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Regret, Relationships, and Reproductive Autonomy- A Critical Narrative Analysis of Requesting and Receiving Tubal Ligation in Canada

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health and Rehabilitation Sciences

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Abstract

Tubal ligation (TL) is a popular and relatively safe form of permanent contraception most often used by women who are content with their family size and by women who do not wish to have children. This thesis presents the narratives of fourteen women who requested and received TL and illustrates the embeddedness of their decisions to prevent or end their potential for reproduction within sexist social discourses of pronatalism and medical paternalism. Guided by the concepts of reproductive justice, relational autonomy, reproductive labour, and health work, narrative interviews were conducted with women located across Canada and who requested, and in ten cases received, TL in order to remain child-free or to end reproduction after achieving a desired family size. The participant narratives were marked by complexities in the ways that women made decisions about ending their reproduction and are presented in five narrative threads: (1) TL as a resolution to complex reproductive histories; (2) forming and negotiating reproductive decisions within intimate and familial relationships; (3) negotiating medical authority and bodily autonomy; (4) TL and reproductive labour; and (5) complicating post-sterilization regret. The findings explore how women ascribe meaning to ending their reproduction through sterilization and the labour that they associated with requesting and receiving sterilization. Particularly, special attention is drawn towards the labour of gathering information about TL and the labour of self-presentation, both of which are symptomatic of systemic institutional failures to provide appropriate and equitable reproductive healthcare. The findings also illuminate how women make reproductive decisions relationally, both within their families and social circles, and in relation to broader social and institutional discourses. By incorporating women's counter-narratives about requesting and receiving TL, this thesis also challenges the medicalized constructions of regret as a condition that should be avoided and the construction of TL as a simple surgical procedure. Storytelling can inform healthcare provider practice and education to highlight the complex nature of decisions about ending reproduction through sterilization and can be mobilized to facilitate social change by challenging post-sterilization regret and highlighting women's reproductive labour visible and the ways in which pronatalism and medical paternalism constrain reproductive autonomy.

Keywords

Tubal Ligation, Sterilization, Reproductive Justice, Relational Autonomy, Reproductive Labour, Health Work, Narrative, Storytelling, Qualitative

Summary for Lay Audience

Tubal ligation (TL) is a popular and relatively safe form of permanent contraception most often used by women who are content with their family size. In Canada, it is the fourth most popular form of contraception and the first most popular among married women. TL is also used by women who do not have children and wish to remain child-free. Despite its popularity, the experiences of requesting and receiving TL have been largely unexplored in the research. This study collected and analyzed the stories of fourteen Canadian women who requested and received TL in order to understand how they made decisions about ending their reproduction and what their stories tell us about how their decisions are restricted and shaped by pronatalist ideals embedded within medical encounters and broader social discourses and cultural narratives that place expectations on women to reproduce. The findings from this study detail the extensive work women engaged in to request and receive TL, including work involved in gathering information about sterilization, finding healthcare providers who would sterilize them, telling and re-telling their TL requests when they were passed from one healthcare provider to the next, managing their self-presentation to boost their chances of getting sterilized, managing the sterilization procedure itself, and performing emotional labour in intimate relationships regarding contraception. The stories challenge the assumption that women regret their decisions to get sterilized and illustrate the range of meanings that women ascribed to TL. For many women in this study, being sterilized meant sparing themselves and their partners from the future emotional toll of miscarriages. For others, TL was a way to affirm their identities as “child-free”. The study findings show how storytelling can be used to provide a better understanding of the complex ways in which women make decisions about ending their reproduction and navigate pronatalist expectations in their health care encounters. Further, these findings can be used to create meaningful change in women’s reproductive healthcare by centering women’s experiences and fostering critical reflection and discussion in medical practice and education.

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Chapter 1

1 Introduction

This thesis presents the stories from fourteen women across Canada who requested and received tubal ligation (TL). TL is a popular form of permanent female contraception (Micks & Jensen, 2015) predominantly used by cis-women who are satisfied with their family size and do not wish to have more children (Edelman et al., 2019). In addition, some women who do not have children seek TL as means of remaining child-free. In this dissertation, I present these women's stories of seeking and receiving sterilization in Canada in relation to theoretical notions of relational autonomy, reproductive justice, and reproductive labour in order to illustrate the constraints of pronatalist discourses on their reproductive decision-making, despite their access to universal healthcare.

One of the threads that weaves throughout the narratives presented in this dissertation is the labour that my participants engaged in to exercise their reproductive autonomy. This labour involved a range of activities, including information gathering, self-advocacy, and self-presentation during medical encounters. Echoed throughout my Findings and Discussion chapters are recollections that illustrate both the frustration and pride of the work that the women in my study had to do to be approved and to receive TL. Despite the labour associated with requesting TL, the child-free participants were not always successful in getting their requests approved. These stories in particular also signify the resourcefulness demonstrated by these participants in negotiating their reproductive autonomy within medical encounters and in resisting and even leveraging pronatalist and sexist medical discourses in order to achieve their desired outcome of sterilization.

This study provides a timely and important response to the overwhelmingly quantitative and post-positivist body of literature currently dominating scholarly discussions about TL (Beshar et al., 2021; Gonçalves et al., 2019; Ida et al., 2021; Potter et al., 2021; Richardson et al., 2018; Schueler et al., 2021; Zite & Borrero, 2011). Through the use of a critical narrative approach, my research findings center the voices and experiences of women and provide empirical grounding for existing feminist critiques of TL medical denials that are made on basis of post-sterilization

regret (Buturovic, 2022; McQueen, 2017, 2020; Richie, 2013a), specifically for child-free women. In order to properly situate my focus of this dissertation on voluntary TL (VTL), in the next section I provide an overview of TL's eugenic and colonial history with a specific focus on Canadian and American sterilization acts. In the subsequent section, I discuss VTL as a form of permanent contraception and its availability and accessibility in Canada. I then discuss how I arrived at the research questions that guided my research and provide an overview of my dissertation chapters.

1.1 Tubal Ligation as Reproductive Violence

Tubal ligation (TL) as means of forced sterilization has a long and violent history rooted in oppression, colonialism, and eugenics. Practiced in almost every colonized region of the world including Canada and the United States, TL has been used to facilitate the practice of eugenics, often under the guise of racist and colonial population control and “family planning” policies (e.g., Gupte, 2017; Haslegrave, 2013; Lopez, 1998; Pandey, 2014). In Canada, mass sterilization of Indigenous women was part of a population control program that targeted women on the basis of race and social status (Dyck & Lux, 2016). More than 1,500 Indigenous women were sterilized under the Alberta Sexual Sterilization Act (between 1928 and 1972) and the British Columbia Sexual Sterilization Act (between 1933 and 1973). Similarly, the California Sterilization Program was carried out at family planning clinics and systematically targeted disabled, poor, and “feeble minded” individuals (Amy & Rowlands, 2018; Ladd-Taylor, 2014; Novak et al., 2018; Page, 2019). Between 1909 and 1979, nearly 20,000 individuals were sterilized under this program (Amy & Rowlands, 2018).

While these explicit eugenic policies were removed in the 1970s (Amy & Rowlands, 2018), there are ongoing reports of coerced sterilization on Indigenous women across Canada, including Saskatchewan, Manitoba, and some parts of Ontario (Barton-Hanson, n.d.; Collier, 2017; Kirkup, 2018; Naik, 2012; Stote, 2017; Wicazo et al., 2016). As recently as 2018, Indigenous women have been subjected to forced and coerced sterilizations (Baig, 2021), with some recalling being threatened by medical professionals that their children would be apprehended by state authorities if they did not consent to the sterilization (Baig, 2021). Currently, collective action lawsuits initiated by Indigenous women from Saskatchewan have prompted public awareness and

conversation about the ongoing reproductive violence against Indigenous women in Canada (Amnesty International, 2020). These efforts have also garnered attention from international human rights organizations, such as Amnesty International and the United Nations Committee Against Torture (UNCAT), with both agencies advocating for the recognition of the ongoing sterilization practices and calling for reparations (Amnesty International, 2020).

1.2 Tubal Ligation as Permanent Contraception: Availability and Access in Canada

In contrast to forced sterilization, TL has also been sought by women as a form of permanent contraception, including women who do not wish to have children. Throughout this thesis, I use the term voluntary tubal ligation “VTL” to refer to when the procedure of tubal ligation (TL) is pursued as a form of permanent contraception and to distinguish it from coerced sterilization when the procedure is done without a person’s knowledge or consent. In Canada, TL is the fourth most commonly used method of contraception (Black et al., 2009) with over 20,000 TLs performed annually. TL is covered under Canada’s publicly funded universal healthcare insurance, meaning that women receiving TL do not incur direct, out-of-pocket costs (Patel, 2019). TL referrals can be received through an obstetrician-gynecologist (obgyn) or a general practitioner; however, no clear guidelines on the referral and approval process exist. While in Canada the only prerequisites to receiving TL is having the cognitive capacity to provide informed consent to the procedure and being 18 years or older, many women still struggle to receive approval (Michelle, 2019). For those who are approved for TL, women have the option of having the procedure performed laparoscopically (typical for procedures performed outside delivery and termination of pregnancy), abdominally (typical for procedures performed during a C-section), and hysteroscopically (typical for outpatient procedures).

Despite universal coverage, the accessibility of the procedure (and of other reproductive healthcare) varies greatly across provinces and territories. In New Brunswick, for example, access to reproductive healthcare, including abortions and contraceptives in general is significantly limited and was deemed “dismal” by the Advisory Council on the Status of Women (Advisory Council on the Status of Women, 2005). Most of New Brunswick’s reproductive healthcare is targeted at youth aged twenty-five and under and abortion services specifically are

severely limited (Advisory Council on the Status of Women, 2005; Brown, 2021). Abortions are performed only in Fredericton area hospitals and women travelling outside of the Fredericton area to receive abortions, such as to other provinces, incur not only clinic fees but also travel costs. As well, doctors' religious and moral beliefs sometimes infringe on patients' reproductive options, such as reversible and permanent contraception, because physicians can stop prescribing contraceptives under the Canadian Charter of Rights and Freedoms. These denials are sometimes protected under the "conscientious objection" clause of the Canadian Charter of Right and Freedoms and allow clinicians to structure the range of options available to women and to "change their minds" about the referrals and kinds of reproductive healthcare services they are willing to provide. This has been the case in Alberta, where physicians can change the scope of their referrals and practice based on their religious and moral beliefs:

If a physician has an experience or learns something new that leads them to change their beliefs, we [College of Physicians and Surgeons of Alberta] would see no issue with that. As long as they follow the rules I outlined from the standard of practice, then the college would not be concerned. Under its standard of practice, the CPSA's "conscientious objection" section is based on its interpretation of the Canadian Charter of Rights and Freedoms and, more specifically, freedom of conscience and religion (Stevenson, 2017).

The harms associated with belief-based treatment refusals as in denials under the "conscientious objection" clause, have been extensively documented and are argued to be a violation of patients' right to health care and moral autonomy (Fiala & Arthur, 2014, 2017; Little & Lysterly, 2013; Meyers, 2001). Thus, while there are no theoretical barriers to TL specifically, the influence of religious and pronatalist values are not mitigated by healthcare policy and are important to consider. Pronatalist values position childbearing and child-rearing as a social good and inherently necessary for a woman's sense of self-fulfillment (Meyers, 2001). These discourses are so ubiquitous that many women do not reflect on their desires to have children and rather see it just "something you do" (Meyers, 2001). As I go on to explore in this thesis, these pronatalist assumptions act as barriers to TL for child-free women whose requests for sterilization are often denied on the basis of physicians' assessments that they are at risk of post-sterilization regret (McQueen, 2020; Richie, 2013).

In addition to these barriers, the COVID-19 pandemic has placed additional restrictions on access to reproductive healthcare. Since the declaration of the pandemic in March 2020, many of these services, including TL, abortions, and STI testing, were deemed non-essential and were suspended to mitigate the spread of COVID-19 (Ontario Association of General Surgeons, 2020). During this time, access to abortion care was significantly limited due to travel restrictions and quarantine requirements which added an additional week to an already time-sensitive procedure (Sexual Rights Initiative, 2021). Similarly, many community clinics offering STI testing and other reproductive healthcare had to either close to limit the spread of COVID-19 or had to relocate their resources towards COVID-19 prevention and testing efforts (Sexual Rights Initiative, 2021).

