sensitive to hormones.

- **Serious Blood Clots**

NEXPLANON may increase your chance of serious blood clots, especially if you have other risk factors such as smoking. It is possible to die from a problem caused by a blood clot, such as a heart attack or a stroke.

Some examples of serious blood clots are blood clots in the:

- Legs (deep vein thrombosis)
- Lungs (pulmonary embolism)
- Brain (stroke)
- Heart (heart attack)
- Eyes (total or partial blindness)

The risk of serious blood clots is increased in women who smoke. If you smoke and want to use NEXPLANON, you should quit. Your healthcare provider may be able to help.

Tell your healthcare provider at least 4 weeks before if you are going to have surgery or will need to be on bed rest. You have an increased chance of getting blood clots during surgery or bed rest.

- **Other Risks**

A few women who use birth control that contains hormones may get:

- High blood pressure
- Gallbladder problems
- Rare cancerous or noncancerous liver tumors

- **Broken or Bent Implant**

If you feel that the implant may have broken or bent while in your arm, contact your healthcare provider.

When should I call my healthcare provider?

Call your healthcare provider right away if you have:

- Pain in your lower leg that does not go away
- the chest
- Sudden shortness of breath, sharp chest pain, or coughing blood
- Symptoms of a severe allergic reaction, such as swollen face, tongue or throat; trouble breathing or swallowing
- Sudden severe headache unlike your usual headaches
- Weakness or numbness in your arm, leg, or trouble speaking
- Sudden partial or complete blindness
- Yellowing of your skin or whites of your eyes, especially with fever, tiredness, loss of appetite, dark colored urine, or light colored bowel movements
- Severe pain, swelling, or tenderness in the lower stomach (abdomen)
- Lump in your breast
- Problems sleeping, lack of energy, tiredness, or you feel very sad
- Heavy menstrual bleeding

What if I become pregnant while using NEXPLANON?

You should see your healthcare provider right away if you think that you may be pregnant. It is important to remove the implant and make sure that the pregnancy is not ectopic (occurring outside the womb). Based on experience with other hormonal contraceptives, NEXPLANON is not likely to cause birth defects.

Can I use NEXPLANON when I am breastfeeding?

If you are breastfeeding your child, you may use NEXPLANON if 4 weeks have passed since you had your baby. A small amount of the hormone contained in NEXPLANON passes into your breast milk. The health of breast-fed children whose mothers were using the implant has been studied up to 3 years of age in a small number of children. No effects on the growth and development of the children were seen. If you are breastfeeding and want to use NEXPLANON, talk with your healthcare provider for more information.

Additional Information

This Patient Brief Summary contains important information about NEXPLANON. If you would like more information, talk with your healthcare provider. You can ask your healthcare provider for information about NEXPLANON that is written for healthcare professionals. You may also call 1-800-622-4477 or visit www.NEXPLANON-USA.com.

Manufactured by: N.V. Organon, Oss, The Netherlands, a subsidiary of **Merck & Co., Inc.**, Whitehouse Station, NJ 08889, USA

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