While the long-term consequences of limited access to reproductive healthcare during and following the COVID-19 pandemic are still unknown, these examples illustrate and bring into sharp relief the complexities of accessing reproductive healthcare in Canada. Despite universal healthcare coverage, many barriers continue to shape and constrain the reproductive decisions that women can make. For many women, these decisions are additionally constrained by existing institutional discourses¹ and practices that effectively deny or otherwise shape access to reproductive healthcare. In the next section, I discuss how I arrived at the research questions that guided my doctoral dissertation.

1.3 Arriving at my Critical Stance

In the summer of 2018, I came across an online *Chatelaine* article “Why is it so hard for some women to get their tubes tied?”. The women featured in this article were child-free, that is, women who neither had children nor wanted to have any in the future. Some of the media

¹ Michel Foucault, whose pioneering work on the discursive framing of deviance, sexuality, and madness has shaped sociological and anthropological scholarship, defined discourse as: “ways of constituting knowledge, together with the social practices, forms of subjectivity, and power relations which inhere in such knowledges and relations. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern” (Weedon, 1987, p. 108).

articles I encountered later, as well as academic literature, referred to these women as “child-less” which aligns with pronatalist values that emphasize childbearing as integral for a women’s self-fulfillment, however, I continue using the label of child-free as I do not believe these women are inherently missing anything.

The Chatelaine article was never more relevant to me than it was then, as I was also becoming *some woman* who was having a hard time getting her tubes tied. I was twenty-seven and fresh out of my Master’s program. I was in a long-term relationship with a man who would later become my husband. I was looking to enroll in a Doctoral program. I was competent, educated, and passing as sane (I had been diagnosed with Bipolar Type 2 six years prior, but have been functioning very well despite not being medicated), and I had never in my life expressed an interest in having children. Then why were doctors so hesitant to listen, so reluctant to allow me to exercise my reproductive autonomy by ending my reproduction before it ever began? Despite attempting to use my psychiatric diagnosis to receive approval for sterilization, I was repeatedly denied and counselled into receiving psychiatric medication to make myself “stable” enough for motherhood. I was also repeatedly informed by healthcare providers that my desire to remain child-free was a symptom and a delusion that accompanied my “mental illness” rather than a genuine desire.

This is how this project began, with a very general and personally driven question of *why is it so hard for child-free women, like myself, to get sterilized?* The more I ruminated on this question, the more anecdotal accounts and academic literature I read, the more complicated the questions I was asking became. What was the legitimacy of post-sterilization regret? Why were some women more likely to be sterilized and not others? What *was* the proper path through medical referrals to get sterilized? As I came to learn through my reading of both media reports and scholarly literature, I wasn’t alone in my confusion; many child-free women were also struggling to get sterilized, healthcare providers frequently denied TL on the basis of preventing post-sterilization regret, and child-free women repeatedly requested and were denied sterilizations for years.

To further complicate my understandings of TL and why it was so difficult to access, 2018 was the year that a class-action lawsuit was filed by Indigenous women from Saskatchewan stating

that they were pressured and coerced into consenting to being sterilized after giving birth in Saskatchewan hospitals (Amnesty International, 2020). The lawsuit illuminated that forced sterilization was still exercised across Canada as a eugenic practice. As I surveyed more media, I came across other problematic TL news stories such one about a Moncton woman, who reportedly was denied life-saving addiction treatment because her current birth control (the patch) was deemed ineffective by her doctor. This story details how she was denied her monthly injection of a medication that would stop her opioid withdrawal symptoms unless she consented to sterilization, despite not dating men and having no interest in having children (Donkin, 2021).

I also read similar alarming stories in the United States. For example, Immigration and Customs Enforcement (ICE) detention centers, beginning with allegation from a nurse, Dawn Wooten, recorded high rates of hysterectomies being performed on the immigrant women detained at the facility (Narea, 2020). These allegations raise concerns about women's reproductive freedom and autonomy and add to a eugenic history of TL in the United States. Forced contraception was also highlighted in the popular media covering Britney Spears' legal battle regarding her conservatorship, which was imposed on the popstar in February 2008, after she had been hospitalized twice and held for a mental evaluation, and prevented her from removing her IUD (Specter, 2021).

As well, many of the media reports I came across covered the experiences of American child-free women who sought to receive TL while they still had health insurance as they wouldn't be able to afford the procedure without it. Other barriers to receiving VTL included the mandatory waiting periods for sterilization for women covered under Medicaid, whereas women who are privately insured could schedule the procedure right away (Cunha, 2019). These reports turned my thinking towards structural barriers to TL such as access to universal healthcare and women's insurance status.

Other media reports about VTL focused on reasons informing medical denials. For example, TL was reportedly denied to women who had no children or who had only one child, were unmarried or married partners with dangerous jobs. Even when TLs were approved, women often recalled having to pass psychological consultations, provide written essays to convince doctors that they had thought through their decisions about sterilization, and demonstrate

permission from their (male) partners (Cunha, 2019). As I would come to understand more clearly through my own research, these and many other media reports highlighted the labour that women engaged in to exercise their reproductive autonomy. My engagement with popular media and other scholarly literature on contraception began to illuminate the multifaceted ways in which seeking TL as a form of permanent contraception was shaped by sexist cultural narratives and institutional discourses reflected in medical paternalism and pronatalism.

Based on my personal experience and this media coverage, I became convinced that women's experiences of TL were an important and timely area of inquiry. Hence, the research I conducted and the findings and discussions I present are a direct response to what I came to understand as the oversimplification of TL in current academic literature and the need to center the voices of women who have sought and received TL. As such, this research aims to highlight the ways in which women ascribed meaning to sterilization and the nuances and ambiguities that arose from managing their contraception with sterilization. Throughout my doctoral research, I came to understand the complex forms of labour that go into managing contraception including the work involved in requesting and receiving TL. As well, I go on to highlight the ways in which my participants' stories challenge current construction of post-sterilization regret. In the next section, I provide an overview of my thesis chapters.

1.4 Chapter Overview

In *chapter two*, I provide an overview of the currently available literature on VTL. I outline how most of the biomedical literature is focused on efficacy and safety of the procedure as well as the risk factors associated with what is often referred to as “post-sterilization regret”. These topics align with the largely post-positivist² assumptions and framings that inform the biomedical

² Similar to the positivist research paradigm, the post-positivist research paradigm assumes that there is an objective reality that can be known through the application of specific measurement techniques and by maintaining researcher objectivity. Post-positivism holds that, while it is not possible to ever access this reality completely or directly, researchers must strive to gain accurate knowledge and representation of reality with the development of precise research tools and analyses. In qualitative research, a post-positivist stance directs research methodology towards the collection of “situational” information from group members themselves to explore the ways in which members attribute meaning to their actions (Guba & Lincoln, 1994).

literature on TL. The qualitative literature included in my literature review is largely post-positivist, however, also includes several theory-driven articles that discuss VTL in relation to eugenic and colonial legacy.

I then contrast these framings with the theoretical work conducted by feminist scholars who focus on the ethics of TL denials, specifically for child-free women, and who argue that such denials compromise women's reproductive autonomy. I conclude this chapter by arguing for the benefits of further TL scholarship that adopts a critical and narrative perspective to center the experiences of the women seeking TL and provide empirical data that ground and support the feminist bioethics literature.

In *chapter 3*, I discuss the theoretical concepts that guided the study, including the frameworks of relational autonomy and reproductive justice, and the notions of reproductive labour and health work. I begin by reviewing the framework of reproductive justice and how it was used to reflect how oppression and inequity constrain women's reproductive decisions (Roberts, 2015; Ross, 2020; Ross & Solinger, 2019). This framework shaped my research and analysis by, first, drawing attention to the ways in which women's requests for TL were often denied on the basis of future regret and, second, by bringing into focus the labour my participants engaged in to exercise their reproductive autonomy.

I then review Susan Sherwin's (1993) framework of relational autonomy and articulate how it challenges the Western biomedical framework of individual autonomy (Igel & Lerner, 2016; Newnham & Kirkham, 2019; Shildrick, 2015; Thachuk, 2007). The concept of relational autonomy informed my research by enabling a view of my participants and their decisions as situated within and influenced by their immediate social circles and also in relation to broader social discourses of pronatalism. I also present and expand on Mykhalovskiy and McCoy's (2002) notion of health work in order to position the work that women engaged in to manage their fertility through their pursuits of TL as a form of permanent contraception as a form of reproductive labour/work. The notion of reproductive labour and health work allowed me to draw attention to the various forms of labour my participants engaged in while requesting and receiving TL, which I present in the findings chapter.

In *chapter four*, I present the critical narrative approach and the methods used to conduct my doctoral work. I begin the chapter by presenting my research questions. From there, I discuss the central tenets of narrative methodology and outline the specific methods I used to generate my study sample, conduct narrative interviews, and complete my analysis. In this chapter, I also include my personal reflexive statement, which focuses on how my understandings of TL have expanded during the research process and how these changes in my conceptualizations were enabled by my critical narrative methodology. I conclude this chapter by including a section on quality appraisal of critical narrative research and how these criteria differ from other, qualitative methodologies.

In *chapters five and six*, I present the findings of my study. In *chapter five*, I present participant narratives that provide an overview of each individual's account of requesting and receiving TL and situate these accounts within their complex reproductive histories. These narratives encapsulate my participants' experiences and their stories of requesting and receiving TL and provide context for the ways in which my participants decided on TL.

In *chapter six*, I present narrative threads that I identified during the analysis phase of my research. These narrative threads included: (1) TL as a resolution to complex reproductive histories; (2) forming and negotiating reproductive decisions within intimate and familial relationships; (3) negotiating medical authority and bodily autonomy; (4) TL and reproductive labour; and (5) complicating post-sterilization regret. Building on the participant narratives presented in *chapter 5*, the first thread complicates the notion of TL as a simple surgical procedure to elucidate the ways in which many of my participants ascribed meaning to TL as a tool to end their complex and often traumatic reproductive histories. In the second narrative thread, *forming and negotiating reproductive decisions within intimate and familial relationships*, I discuss the social shaping and embeddedness of women's decision-making about TL, drawing particular attention to the influence of my participants' social networks. In my third narrative thread, *negotiating medical authority and bodily autonomy*, I discuss the ways in which my participants resisted medical authority to exercise their reproductive autonomy across multiple medical encounters. In *TL and reproductive labour*, I present my findings about the various forms of reproductive labour my participants engaged in to request and receive TL. I

conclude this chapter with the *complicating post-sterilization regret* narrative thread, where I explore how the findings from my research contest assumptions about post-sterilization regret that position regret as frequently occurring following sterilization, and as a condition that should be avoided.

In *chapter seven* I put my findings in conversation with theoretical concepts I introduced in *chapter three*. Specifically, I discuss how my findings expand the notion of reproductive justice and reproductive labour by drawing attention to the work that my participants engaged in to receive TL and how this work was normalized by the participants themselves. In this chapter, I also present several interpretive themes such as *Leveraging Class and Reproductive Fitness Assumptions Through Self-Presentation, TL as Identity Affirmation and Disruption*, and *Exercising Medicalized Agency to Uphold and Subvert Medical Authority*. I then discuss how my findings challenge current constructions of post-sterilization regret. As well, I discuss how my participants navigated institutional discourses of sexism to receive TL and the ways in which my participants made decisions about TL relationally, both through their social circles and by navigating broader social discourses. I conclude the chapter by reflecting on the implications of these research findings for Canadian reproductive healthcare providers, future directions, and the interpretational boundaries of my research.

Chapter 2

2 Literature Review

In this chapter, I situate my doctoral research in the currently available literature on voluntary tubal ligation (VTL). I begin by describing TL as a medical procedure and as a popular form of female permanent contraception and reviewing the possible secondary health complications associated with TL. From there, I distinguish my focus on VTL, which emphasizes women's desires to remain child-free or end their reproduction through sterilization. Then, I explore the relationships between TL and marginalized social identities and TL and post-sterilization regret. As well, I discuss the largely theoretical literature that comments on child-free women's experiences of requesting and receiving TL to retain their child-free status. Much of the research covered in this review is about post-sterilization regret, the experiences of child-free women and TL, and the social patterns in long-acting contraceptive use and TL. Importantly, I draw attention to the ways in which the largely quantitative, post-positivist body of literature on TL has produced important, yet decontextualized and reductionist, understandings of TL-related experiences, and I note how my doctoral research adds to the existing body of scholarship by placing individual narratives of seeking and receiving TL within broader social discourses.

2.1 Tubal Ligation as Medical Procedure and Permanent Contraception

Since its conception as a reproductive technology in 1880, in the United States, TL slowly gained popularity as a permanent form of birth control, until, propelled by the women's movement and second wave feminist during the 1960s and 1970s, it became the number one most frequently form of birth control used by married or in-union women (i.e., cis-gendered women in long-term relationships³) (Dickens, 2011). Currently, about one third of married and in-union women rely on TL as a means of contraception in the United States (Dickens, 2011) and over twenty-thousand TLs are performed annually in Canada (Papamarko, 2011).

³ In this thesis, the term women refers to cis-women unless otherwise stated, as most of TL literature is conducted with the assumption that their participants are cis-gendered.

TL is a procedure where the fallopian tubes are occluded, “tied”, or cauterized to prevent an egg from descending and being fertilized (Pati & Cullins, 2000). TL is a relatively safe procedure with most side effects including bloating, mild cramping, and changes to menstrual flow (Mao et al., 2015). The procedure can be performed after caesarian delivery, termination of pregnancy, or any time in between. Given that TL is a surgery requiring sedation, patients must be notified by their surgeons of the risks associated with general anesthesia (e.g., breathing difficulties, muscle and heart damage, decreased blood pressure) (Gottschalk et al., 2011).

An outpatient procedure for TL was also available until its discontinuation in 2019. Essure was marketed as a sterilization procedure that could be completed in an obstetrics office with minimal or no anesthetic, hence reducing the recovery time and cost associated with inpatient surgery (Câmara et al., 2017; Lessard & Hopkins, 2011). During the Essure procedure, coils are placed transvaginally into the fallopian tubes and the formation of scar tissue around the coils then prevents eggs from descending. Essure was permanently discontinued in January 2019 following a rise in reported serious side effects, which ranged from severe abdominal cramping to perforation of the uterus. Most cases required surgical intervention and resulted in more than 16,000 lawsuits being filed against Essure (Lee, 2018). Currently, there are no other outpatient alternatives for TL.

A significant portion of the literature on TL explores the incidence of secondary health complications following the procedure. These include changes to menstrual flow and negative psychological outcomes such as depression. Changes to menstrual flow, including absent or prolonged bleeding, are the most common side-effects of TL and are reported commonly across the literature on women’s health and fertility (Harlow et al., 2002; Jahanian Sadatmahalleh et al., 2016; Shobeiri & AtashKhoii, 2005). However, a study with over nine thousand women who had received TL demonstrated no statistically significant differences between sterilized and non-sterilized women with regard to menstrual irregularity, such as absent or prolonged bleeding, pain, and amount of bleeding (Peterson et al., 2000). Other reported side-effects following TL include bloating and abdominal cramping (Jahanian Sadatmahalleh et al., 2016), which are experienced by most women immediately following the procedure.

In addition to these side-effects, the catch-all term “post-sterilization syndrome” was first reported in the 1950s to describe complications associated with TL, such as changes to menstrual flow, headaches, changes in libido, depression, and anxiety (Gentile et al., 1998). However, there is little consensus in the literature about whether post-sterilization syndrome exists; thus, there are no definitive statistics on the rates of post-sterilization syndrome. Many obstetricians suggest that most of the changes and symptoms women experience following sterilization can be attributed to the discontinuation of hormonal birth control (Gentile et al., 1998).

Another body of research examines the relationship between TL and various reproductive cancers. In a longitudinal study of over one million women who received TL between 1996 and 2001, TL was associated with significantly lower instances of tubal, peritoneum, and ovarian cancers (Gaitskell et al., 2016). While TL has been suggested to reduce the risks of these cancers, the mechanisms of action underling this relationship are unknown (Cibula et al., 2011; Hanley et al., 2022; Loghmani et al., 2019; Madsen et al., 2015; Nichols et al., 2013).

2.2 Social Patterns in Long Acting and Permanent Contraception

While women who pursue TL are not explicitly coerced, research on voluntary TL (VTL) suggests social patterns that tend to fall along lines of identity that reflect practices of forced sterilization aimed at racialized, disabled, and poor women. For example, research indicates that, in the United States, Black women and Hispanic women are sterilized at higher rates than their non-racialized counterparts (S. Borrero et al., 2007, 2010a, 2011a; Leyser-Whalen & Berenson, 2013; Lopez, 1993, 1998, 2020; Oliveira et al., 2007; Wu et al., 2017). As well, Indigenous and Black women have significantly higher rates of sterilization (42% and 36% respectively) as compared to white women (30%) (Shreffler et al., 2015b). Borrero and colleagues (2010, 2011) suggest that these disparities may be influenced by instances of unwanted pregnancies among minoritized women resulting in sterilization being sought to prevent further unplanned pregnancies and by a family history of using TL for permanent contraception, as frequently reported by Black women (Borrero et al., 2010b, 2011b).

Contemporary traces of eugenic practices can also be identified in uneven contraceptive counselling in the United States between marginalized and racialized women, and white women. Research suggests that Black and Hispanic women are more likely than white women to be counselled by medical practitioners to take contraceptives to limit their family size (S. Borrero et al., 2009; Downing et al., 2007; Harrison & Cooke, 1988) and Hispanic women are more likely to be counselled to receive sterilization compared to white women (S. Borrero et al., 2009).

This stratification of TL across social identities has also been found in research conducted in Brazil. In her qualitative research with young, Black, Brazilian women seeking sterilization, Edu (2018) discusses how Brazilian doctors perform TL unevenly along the lines of class and race, which leaves poor, Black women unable to receive sterilization (Edu, 2018). While the TL denials appear to “protect” poor, Black women from sterilization, Edu (2018) argues that the denials instead subject them to continued medical surveillance and poverty.

Due to the strong medical preference for long-acting reversible contraception (LARC), such as IUDs, women who are unable to access sterilization are disproportionately subjected to the medical gaze and must risk additional unwanted pregnancies:

In sum, when doctors don't tie, it is in part due to this prioritization of LARCs over non-modern contraceptive methods and the irreversible nature of tubal ligation, but what is unsaid in all of this *official verbiage about the advantages of LARCs is that because they are prioritized, they make obtaining sterilizations less possible for poor black women, inadvertently reinforcing already existing social stratification in Brazilian society* (Edu, 2018, p. 563, emphasis added).

As noted in this passage, such restrictions on sterilization for poor, Black women reinforces social hierarchies and further entrench the relationship of dependency between women's reproductive autonomy and medical authority.

To illustrate how colonial legacy shapes women's reproductive decisions intergenerationally, Iris Lopez (1993) examines why Puerto Rican women living in New York typically pursue TL as a form of contraception. Her ethnographic work shows how women's choices and experiences of

TL are shaped by colonial histories, financial struggle, and medical racism. Historically, TL was used in Puerto Rico as means of population control under the pretense of “family planning” strategies (Ordovery, 2014). In 1968, thirty years after TL was introduced in Puerto Rico by Proctor & Gamble, Puerto Rican women had the highest sterilization rates in the world (Ordovery, 2014). During this time, poor Puerto Rican women were also recruited by Proctor & Gamble for clinical trials of progesterone based oral contraceptives, which later would enter the American market (at much lower and safer doses) and become known as “The Pill” (Buffie et al., 1999).

In addition to this colonial legacy, the women in Lopez’s study reported finances as a reason informing their sterilization decisions. This is also reflected in the quantitative literature on VTL that addresses how financial hardship shapes women’s decisions about TL. In the United States, specifically, women’s decisions about TL are often presented in this body of literature as shaped by the relative accessibility of TL through public insurance schemes and by the difficulties of providing care for their existing children, either due to the size of the family or the family situation (e.g., absent or “no good” spouse) (S. Borrero et al., 2007, 2010c, 2011b, 2014) (Borrero et al., 2011, 2007; Leyser-Whalen & Berenson, 2013). While this literature recommends that healthcare providers counsel women to use reversible contraceptives, Borrero et al., (2007) recognize that the financial burden of out-of-pocket costs discourages women from seeking these reversible contraceptives. Interestingly, while research suggests that Hispanic and Black women are more likely than white women to be sterilized, (S. Borrero et al., 2007; S. B. Borrero et al., 2008), studies on economically disadvantaged women suggest that there is no difference in the rates of sterilization between these groups (Borrero et al., 2007). These financial considerations are also reflected in suggestions that long acting forms of contraception, such as the IUD, are prescribed as a “poverty cure” (Dehlendorf & Holt, 2019), which overlooks the social causes of poverty and enforces discourses about the individual responsibility to curb reproduction. This suggests that economic considerations play a major role in influencing sterilization decisions.

There is limited study of how disability shapes experiences of TL. For example, in their qualitative research in Taiwan, Chou & Lu (2011) and Li et al. (2018) explore why women with physical and intellectual disabilities also have higher rates of sterilization (Chou & Lu, 2011; Li

et al., 2018) and are more likely to be counselled to receive long-acting birth control (e.g., IUDs) than their non-disabled counterparts . This research suggests that disabled women are more likely to receive hysterectomies as both a method of sterilization and of stopping menstruation and tend to be younger than their non-disabled counterparts when they receive these procedures (Chou & Lu, 2011; Li et al., 2018). As well, this research suggests that disabled women are sterilized because they are deemed by both healthcare providers and their caregivers (usually family members) as unable to care for children, as “at risk” of passing on their disability (if the disability is genetic), and as constituting a burden on caregivers who must manage their menstruation (Chou & Lu, 2011; Li et al., 2018). Other research on the relationship between intellectual disability and sterilization tends to focus on policy review, rather than empirical study. For example, a review by Roy and Roy (2012) discussed policies on the sterilization of intellectually disabled women in the United Kingdom, United States of America, Canada, Australia, Germany, Belgium, Scandinavia, Japan, China, South Africa, India, and Taiwan (Roy et al., 2012). Their findings indicate that sterilization (hysterectomies specifically) continues to be performed for menstrual management on women with intellectual disabilities in several countries including Australia and the United States. In their population-based study in Belgium, Servais et al., (2002, 2004) found that 22% of the women surveyed were sterilized, almost exclusively through tubal ligation (Servais et al., 2002, 2004). The paucity of literature highlighting the perspectives of disabled women signals an urgent and specific need for research on sterilization that is conducted by and for women with disabilities.

2.3 Barriers to Tubal Ligation

A significant portion of literature on VTL is concerned with the access and barriers to TL (Gilliam et al., 2008; Gormley et al., 2021; Guiahi et al., 2017; Kramer et al., 2021; Potter et al., 2021; Richardson et al., 2018; Stulberg et al., 2014). Many of the studies exploring the barriers to TL are qualitative and use surveys, questionnaires, and semi-structured interviews to gather data. While several structural barriers to receiving TL are described, such as religious barriers (i.e., TL denials made in Catholic affiliated hospitals) and economic (i.e., publicly insured women unable to receive adequate post-partum care including TL) these are presented descriptively and are not analyzed in relation to social discourse.

Religious barriers to TL were identified in several qualitative works exploring both women's and obgyns' experiences of requesting and proving TL in Catholic affiliated institutions (Guiahi et al., 2017; Kramer et al., 2021; Stulberg et al., 2014). A common frustration, identified by Stulbert et al., 2014 in their interview-based study of obgyns' experiences proving TL care in a Catholic hospital was that despite the positive attitudes towards sterilization by the obgyns, sterilization during a C-section delivery was still prohibited (Stulberg et al., 2014). Obgyns felt that these policies placed low-income patients and those with insurance restrictions at increased medical risks (Kramer et al., 2021) from either future unplanned pregnancy or subsequent surgery to receive TL (Stulberg et al., 2014). These findings are also echoed in a survey-based study by Kramer et al, 2021 that found that rural dwelling Wisconsin women were three times more likely to be denied TL at Catholic affiliated hospitals than urban dwelling women (Kramer et al., 2021).

Insurance constraints, as well, often shaped the types of reproductive healthcare women services can access. In the United States, women seeking sterilization often rely on Catholic affiliated and Catholic owned hospitals for their reproductive healthcare due to their insurance status. First, publicly insured women are more likely to receive healthcare in a Catholic affiliated hospital (Stulberg et al., 2014). Further, some private insurance providers do not include enough accessible secular hospitals under the insurance coverage (Kramer et al., 2021).

While sterilization immediately post-partum is recognized as beneficial for maternal health (Richardson et al., 2018) many women's requests for TL are still not met. Thurman et al., 2009 identified that private medical insurance, prenatal care, being a U.S. resident, and being married increased women's likelihood of having their post-partum sterilization requests met (Thurman & Janecek, 2010). Wolfe et al., 2017, as well, identified that a federally mandated consent to TL (completed during pregnancy and before delivery) was the principal cause of unfulfilled post-partum sterilization requests and affected primarily women who lacked sufficient prenatal care (Wolfe et al., 2017). In their interview study, Gilliam et al., 2008 identified that while women may have been denied sterilization immediately post-partum due to "last-minute misgivings", delivery complications, and a lack of a valid Medicaid consent form, their attitudes around these denials were largely shaped by the sense of autonomy they felt about the sterilization decision

(Gilliam et al., 2008). Notably, in their two-year cohort study to estimate the unmet need for post-partum sterilization, Potter et al., 2021 conclude that most unmet need for sterilization was uncovered in a targeted prompt in their questionnaire. This suggests that unmet demand for sterilization could be higher than previously reported since it would not have been evident from clinical records or from consent forms themselves (Potter et al., 2021).

The overall findings from the body of literature on barriers to TL points to structural barriers that can restrict TL access for women who wish to be sterilized by reducing the opportunities for sterilization through religiously affiliated hospitals or through inadequate access to and education during prenatal care.

2.4 Regret and Tubal Ligation

Within the literature on VTL, a number of studies examine the risk factors associated with post-sterilization regret (Eeckhaut & Sweeney, 2018a; Hillis, Marchbanks, et al., 1999; Jamieson et al., 2002; Kariminia et al., 2002; Kelekçi et al., 2005b; McQueen, 2017; Platz-Christensen et al., 1992; Shreffler et al., 2016b). For example, factors used to construct profiles of women considered “at risk” for post-sterilization regret include younger age, lower levels of education, lower income, changes in marital status, and the number of children a woman already has (with fewer children suggesting higher risk for regret) (Hillis, Marchbanks, et al., 1999). Marital instability or having a new partner were reported as strong predictors of post-sterilization regret in three studies (Burnell & Norfleet, 1986; Eeckhaut et al., 2018; Marcil-Gratton, 1988; Platz-Christensen et al., 1992).

In the literature, regret is measured and studied using questionnaires and statistical methods (Eeckhaut & Sweeney, 2018b; Jamieson et al., 2002; Osis et al., 2002; Shreffler et al., 2015b), often using a single, dichotomizing (yes/no) question or Likert scale. While such questions allow participants to indicate the presence, absence or relative degree of regret they experience, they oversimplify regret by equating women’s desires to have more children as a sign of post-sterilization regret. The questions also fail to reflect the transient nature of such choices. As such, while women may come to regret their decisions about sterilization in the future, this does not

preclude the possibility that sterilization may have been right for them at the time the decision was made (Sadatmahalleh et al., 2017).

Within this body of literature, child-free women are identified as most likely to be denied TL on the basis of being “at risk” for post-sterilization regret (Ehman & Costescu, 2018a; Richie, 2013a). However, some studies suggest that child-free women who undergo sterilization to remain child-free report the lowest rates of post-sterilization regret as compared to women who already have children (Ehman & Costescu, 2018). Notably, studies examining post-sterilization regret rarely include child-free women in their samples (Kelekçi et al., 2005a; Mertes, 2017a; Serrano Cardona & Muñoz Mata, 2013; Shreffler et al., 2016a). When child-free women are discussed in literature on regret, this is often done from a theoretical standpoint without findings that are empirically grounded.

Feminist scholars critique these constructions of post-sterilization regret as a condition to be avoided and argue that TL denials based on “sparing” women from post-sterilization regret are unethical and perpetuate medical paternalism, which I will explore in greater depth in the following chapter. Similarly, Buturovic (2019) suggests that “future” regret is the wrong measure by which to assess whether women should be approved for TL, arguing that regret is not synonymous with changing one’s mind. However, Buturovic remains a proponent of “having to prove” that one is serious about sterilization, especially if one is child-free. As well, she challenges the notion that easier access to sterilization effectively benefits women as it reinforces the trend of women bearing disproportionate labour associated with contraception (Buturovic, 2022).

Mertes (2017) also argues that the potential for future regret is not appropriate to assess whether someone should be approved for sterilization. By drawing parallels to the uncertainty of parenthood, Mertes (2017) argues that there is insufficient evidence to suggest that child-free women who remain child-free through sterilization are any more likely than women who already have children to experience regret or a lower quality of life. From this perspective, sweeping averages of quality of life measures are poor indicators of whether or not someone’s life may improve from having children. For example, a couple who spent many years and financial resources towards becoming pregnant may never challenge the idea of parenthood and whether

their lives would have been better without it. However, a person who enters parenthood unwillingly may come to later regret this decision. Mertes (2017) concludes by suggesting a more mindful engagement with decisions about both parenthood and sterilization. Through this engagement, she hopes that: (i) those who want to become parents will be more actively challenged to weigh the pros and cons of this important life decision in the context of reproductive medicine and (especially) in the general population; and (ii) those who do not want to become parents are given more credit for their choice, as they are not jeopardising their well-being any more (and perhaps are doing so even less) than those who opt to become parents. (Mertes, 2016)

A number of ethical concerns have also been raised by McQueen (2017) with regard to TL denials aimed at child-free women. McQueen argues that the possibility of future regret is a condition of autonomy, thus challenging the idea that regret is normatively undesirable by stating that an individual's current wishes should be honored above their potential future wishes (or regrets). McQueen also points to gender inequity in access to sterilization and provides evidence for the ease of access that men have to sterilization as compared to women with the same number of children, illustrating how TL denials are supported by patriarchal discourses and pronatalist expectations of motherhood (McQueen, 2017). Even when women express their desire never to have children, clinicians often assume that this will change once their "biological clock" (McQueen, 2017, p. 312) starts ticking. Therefore, the decision to get sterilized is considered by clinicians as fundamentally counterproductive to a woman's "fundamental nature" of being a mother (McQueen, 2017, p. 312).

2.5 Limitations of Existing Research on TL

TL is presented in several ways across academic literature. First, the post-positivist and medical framing presents TL as a medical procedure and focuses mostly on the efficacy of TL as a sterilization method and its safety. Knowledge produced about TL in this paradigm is decontextualized, removed from both social and political contexts. In this body of literature, researchers mostly rely on descriptive statistics that not only fail to contextualize or explain the observed relationships between social identities and patterns in VTL but also fail to consider how the statistics are produced and how they may reflect and reproduce systemic oppressive

structures or power imbalances. My review of the quantitative studies on TL also suggests that the rigid parameters for data collection set out by questionnaires and surveys erase the experiences and perspectives of study participants.

In direct contrast to this reliance on quantitative methods, much of the literature investigating the experiences of child-free women seeking TL relies on philosophical and theoretical arguments (Buturovic, 2022; McQueen, 2020; Mertes, 2017b; Richie, 2013a). While this literature is integral to understanding the ethics of TL denials and facilitating conversations about women's reproductive autonomy, specifically among child-free women, it also tends to obscure the views and experiences of women through its reliance on theoretical argument and lack of empirical grounding.

Much of the limited qualitative work on TL is also post-positivist. Apart from Lopez's (1993) and Edu's (2018) studies, researchers rely on the use of semi-structured interviews and descriptive thematic analysis. Generally, qualitative studies on TL focus on addressing the structural barriers that women encounter when requesting TL, such as religious views and economic barriers, as well as women's opinions about TL. This work contributes significantly to the understanding of the barriers to sterilization, and the reasons that women give for sterilization. For example, while several studies examine how hospital religious affiliation (usually Catholic) limits women's access to sterilization (Guiahi et al., 2017; Kramer et al., 2021; Stulberg et al., 2014), these studies fail to situate their findings within broader social discourse and as such do not discuss the ways in which racism, ableism, as well as medical paternalism and pronatalism shape experiences of TL.

In my doctoral research, I used a critical feminist narrative methodology to elicit rich narratives from my participants about their experiences requesting and receiving TL. By using a critical narrative methodology, I was able to explore the TL experience in novel ways that have not been addressed by previous research. Specifically, I explore the ways in which women decide on TL as well as their experiences requesting and receiving TL in Canadian medical institutions. My critical lens also illuminates the labour of contraceptive management my participants engaged in and the labour of information gathering that they took upon themselves to compensate for inadequate information provided by healthcare providers. I was also able to place participant

narratives in conversation with structural, social, and institutional discourses such as medical sexism and pronatalism. These interpretations add to the existing body of literature by providing an understanding of how women make decisions about their reproduction and how these decisions are enabled and constrained by social discourses.

2.6 Conclusion

In this chapter I provided an overview of the existing literature on VTL. The existing literature on VTL falls mostly within two categories. First, much of literature on VTL is post-positivist and relies on statistical analysis and structured questionnaires to reach their results. This literature focuses on exploring the efficacy and safety of TL, the social patterns in long acting and permanent contraception, and the rates of post-sterilization regret. Second, there is a growing body of feminist theoretical and philosophical work on the ethics of TL denials, specifically in relation to child-free women. While there is a small body of qualitative work that explores women's perspectives and experiences of seeking and receiving TL, many of these studies are not theoretically grounded and produce de-contextualized results therefore neglecting to place TL in conversation with social discourses of pronatalism, sexism, and medical paternalism.

By In the next chapter, I provide an overview of these theoretical frameworks and discuss how these informed my research and analysis.

Chapter 3

3 Theoretical Concepts

In this chapter I discuss the key concepts that guided my research questions and analytic process and shaped my findings: reproductive justice, relational autonomy, and reproductive labour. First, I begin by introducing the concept of reproductive justice, a theoretical framework and social justice movement. I discuss how reproductive justice complicates and moves beyond choice binaries (e.g., pro-choice/pro-life) by adopting an intersectional lens and how this framework informs ideas about women's reproductive decision making. From there, I discuss the concept of relational autonomy and draw attention to the ways in which it challenges individualized framings of autonomy assumed by biomedical views. I also discuss the notion of medical paternalism and how it constrains women's reproductive autonomy. Finally, I place reproductive labour in conversation with the notion of health work, a concept emerging from Mykhalovskiy and McCoy's (2002) research on patients' labour in the self-management of HIV/AIDS diagnosis. By situating my research in relation to these theoretical ideas, I draw attention to the complexities of women's reproductive decision making and how these decisions are influenced by broader social discourse reproduced through medical institutions. I conclude by discussing the labour women engage in when navigating TL decisions, which are explored further in my Findings chapter.

3.1 Reproductive Justice

Reproductive justice is a social justice movement and a conceptual framework developed during the 1994 International Conference on Population and Development in Cairo by Black feminists and activists to reflect how oppression and inequity constrain women's reproductive decisions (Roberts, 2015; Ross, 2020; Ross & Solinger, 2019). The reproductive justice framework complicates debates about reproductive rights and freedom that focus exclusively on individual notions of "choice" and that have informed much of the pro-choice/anti-choice rhetoric in relation to abortion access. Instead, reproductive justice creates a more inclusive vision for reproductive freedom that pushes back against oppressive structural conditions (Ross, 2017b). Within this framework, reproductive justice is achieved when women have: (1) the right to have

a child; (2) the right not to have a child; and (3) the right to parent the children [they] have, as well as to control [their] birthing options, such as midwifery (Ross, 2007).

First and foremost, the reproductive justice framework challenges the notion that all women have the same opportunities to exercise their reproductive autonomy (Gamble, 2021; Roberts, 2015; Ross, 2020; Ross & Solinger, 2019). While the individualist “choice” paradigm frames reproductive decisions as available to everyone equally, reproductive justice draws attention to structural barriers that constrain and shape agency and reproductive decision-making. The reproductive justice framework also highlights the ways in which structural oppression constrains reproductive decisions across multiple intersecting social positions (Roberts, 2013; Ross & Solinger, 2019). This position draws attention to how racist, colonial, and imperialist discourses exert control and engage in the “exploitation of women, girls, and individuals through our bodies, sexuality, labor, and reproduction” (Ross, 2017b, p. 90).

For example, using a reproductive justice lens, Dorothy Roberts discusses the use of assistive reproduction technologies (e.g., IVF) in increasing reproductive inequities between white, middle-class women, and poor, women of colour (Roberts, 2013). Drawing on Rayna Rapp’s (1999) work on stratified reproduction, Roberts provides a nuanced understanding of the eugenic aspects of these technologies by illustrating how white women are brought under increased reproductive surveillance and governance in ways that support pronatalist discourses while women of colour and poor women are consistently dissuaded or actively prevented from having children (Roberts, 2013).

As well, the reproductive justice framework has been integral to challenging those who claim that LARCs provide a cure for unintended pregnancy and press their use on all fertile people who they identify as likely to have an unintended pregnancy—first and foremost, low-income women of colour (Ross, 2017, p. 156). In her commentary, Jenny Higgins (2014) discusses how LARC promotion and dissemination currently masks the eugenic traces that are carried by these reproductive technologies and the policies that govern their access and uptake. For example, racialized and marginalized women are disproportionately targeted for the use of oral contraceptives and sterilization, often through financial incentives (Higgins et al., 2016). Higgins suggests that, in order to align LARC promotion with reproductive justice goals, marginalized

women should have the same access to LARCs as their non-marginalized counterparts regardless of insurance status (financial security). As well, marginalized women should be able to decline LARCs without undue pressure or resistance from healthcare providers and have the opportunity to remove LARCs regardless of insurance status (Higgins et al., 2016; Moniz et al., 2017). These suggestions are echoed by Moniz and colleagues (2017) who use reproductive justice to inform their critical examination of IUD insertion following delivery. This analysis provides insight into how reproductive technologies, including LARCs (e.g., IUDs), serve to uphold pronatalist norms among white women and to limit the reproduction of racialized and poor women (Roberts, 2013). This is evident in the ethnographic research conducted in Brazil, which draws attention to the ways in which LARCs have been promoted specifically to women who are deemed “vulnerable” by healthcare providers such as poor women, HIV positive women, and women who use drugs (Brandão & Cabral, 2021).

While forced sterilization has been explored extensively through a reproductive justice lens, specifically in relation to Indigenous, racialized and disabled individuals (Bagenstos, 2019; Honkasalo, 2018; Radi, 2020; Ross, 2017a; Vasquez Del Aguila, 2020), discussions about access to voluntary sterilization are still sparse. In my doctoral work, reproductive justice informed the conceptualization of my research questions, the approach I took to data collection and analysis, and the presentation of my research findings. First and foremost, reproductive justice informed my concern with the way in which women’s decisions to pursue TL are denied on the basis of future regret. In particular, based on my personal experience of being denied TL, and findings from the literature, I was concerned with how child-free women’s desires to remain child-free are constrained by pronatalist assumptions that inform these medical denials. This is a novel application of the framework as it currently hasn’t been applied to the experiences of child-free women who are repeatedly denied TL. To date, critical analyses of voluntary sterilization as an aspect of child-free women’s reproductive freedom have been limited to theoretical work conducted by feminist scholars and bioethicists.

While the reproductive justice framework has been developed to reflect the intersectional identities and experiences of marginalized women, Hillsburg (2013) draws attention to the complexities of addressing intersectional social identities as well as account for the “fluidity” of

these markers. Hence, in line with my critical feminist narrative methodology (Chapter 4), I examined what categories of identification animated women's narrations of requesting and receiving TL rather than focus on attaching these narratives to preconceived identity categories. As such, my participants were provided space to narrate their identities in any way they saw fit. The ways in which my participants narrated their identities is discussed in Chapter 4.

The reproductive justice framework also shaped my analysis as ideas about access to sterilization and other reproductive healthcare came up frequently in my participants' narratives, as did the work they engaged in in order to gather and access information about TL and optimize their chances of medical approval for TL.

3.2 Relational Autonomy

In her book, *No Longer Patient*, and in many of her subsequent works, Susan Sherwin discusses a feminist and relational framework of autonomy (McLeod & Sherwin, 2000; Sherwin, 1998; Sherwin, 1989; Sherwin & Stockdale, 2017)⁴. Relational autonomy challenges the medical framework of autonomy common to Western medicine (Igel & Lerner, 2016; Newnham & Kirkham, 2019; Shildrick, 2015; Thachuk, 2007) in which “conceptions of autonomy [are] viewed as the instrument of agency for individuals who are perceived as separate, independent and ‘fully rational’” (Sherwin, 1998, p. 137). Sherwin argues that this idea of autonomy is both unrealistic and pernicious and fails to account for the way that autonomy can be compromised by structural forces of oppression (McLeod & Sherwin, 2000). As McLeod and Sherwin (2000) suggest, while oppression can present in forms of coercion, compulsion, and ignorance, most often it is displayed in “complex and often largely invisible ways, affecting social groups rather than simply disrupting isolated individuals; as a result, its effects tend to be ignored within the traditional autonomy framework that focuses solely on individuals” (p. 259).

⁴ While Susan Sherwin is often recognized for her work developing the relational autonomy framework, the framework was first conceptualized by Jennifer Nedelsky (Nedelsky, 2012).

Women are particularly vulnerable to experiencing oppression in medical settings and this oppression can take two forms (Sherwin, 1992). First, Sherwin argues that women are more likely to undergo medical procedures than men. Second, women have significantly less access to therapeutic interventions that are considered medically appropriate and potentially lifesaving. In *No Longer Patient* Sherwin (1992) presents the findings of Richard McMurray's (1990) work, stating that women are 30% less likely to receive kidney transplants than men and 50% as likely to be referred to diagnostic testing for lung cancer (Sherwin, 1992). Gender differences in access to sterilization are also evident. McQueen (2017) suggests that men face fewer barriers to being sterilized (McQueen, 2017) and Lalonde (2018) argues that the very lack of literature on the experiences of men seeking sterilization demonstrates ease of access (Lalonde, 2018).

For women, the medical view of individual autonomy fails to recognize the ways in which their decision making is constrained, often by medical professionals. With respect to contraception use, for instance, women are often encouraged by healthcare providers to go on hormonal contraceptives to prevent unwanted pregnancy despite the known risks (Sherwin, 1992). Healthcare providers have also been reported as dismissing and downplaying women's pain during IUD insertion and continue to recommend these methods of contraception as convenient and painless despite the building evidence for pain during IUD insertion (Janzer, 2017; Smothers, 2016).

One of the ways in which patient autonomy is protected in the medical framework is through informed consent. However, as Sherwin argues, in practice, obtaining consent often fails to protect patient autonomy, especially when patients are members of oppressed groups (Sherwin, 1992). These patients may not be provided with comprehensive information about medical procedures and their associated success rates or their full range of treatment options. For example, in her recent ethnographic study, Lopez (2020) discusses that many of her Puerto Rican participants who received full hysterectomies to treat uterine tumors were not informed of other, non-invasive treatment options prior to their hysterectomies and that most uterine tumors were benign (Lopez, 2020). Instead, hysterectomies were recommended before they were medically necessary and were often presented by the healthcare providers as the only course of treatment. In the absence of accurate and comprehensive medical information, these women were unable to

make reproductive decisions that were best for them. Lopez (2020) elaborates on this finding, identifying this medical (in)action as a form of “reproductive abuse”:

Their doctors told them that if they did not have a hysterectomy, they might develop cancer, which is contradicted by the medical information provided by the federal government’s fact sheet on uterine fibroids. Dona Hilda and Dona Margo (participants) did not know about this fact sheet, and they did not have other sources of medical information. Moreover, the doctors did not explain any alternative treatments or provide them with sufficient information to allow them to make an informed choice about their treatment. Dona Hilda and Dona Margo were frightened into thinking that if they did not have a hysterectomy, they would get cancer. I would argue that this medical practice used against poor women is unethical and constitutes reproductive abuse (Lopez, 2020, pp. 136-137).

In other research on women undergoing infertility treatment (e.g., IVF), Carson et al., (2021) found that women are rarely informed about the low success rates of these technologies yet are also responsabilized for its failures (Carson et al, 2021; Throsby, 2004).

The individualized framework of autonomy is also limited as it presumes that all patients have the same opportunities and resources to exercise their decisions and will do so rationally (McLeod & Sherwin, 2000; Sherwin, 1989a, 1998a). These assumptions tend to privilege those who have access to many resources to simplify their decision making and facilitate the illusion of personal agency and success. As Sherwin (1998) articulates:

Within North America it seems that people who were raised in an atmosphere of privilege and respect come rather easily to think of themselves as independent and self-governing; it feels natural to them to conceive of themselves as autonomous. Having been taught that they need only to apply themselves in order to take advantage of the opportunities available to them, most learn to think of their successes as self-created and deserved (p. 25).

These views of autonomy tend to obscure the social factors and inequities that shape and constrain women's reproductive decisions. In medical settings, the unwillingness to acknowledge these inequities perpetuates stereotypes that disproportionately affect marginalized and racialized patients and promote medical paternalism (Sherwin, 1992, 1998a). For example, the popularity of LARC has been attributed largely to it being a "hassle-free" form of contraception management and to its long-term effectiveness. However, this overlooks that LARCs are also commonly covered by public insurance schemes and are thus readily accessible to women in financially precarious situations over other contraceptive options. This ease of access to LARCs for publicly insured women (in the United States), and particularly for those who are racialized and otherwise marginalized, has been noted by some researchers as reminiscent of financial incentives provided to marginalized women who agreed to take oral contraceptives or consented to sterilization (Moniz et al., 2017).

To address the ways in which various forms of social inequity and oppression constrain autonomy, Sherwin proposes a relational account of autonomy. Contrary to the isolated, privileged individual who is presumed within Western biomedicine to act autonomously and make decisions about their care objectively and free from social discourse, this relational understanding of autonomy articulates that patients are "inherently social beings that are significantly shaped and modified within a web of interconnected (and sometimes conflicting) relationships" (Sherwin, 1998, p. 35). Relational views of autonomy help provide insight into how women's reproductive decisions are shaped and constrained by social discourses, such as pronatalism, which reflect colonial, sexist, and ableist forms of power and oppression (McLeod & Sherwin, 2000; Sherwin, 1989, 1998).

This relational view of autonomy is illustrated in research on reproductive decision-making by Ehrich et al. (2007) in the United Kingdom who examined how parents negotiate their autonomy and decisions about embryo implantation. These researchers argue that parents must negotiate their reproductive autonomy in relation to implantation technicians' decisions about which embryos will be implanted, which are made in relation to social and culturally normative discourses about health and normality (Ehrich et al., 2007). This study illustrates the moral tensions that PGD technicians negotiate while conducting genetic testing on pre-implanted

embryos and how the parents negotiate their autonomy during this genetic testing. Technicians negotiated these interactions by focusing on providing clients with the information that would lead to the most successful implantation (Ehrich et al., 2007). This study explores relational autonomy in two ways. First, it highlights the complexities of technician decisions about embryo selection and the ways in which these decisions are negotiated in relation to professional and personal ethics. Second, the study suggests that the clients are also making decisions about embryo implantation based on cultural norms such as the heightened cultural value of a male child (e.g., in China, India, Vietnam), and social conceptions of what constitutes a “healthy” embryo (Ehrich et al., 2007).

In her recommendations on implementing relational autonomy in medical practice, Sherwin suggests that, in order to uphold a relational view of autonomy, we must look beyond simply providing those experiencing marginalization more opportunities to exercise autonomy, such as more options for medical treatment (Baylis et al., 2008; Sherwin, 1989b; Sherwin & Stockdale, 2017). Rather, medical practice must move towards challenging the engrained power relations within medical institutions that tend to privilege the knowledge and expertise of medical professionals over that of their patients. By having members of historically marginalized and oppressed groups take a greater role in the planning and goals of medical treatment, there is a potential towards subverting existing power structures.

There are several responses to the relational autonomy framework. For example, John Christman (2004) interprets the framework as only feasible if someone were brought up in an environment completely free from oppression. (Christman, 2014). In his argument, he draws on Oshana’s (1998) work which proposes an “externalist” view of autonomy, that is to say that a person’s social environment must allow significant choices and options for the agent to be truly autonomous. Therefore, a person’s decisions to support conditions that oppress her cannot be viewed as autonomous. Andrea Westlund, however, proposes that it is self- and critical reflection that are the hallmarks of agency, rather than an ideal, oppression-free environment. For Westlund (2009), while we may not always choose what appears “best” or most “liberating”, our choices are genuine and agentic when we are aware and consider the consequences that may follow our decisions (Westlund, 2009). These re-conceptualizations and critiques of relational

autonomy complicate medicalized views of autonomy which focus on individualized decision making regardless of circumstance. Regarding reproductive healthcare, such critiques of relational autonomy raise questions about reproductive decisions and how these decisions are exercised. Specifically, Westlund's work facilitates a discussion about how women may exercise their reproductive autonomy when their opportunities for making these decisions are constrained. For example, Morgan (1998) refers to this form of decision making as "medicalized agency" whereby women may reproduce and resist medicalized views in distinct ways to achieve their unique goals (Morgan, 1998). As I will go on to explore, the findings from my study illustrate how women found ways to leverage existing sexist and pronatalist medical discourses to secure TL.

In my doctoral research, relational autonomy guided both my interviews and my data analysis. By adopting the view that my participants were relational beings, during the interviews my attention was drawn towards how their decisions about TL were shaped by both interpersonal relationships and sexist, classist, and pronatalist medical discourses. My application of relational autonomy aligns with Westlund's arguments regarding critical self-reflection. As I observed in my interviews, many of the women in my study engaged in deep self-reflection before deciding to pursue TL. This was especially relevant for child-free women who regularly engaged in critical self-reflection about their desires to remain child-free and who, like other women in the study, experienced multiple barriers to, and denials of their requests for, TL. Through the conceptualizations of relational autonomy elaborated by Sherwin (1992) and Westlund (2009), I was able to attend to the ways in which my participants' decisions about TL were shaped by their previous reproductive histories as well as their own family experiences and histories. Additionally, these views of relational autonomy enabled me to examine the participant narratives with attention to the ways that they negotiated their autonomy in medical settings and resisted medical authority. As I will go on to illustrate, such negotiations of autonomy were particularly constrained for the child-free women in my study by pronatalist discourses reproduced within the medical institution.

3.2.1 Medical Paternalism and Relational Autonomy

From her feminist perspective, Sherwin notes the ways in which medical encounters with women are disproportionately shaped by medical paternalism. In Western medicine, medical paternalism is justified by views of the female body as inherently flawed and disorderly, and of women themselves as emotional and irrational (Sherwin, 1998b). Some examples of gender specific medical paternalism include interference in birthing plans (Cook & Loomis, 2012) and withholding reports of IUD insertion pain to patients seeking long-acting contraception (Campbell, 1999; Janzer, 2017; Ruff, 2019). Regarding TL, medical paternalism underlies TL denials, which are often justified by claims of preventing future post-sterilization regret (Curtis et al., 2006). For child-free women specifically, denials of TL are often followed by counselling women into unwanted temporary and long-acting birth control, such as has IUDs, (Richie, 2013a) to “preserve” their future fertility. Feminist scholars have critiqued TL denials based on the potential for future regret by emphasizing that the possibility of future regret is an essential characteristic of autonomous decision making (McQueen, 2017; Richie, 2013). These authors argue that any autonomously made decision may lead to regret, and thus paternalistic efforts to “spare” women from this risk deny women of their right to reproductive autonomy (Heitlinger, 1991; McQueen, 2017; Richie, 2013a). McQueen (2017), for example, argues that the possibility of regret is necessary for a decision to be truly autonomous as it suggests that other decisions were available to be made. McQueen also challenges the idea that regret is normatively undesirable by arguing that an individual’s current wishes should be honored above their potential future wishes (or regrets). This is especially important given that some research suggests that a person’s beliefs may remain fairly constant over their lifetime (McQueen, 2017).

Medical denials of TL requests on the basis of future regret are supported by dominant pronatalist discourses that reinforce gendered social norms surrounding motherhood and childbearing. McQueen (2017) points to the patriarchal and pronatalist discourses that structure gender inequity in access to sterilization. Pronatalist discourses frame childbearing and parenthood as a social good and are necessary for the continuance of humanity (Meyers, 2001b) and position women’s roles as biological mothers as imperative to their self-actualization and well-being (Gotlib, 2016; Heitlinger, 1991; Lalonde, 2018a; Russo, 1976, 1979). This

“institution of motherhood”, as Adrienne Rich describes it, defines women’s lives and their potential in terms of motherhood even if they never go on to have children (Rich, 1978). Like other institutions, motherhood comes with its own rules and regulations, typically reproduced by outsiders (those who are not mothers), and other mothers alike who survey and discipline women into being “good” mothers (Rich, 1978).

The ways in which medical paternalism and pronatalist discourses are applied to women’s bodies specifically are reflected in the relative ease of access that men have in accessing sterilization as compared to women with the same number of children (McQueen, 2017). Even when women express their desire to never have children, clinicians often assume that this will change once their “biological clock” (McQueen, 2017, p. 312) starts ticking. Therefore, the decision to get sterilized is considered by clinicians as fundamentally counterproductive to a woman’s “fundamental nature” (McQueen, 2017, p. 312) of being a mother.

The powerful influence of pronatalist discourses on reproductive autonomy and decision-making has been illustrated in research about how women struggle to end infertility treatment (Carson, 2019; Carson et al., 2021). In this work, Carson et al., 2021 demonstrate that women find it difficult to end infertility treatment even when treatment repeatedly fails. Notably, rather than suggesting that women stop treatment after several unsuccessful cycles of treatment, healthcare providers tend to responsabilize women for their infertility by reinforcing views of women’s bodies as deficient. As noted in this study, women internalize this blame and view their bodies as inherently flawed and dysfunctional:

Pronatalist assumptions that equate womanhood with motherhood are bolstered by discourses in reproductive healthcare which characterize infertility as ‘failure’ or physiological deficiency. These assumptions were reflected in the participant narratives as many of the women grappled with conflicting feelings towards their bodies and voiced their frustrations that their bodies were ‘not doing what [they were] supposed to do’ (Brittany). In this sense, participants frequently internalized blame for fertility problems, even in cases where their problems conceiving were left undiagnosed or labelled as ‘unexplained infertility’ and when their male partners experienced fertility issues (Carson et al., 2021, p. 6).

As such, medical paternalism greatly shapes women's medical encounters and constrains their ability to exercise reproductive autonomy. In my own work, paternalistic encounters were quite common, especially for child-free women.

3.3 Reproductive Labour as Health Work

In this section, I draw on notions of “reproductive labour” to draw attention to contraceptive management and accessing sterilization as forms of unpaid work that women must engage in to manage their reproductive health. This conceptualization of reproductive labour is informed by both materialist feminist articulations of reproductive labour (Bahn et al., 2020; Bergmann, 1974) and by Mykhalovskiy and McCoy's (2002) notion of “health work”. During the analysis stage of my research, it became apparent that much narrative space was devoted by the women to describing the labour they engaged in to manage their reproduction. This was reflected, for example, in the ways that the women discussed self-advocacy and self-presentation as distinct forms of labour that they engaged in to get approved for TL, which I explore further in the Findings chapter.

Within materialist feminist literature, the terms “reproductive labour” and “reproductive work” are often used interchangeably and describe the forms of labour that reproduce the labour power necessary to maintain production (Smith, 2013). During the 1970s the term was extended by social feminists to draw attention to the invisible labour that women engaged in within the domestic sphere including caring for children, the elderly, cooking, and cleaning (Smith, 2013). Contemporary material feminists also use the term “social reproduction” to describe the unpaid domestic or reproductive labour that is necessary to nourish and sustain the social order (Bakker, 2007; Laslett & Brenner, 1989). Recently, definitions of reproductive labour have grown to include embodied labour, such as contract pregnancy (McLeod, 2009; Vertommen & Barbagallo, 2020) and oocyte (egg) donation (McLeod, 2009; Waldby, 2008). As a growing industry, oocyte donation tends to favour white, highly educated, and traditionally attractive donors (Waldby, 2008). In these cases of reproductive labour, women are often uninformed about the risks and invasiveness of the labour associated with their participation in medical procedures (McLeod, 2009; Waldby, 2008). As part of this labour, women expose themselves to harmful hormone

treatments, painful tests, and procedures, and surrender to medical surveillance (McLeod, 2009; Waldby, 2008).

While many women who engage in this form of reproductive labour may not view it as “work” (Vertommen & Barbagallo, 2020), the mere process of being selected to be a surrogate or donor is often physically arduous and labour-intensive. Women are required to undergo medical tests, fill out forms “often as long as college admissions” (McLeod, 2009, p. 5), and attend multiple medical appointments. Others note that women selected as donors or surrogates are required to attend additional medical appointments, receive hormone therapy, and follow a strict daily regime, which may involve abstinence from sexual intercourse for the duration of the pregnancy, and avoidance of drugs, alcohol, and heavy lifting (Hester, 2018).

The ethical and moral implications of contract pregnancy and oocyte donation have been explored previously in academic literature (McLeod, 2009; Vertommen & Barbagallo, 2020; Waldby, 2008). Some feminist scholars suggest that this reproductive labour can never be conducted ethically and risks reducing women to the state of “breeders” (Corea, 1985; Mies, 1987). One of the major feminist critiques of contract pregnancy and oocyte donation is that women’s reproduction becomes commodified, and hence diminishes “the personhood of women” (Radin 1991, p. 349). These critics claim that the commodification of reproduction leads to the exploitation and objectification of women, especially poor women who may engage in contract pregnancy and oocyte donation due to a lack of other lucrative employment opportunities. Contract pregnancy also enforces a view of pregnancy as no longer belonging to the woman; rather, it is either a state of developing the fetus, for which the woman is a mere container, or as an objective, observable process under scientific scrutiny, and objectified by the woman herself and medical practitioners, as a condition that must be medically surveyed (McLeod, 2009). However, as others note, the labour of contract pregnancy and oocyte donation also provides women with financial compensation that can, in turn, allow women more financial freedom. McLeod, 2009 suggests that, moving forth, intersectional and interdisciplinary feminist work can create a deeper and more nuanced understanding of women’s reproductive labour through a “cross-pollination” of ideas:

Feminists writing on oocyte vending and commercial contract pregnancy could also draw valuable insights from feminists who have theorized not about these practices, but about others that raise similar moral issues for feminists. For example, feminists have done detailed work on what it means to say that women are autonomous in choosing cosmetic surgery (Morgan 1991) or medical interventions in pregnancy (Sherwin 1998; McLeod 2002) (McLeod 2009, p. 279)

While the above examples illustrate the reproductive labour women engage in through their interactions with reproductive technologies to “reproduce” the population, my doctoral work considers the reproductive labour involved in ending reproduction with the aid of medical technologies. In this research, I draw on the notion of health work to expand the definition of reproductive labour to include the activities that women engage in to access and secure TL as a form of permanent contraception. The narratives generated throughout this project shed light on the labour my participants engaged in to manage their reproduction and the gendered expectations that shaped this labour. By expanding the definition of reproductive labour to include numerous forms of health work that women engaged in, I include the unpaid and invisible work that women take on to manage and maintain their reproduction.

In their research on the management of HIV diagnoses, Mykhalovskiy and McCoy (2002) introduce the notion of “health work” to define the “range of practices that people engage in around their health” (p. 24). Through ethnographic methods, the authors make visible and reflect on the labour their study participants do in order to adhere to their medication regimens (most of which needed to be taken at specific times throughout the day) and attend their medical appointments (many of the participants did not have access to a car and relied public transportation). Engaging in this sort of “health work” is often informally enforced by physicians in interpersonal interactions with their patients through an accommodating and warm bedside manner. As such, patients managing their HIV+ diagnosis are disciplined into the “ideal” HIV+ patient who is assertive, knowledgeable, and punctual. Failure to meet these ideals is often positioned as a moral failure rather than the result and failure of health and social services. In Mykhalovskiy and McCoy’s (2002) study, participants with marginalized social identities often “failed” to become ideal patients. For example, poor patients experiencing homelessness had no

reliable access to transportation to get to their medical appointments. They often lacked the bare necessities and often had to make trade-offs between paying for transportation to their medical appointments and having enough to pay for food. As well, these patients often failed to take their medication as instructed, that is to say, at regular meals, and were often reprimanded for this by their healthcare providers.

This notion of health work is useful in order to make visible the gendered forms of labour that patients must engage in to access healthcare. As previous research suggests, similar demands can be observed in reproductive healthcare and fertility management. In heterosexual relationships, women engage in work to manage their fertility to a much greater degree than men (Lowe, 2005), with this work placing significant physical demands on women such as attending medical appointments, choosing, and paying for contraception. Women also perform additional labour to negotiate the use of contraceptives with their partners and decide on the right contraceptive for themselves (Kimport, 2018). In their qualitative research, Kimport (2018) describes that even when women felt they were happy with their family size and expressed that they did not want to have any more children, the burden of deciding on sterilization often fell entirely on them instead of their partners who rarely engaged in these conversations. While doctors often suggested that the women's husbands get a vasectomy, this requires women to engage in additional labour to convince their husbands that a vasectomy is an appropriate contraception choice (Kimport, 2018).

3.4 Conclusion

In this chapter I reviewed the theoretical concepts that informed and framed my analysis, specifically reproductive justice, relational autonomy, and the notions of reproductive labour and health work. Both reproductive justice and relational autonomy frameworks are integral to understanding how women request and receive TL and negotiate medical authority in their attempts to secure TL approval in relation to broader social structures and discourses of pronatalism and medical sexism. Additionally, the notion of reproductive labour illuminates the work that women must engage in to receive TL and to exercise their reproductive autonomy. Notably, drawing on the notion of reproductive labour brings into focus the gendered dimensions of contraceptive management, which are also evident in my participant narratives. With these

theoretical concepts in mind, in the next chapter, I outline the critical narrative methodology that I used to collect and analyze women's narratives of requesting and receiving tubal ligation and how these theoretical concepts shaped and guided my analytic process.

Chapter 4

4 Methodology

In this chapter I introduce the research questions that guided my doctoral research and provide an overview of the methodologies and methods that were used to address these questions and objectives. I begin by articulating my research questions, which respond to previously identified gaps in scholarly literature about VTL discussed in the Literature Review chapter. Following this, I present the methodological approach that I used to conduct the project including recruitment of participants, data collection, and analysis. Finally, I discuss the issues of quality appraisal and how I addressed these in my project. From here on, I use pseudonyms to protect participants' identities. As well, any potentially identifying information was also removed from direct quotations.

4.1 Research Questions

The purpose of my doctoral research was to use critical feminist narrative inquiry to explore women's experiences of requesting and receiving TL. Specifically, this research examined how women at various stages of the TL process (those approved for and waiting to receive TL, those who have been denied TL, and those who have received TL) story these experiences. In keeping with the inductive character of qualitative data collection and analysis, a question pertaining to the labour involved in requesting and receiving TL was added as my interviews progressed. In summary, the questions guiding my research were:

1. What do women's narratives about requesting and receiving TL tell us about how they make decisions about ending their reproductive potential?
2. What do these narratives tell us about the broader discourses and contexts that shape women's experiences of requesting and receiving TL, and their reproductive autonomy?
3. What do these narratives tell us about the work women must engage in in order to enact their reproductive autonomy?

4.2 Methodological Approach: Critical Feminist Narrative Inquiry

To address the above research questions, I used critical feminist narrative inquiry to generate knowledge about the complex relationships and contexts that inform women's requests for, and experiences of, TL. This methodological approach is consistent with the feminist analytic lenses of reproductive justice, relational autonomy, and reproductive labour that guided my doctoral research, as I described in the previous chapter. Furthermore, the narrative approach enabled me to ground my analysis within the experiences of women as they were articulated in their storytelling.

A central claim of narrative methodologies is that narratives or purposefully told stories are how we make sense and meaning of the world and our experiences (Polkinghorne, 1988). Narrative is assumed as the "primary scheme by which human existence is rendered meaningful" (Polkinghorne 1988, p. 11) and enables us not only to understand past experiences, but also our interpretations of future events. Narrative approaches to inquiry require researchers to examine not only the content of narratives (what is told) but also, *how* and *why* events are storied in particular ways, that is to say, the language and structure that is used in narration (Riessman, 1993a; Squire, 2008).

Narrative methodologies are grounded in constructivist epistemology, which assumes the presence of multiple realities that are understood as socially constructed. In a constructivist paradigm, the research findings are literally created through the research process that involves interactions between the researcher and the study participants (Guba & Lincoln, 1994). Therefore, the narratives that are elicited and ultimately presented by the researcher during the research process are co-constructed, a collective product of the research participants' responses to the researcher's interests, elicitations through interview questions, and interpretations, and representations, of these responses (Connelly & Clandinin, 2019). As such, co-construction of participant narratives extends throughout the entire research process, from the theorization of the research, to the articulation of the research questions, to the formulation of interview questions, to the data collection and analysis stages. This continual co-construction facilitates the meaningfulness of the narrative to emerge in the interactions between the teller and the listener,

and between the writer and the reader (Patterson & Williams, 2002; Ricœur, 1984; Riessman, 1993b).

Narratives also serve as means of self-construction whereby, through the process of story-telling, we shape our identities and make sense of things that happen to us throughout our lives in relation to broader discourses (Ricœur, 1984). By telling (and re-telling) stories we are able to articulate who we are and how we position, navigate, and construct our identities in relation to these social norms and discourses (Lieblich et al., 1998). In narrative-informed qualitative health research, stories can be analyzed for how study participants navigate decisions and position themselves as moral agents in relation to existing systems of power and control, which also become visible and subject to scrutiny (Polzer et al., 2014; Riessman, 1993b).

Similarly to other narrative methods, critical feminist narrative inquiry is founded on the belief/assumption that the process of narrating stories, or narrativity, acts as a means to “secure voice, power, and agency in a frequently disenfranchised world” (Pitre et al., 2014, p. 124). This methodology is congruent with feminist epistemology as it values subjective experience as a source of knowledge rather than positioning it as a source of bias (Code, 1995; Jackson & Mazzei, 2008). Each story is viewed as reflecting multiple dimensions of the “situated self”, including those that are personal, historical, social, structural, and ideological. In this sense, critical feminist narrative inquiry views and analyzes stories as inevitably situated within and shaped by surrounding social, cultural, historical, and structural forces (Pitre et al., 2014). The aim of this approach to narrative inquiry is therefore to understand the “forces and conditions that shape particular experiences and delineate the boundaries of individual or collective agency, voice, identity, and reflexivity.” (Pitre, et al., 2014, p.119).

Like other interpretive qualitative approaches, narrative inquiry uses a hermeneutic process, which involves describing research participants’ stories thematically and developing overarching narrative threads that overlap across multiple stories (Riessman, 1993a; Squire, 2008). In my work, I define “story” as an account with one core focus, such as loss of pregnancy. Building on these stories, “narrative threads” are more interpretive and stretch across several participant stories.

Critical feminist narrative inquiry uses a double-hermeneutic analysis, which involves, first, a *hermeneutics of faith* and, then, a *hermeneutics of contextualization* (Pitre et al., 2014). The purpose of a *hermeneutics of faith* analysis is to establish storylines present across multiple interviews. During multiple readings, the objective is to first identify narrative threads that are present across multiple stories. These narrative threads often relate to a specific dimension of the overall experience under study. Narrative threads reflect aspects of experience that are relevant and important to many participants in nuanced and different ways. For example, in my work, the narrative thread of being denied TL was very prominent across the TL experiences of child-free women. Key metaphors, for example, begun to emerge at this stage, and these informed my interpretation of storylines. For example, one of my participants likened the process of gaining approval for TL to that of a “job interview” and described how she dressed professionally and “flaunted” her career successes to appear as a “competent” and “ideal” candidate for sterilization.

The purpose of a *hermeneutics of contextualization* analysis is to situate storylines in a particular storied space that participants inhabit (e.g., pronatalist and sexist discourses, medical paternalism). Storied space is described as:

Where stories are delineated by the nature and boundaries of a chosen phenomenon, where storytellers and their stories can be located within their particular and larger world, and where stories are co-constructed between storyteller and listener given a particular purpose and setting (Pitre et al., 2013, p. 124).

This storied space acts as the setting for the narrator’s story, which refer to or invoke the “embedded rules, routines, and expectations” of a particular phenomenon (Pitre et al., 2013, p.124). Storied space reveals the implicit and explicit rules, routines, and conceptions that the researcher can explore to understand how the narrator is influenced by their immediate and broader social contexts (Pitre et al, 2013). When exploring the storied space, narratives are examined to gain understanding of forces and conditions that are constraining and enabling participants’ reflexivity, agency, voice, and identity. Each reading aims to explore participants’ interactions with historical, ideological, and structural worlds. The researcher can also understand storied space by exploring how participants story their interactions and engagements

with key actors and institutional discourses, such as those reproduced by healthcare professionals.

During my reading of storied space, the feminist orientation of this approach also required me to stay attuned to gendered relations of power to identify oppressive conditions that foster domination, inequity, and marginalization (Pitre et al., 2013b), including sexism, racism, classism, ableism, ageism, homophobia, and transphobia (Pitre et al., 2013b). For example, in my work, many stories about TL denials were situated within the storied space of sexist and classist pronatalist discourse whereby my participants were denied sterilization on the basis that they may want children in the future and will regret their decision to be sterilized.

4.3 Methods

4.3.1 Participant Recruitment

The initial recruitment phase began after initial ethical approval, which was acquired from the University of Western Ontario's Non-Medical Research Ethics Board on October 12, 2020. During the initial recruitment phase, I put up posters in public spaces around London, Ontario (i.e., coffee shops, grocery stores, local YMCA), as well as online spaces for Ontario residents (i.e., obstetrics rights groups, women's issues groups). Posters contained a brief study summary and my contact information (phone number and email).

After the initial recruitment phase yielded only three participants, amendments were made to the recruitment protocol to boost recruitment by adding recruitment sites (with these amendments approved on November 27, 2020, and January 12th, 2021). The first amendment added Women's College Hospital, located in Toronto, Ontario as a potential recruitment site. However, after receiving no responses about possible recruitment options through the Hospital, another amendment was warranted. The second amendment increased the recruitment area to all of Canada instead of the province of Ontario.

After this second amendment, I approached the coordinators of the Obstetrics Justice Project (<https://obstetricjustice.org/>) and asked them if they would circulate the study advertisement poster on their website. The Obstetrics Justice Project is an online website and blog that shares

stories of obstetric violence experienced by Canadian women. It is a place for women to share their often traumatic experiences and receive peer support. The Project shared my recruitment poster on their blog which helped me reach my goal of recruiting between 10 and 15 participants. Snowball sampling, a method by which participants refer others who are appropriate for the study to the researcher (Harwood et al., 2012), was also used. In my study, one participant became aware of the project through the snowball sampling method.

Potential participants recruited through the methods outlined above were instructed to contact me by phone or e-mail to schedule a time for an initial screening interview. The purpose of the screening interview was to establish participant eligibility for the study and explain the narrative interview process. Participants were eligible to participate in the study if they resided in Canada and if they: (i) had received TL within the past five years; (ii) had been denied TL within the past five years; or (iii) were in the process of requesting TL. The eligibility requirement of having received TL within the past five years ensured that participants would be able to recall and narrate their experiences in detail. If there were too many participants at the same stage of their TL process, participants would be asked if they were willing to be placed on a waitlist. However, no participants were waitlisted during this project.

During the initial screening interview, I asked future participants about which province they resided in, whether they had received or been denied TL. For the complete list of questions asked during the screening interview see Appendix A. I also explained the narrative interview process to the potential participants and informed them that the interview would last about an hour. If the participants agreed to continue with the narrative interview, we scheduled a time that worked well for them to do the interview.

4.3.2 Study Sample

In total, fourteen women participated in the study. Ten of the women had received TL within the past 5 years and 4 women had been denied TL at the time of the interview and were still actively pursuing TL. All the women who participated in this study lived in Canada, with the majority residing in Ontario (n=9). As revealed during the interviews, four of the participants identified as child-free, meaning that they did not have children and did not wish to have any children in the

future, and sought TL as means of remaining child-free. Of the four participants who identified as child-free, two had received TL and two were pursuing TL at the time of the interview. All other participants were mothers, had between one and five children and sought TL to end their reproductive histories.

During the interviews, most of the participants (n=10) disclosed that they were married, two participants shared that they were divorced and only one participant described themselves as single. Most of my participants narrated their social status through their employment. For example, my sample included two teachers, a doula, two civil servants, and one participant who worked in the arts industry. This narration was especially explicit in the child-free women's interviews. Participants who were mothers, referred to the number of children they had rather than explicitly referring to themselves as "mothers". Full participant narratives are presented in Chapter 5. A summary of participant characteristics is also presented in Table 1.

Table 1 Summary of Participant Characteristics

Pseudonym	Province	Relationship Status	Number of Children	TL Status
Participants who used TL to end reproduction				
Jennifer	ON	Married	2	Received TL in 2019 following C-section.
Katie	NB	Married	1	Received TL in 2018
Cathy	ON	Married	3	Received TL in 2017 after C-section
Rachel	ON	Married	3	Received TL 2020
Angela	ON	Married	4	Received TL in 2021 following C-section
Rebecca	ON	Married	5	Denied TL last in 2021
Joy	NFLD	Divorced	1	Denied TL last in 2021
Mary	ON	Married	2	Received TL 2018
Annie	ON	Married	2	Received TL in 2021 following a C-section
Danielle	AB	Married	2	Received TL following C-section
Participants who used TL to remain child-free				
Natalie	ON	Married	0	Denied TL last in 2021
Rose	ON	Single	0	Received TL
Kristine	QC	Divorced	0	Denied TL last in 2021
Miley	MN	Divorced	0	Received TL in 2020

4.4 Data Collection and Analysis

Each of the 14 study participants completed one narrative interview. Interviews were conducted between November 2020 and February 2021. Due to the COVID-19 pandemic, interviews were conducted by telephone. Although the option to conduct the interview by Zoom was provided, all participants opted for a telephone interview. Verbal consent was obtained prior to the interview and was recorded for study records. The interviews lasted between 25 and 60 minutes, and participants were compensated with \$30.00 that was transferred directly to their bank accounts by e-transfer following the interview.

An interview guide was used to elicit participant narratives during the interview. I used a minimally structured interview guide to allow women to story their experiences of TL in any way they saw fit. In keeping with narrative interviewing approach outlined by Polzer et al., 2014, I began each interview with the broad opening statement in order to elicit the participant's narrative: "In as much detail as you can, tell me your story of requesting or receiving TL. Feel free to start wherever you want and end wherever you want – it's completely up to you. You are more than welcome to take some time to think about it before you begin." I used non-directional prompts such as "Can you say more about that?" and "What do you mean by that?" during the interviews to invite my participants to elaborate on their stories in further detail. Following this initial narrative elicitation, I followed up with directional probes to elicit stories about specific aspects of their TL experience, and that were of particular interest to me, such as how they came to learn about TL, what their interactions with healthcare providers were like, and whether they regretted their TL. For the full interview guide, see Appendix B.

In keeping with the inductive character of qualitative analysis, the interview questions were revised as the data collection process unfolded to explore storylines that were elicited in prior interviews. For example, after my fourth interview, a significant number of storylines emerged, and I revised my interview guide to include questions that reflected these new storylines. These new questions reflected particular aspects of TL that were emerging across participant interviews and focused on satisfaction with sex following TL, information seeking about TL, and the effects of negative contraception experiences on decisions for TL. At this point in the interviewing

process, the idea of “reproductive health work” became an unanticipated yet central focus of the participants’ narratives. Most of the narrative space during the interviews was occupied by various forms of “work” that the women had to do to request and receive TL. These stories about the work that was undertaken by my participants is discussed in my findings chapter, under the heading of “Reproductive Labour”.

Data analysis was conducted concurrently with data collection and involved: post-interview memos as part of reflexive writing, the writing of participant summaries, reading and coding for stories within and across interview transcripts, completing detailed annotations of the participants’ stories regarding TL, and identifying narrative threads. Each of these analytic strategies is described further below.

4.4.1 Post-Interview Memos

Following each interview, I completed detailed memos about my first impressions of the interview. Memoing is a flexible writing strategy engaged by qualitative researchers throughout the research process that helps them make conceptual links between their raw data (stories, in this case) and the theoretical lenses that inform their interpretations (Birks et al., 2008). In addition to informing the process of interpretation, memoing can also be used to document the research process and maintain analytic momentum.

There are no strict rules for memoing and this practice can take many forms from electronic note taking to pen-and-paper reflection following interviews to writing notes in the margins of coded interview data (Birks et al., 2008). After each interview I made notes about what I felt was the main theme of the interview, how I felt about the interview, what went well, and what was unexpected. Post-interview memos were also used to highlight the ways in which the TL stories compared across participant interviews, including similarities and differences with stories shared in earlier interviews. As well, I used my memos to reflect on how I felt during and after interviews. Through this process, I became aware of the discomfort I often felt when my participants shared personal details about their lives, especially when those details were traumatic. I would often go back to these memos and reflect on them between subsequent interviews to help me better prepare specific lines of questioning.

In the time between interviews, I read and reflected on academic literature and incorporated new ideas and insights based on this reading into the memos. For example, one of my notes about how much work my participants had to undertake to receive TL led me to search for literature on how work is performed by patients in medical settings to access services and to manage their diagnoses. This guided me towards the conceptual framework of health work and then towards the notion of reproductive labour. The notion of reproductive labour later became one of the conceptual lenses through which I developed and presented my findings.

4.4.2 Constructing Participant Narratives and Narrative Threads

Following memo-writing, I generated two analytic products through multiple close readings of the interview transcripts: (i) individual participant narratives; and (ii) narrative threads. While these are described as having occurred in discrete stages, in reality these phases of data analysis were iterative and overlapping.

4.4.2.1 Participant Narratives

First, informed by my post-interview memos, I began to develop the participant narratives by applying a set of guiding questions that were developed in consultation with my supervisor and thesis committee. Some of the questions that guided this process were “When did the participant first begin thinking about TL?” and “What did the participant know about TL before pursuing it?” For the complete list of guiding questions, see Appendix C. These narratives situated each participant’s experiences of TL within their respective and complex reproductive histories. Hence, the participant narratives provide context for the ways in which my participants decided on TL. These narratives also allowed me the space to reflect on how I came to know each of my participants’ stories through the narrative interview process. These narratives went through multiple iterations and were refined as I coded for each participant’s stories about their TL trajectory and experiences.

4.4.2.2 Reading and Coding for Stories about TL

To identify individual stories within the participant narratives, I first completed several close readings of my interview transcripts. While reading, I identified individuals’ stories about TL, which were then coded systematically with the assistance of NVivo 12 Pro (released March 20,

2018)(QSR International Pty Ltd., 2020). In total, I coded for 25 stories (Appendix D) . At this stage of my analysis, and in keeping with the analytic process outlined by Pitre et al., (2013), I asked myself questions such as, “What is the participant trying to tell me with this story?” and “How is my participant positioning themselves in the telling of this story?”. For example, some of the stories I identified and coded for included: “Stories about TL Denials”, “Stories about Receiving TL”, and “Stories about Medical Failures”. For example, the following passage from my interview with Natalie was coded as a story of “TL denial” and is an example of the complex stories child-free women told about their TL denials and their embeddedness within their experiences with other forms of contraception. The end of this story importantly points to a series of future denials, as demonstrated by the phrase “so that was the first rejection”:

Um, and so in 2017, that was when my IUD was due to be switched and so that’s when I first started asking my medical providers about it [TL]. Um, so at first I just got a new IUD because I had read about the process before online for TL and I kind of went into it...jaded? I guess you could say? I expected it to be a slow and terrible process and so I was [...] I decided I would just put in a new IUD so I could be, get it all sorted out. And so um after I got my IUD placed that’s when I got my first referral um...that one was...not so bad? Um the doctor just said “no I don’t do that” and I moved on. But they didn’t really, I don’t know, impose their personal beliefs on me or say anything shoddy and illegal. Um so that was the first rejection

4.4.3 Detailed Annotations and Refining of Narrative Threads

The final step of analysis involved producing detailed annotations of the coding reports of the participant stories. NVivo-generated coding reports, which compiled the coded stories across the study participants, were then subjected to multiple close readings. With the help of a highlighter and sticky notes, I wrote detailed annotations and through this process of annotation, I began to identify similarities and complexities across the stories and identify narrative threads. Similar to Pitre et al.’s (2013) notion of *storylines*, these narrative threads wove through several of the participants’ accounts in nuanced and sometimes conflicting ways. At this stage of my analysis, I asked questions of my data such as, “Where have I heard this story before?” and “What is similar and different across my participants’ accounts?” Whereas stories stayed very close to the

participants' descriptions of TL, the narrative threads were more interpretive and involved making connections across the stories as well as placing these threads in conversation with the theoretical perspectives that informed my project (i.e., relational autonomy, reproductive justice, and health work).

For example, analysis of coded stories about medical failure, pregnancy and birth, and pain informed my construction of the narrative thread of negotiating medical authority that weaved through most of my participants' accounts of their experiences accessing TL. As well, my readings of participants' stories about their relationships with their physicians and of their stories of how they acquired knowledge about TL informed the narrative thread of reproductive labour, which includes the range of activities the women engaged in securing access to TL (e.g., information seeking, advocacy).

At this stage of my analysis, I began to incorporate my critical perspective into the annotation process by putting the emerging narrative threads in conversation with my theoretical lenses concerning reproductive justice, relational autonomy, and reproductive labour. For example, I began to conceptualize the activities that my participants engaged in to be approved for TL as a form of reproductive labour. As such, self-advocacy, self-presentation, and the telling and re-telling of stories all became forms of reproductive labour that I discuss in greater detail in Chapter 6. As well, I began to examine the complex ways in which my participants made decisions about TL. For example, for many of the women in my study, TL was a resolution to complex and traumatic reproductive histories, and a way to re-claim their bodies as their own.

4.5 Quality Criteria

Qualitative research can be evaluated in several different ways given the variety of methodological approaches and various aims of qualitative research (Dixon-Woods et al., 2004; Denzin & Lincoln, 2011; Tracy, 2010). Regarding narrative approaches to qualitative inquiry specifically, Mertova and Webster (2019) argue that rigor should not be evaluated based on general quality criteria as discussed above, as it is a storytelling approach where the stories aren't interpreted as an exact account of what happened (Mertova & Webster, 2019). Polkinghorne

(1988) also suggests that quality appraisal of narrative inquiry should focus on method and methodological alignment rather than the result of the study (Polkinghorne, 1988).

To address the question of rigor in my research, I relied on Tracy and Hinrichs's (2017) criteria for quality appraisal. Specifically, I focused on: (i) meaningful coherence; (ii) sincerity through transparency and reflexivity, and (iii) credibility through trustworthiness and multivocality. These quality criteria align with the tenets of narrative inquiry in that they reflect and document the research process and methodological alignment rather than assess the truthfulness of the study results. As well, to address the question of rigor with regard to the critical orientation of my research, I draw on Denzin (2017) to discuss how critical research can create tangible change both through traditional research dissemination techniques, and through advocacy, and policy change.

4.5.1 Meaningful Coherence

Meaningful coherence refers to the ways in which research studies should logically connect academic literature on the topic of inquiry, research questions, and methodology to create alignment. For example, Tracy and Hinrichs (2017) explain how “the literature reviewed in a study should give rise to and establish a fitting context for related research questions. The research questions, in turn, should be suitably addressed by appropriate methods that fit the paradigmatic and research alliances.” (p. 9). I established a fitting research context for this project through a literature review of scholarly work on VTL. Hence, my doctoral work responded to the primarily post-positivist framing of VTL and the reductionist conceptualization of post-sterilization regret. Specifically, in my literature review, I take note of the ways in which current literature on TL relies on questionnaires and surveys to collect its data. Literature concerning post-sterilization regret tends to focus on building profiles of women who would be most likely to experience post-sterilization regret. Some studies that I identified were concerned the experiences of child-free women who sought and were denied TL, however, these studies were theoretical and were not empirically grounded. Hence, my research project aimed to challenge the current post-positivist and de-contextualized framings of TL by using a critical narrative methodology and centering participant voices as well as providing an empirical grounding for the theoretical work on child-free women.

My methodology provided a coherent framework for the study in that my interviewing strategy was directly informed by the concerns and tenets of narrative methodology. In this regard, I conducted minimally structured interviews with my participants so that they could story their experiences in any way they liked and disclose aspects of their experiences and identities that they felt were most important. Finally, I achieved meaningful coherence by placing my findings in conversation with theoretical frameworks of relational autonomy, reproductive justice, and reproductive labour, which I elaborate in my Discussion chapter.

4.5.2 Sincerity Through Transparency and Reflexivity

Tracy & Hinrichs (2017) discuss how researchers can achieve sincerity in their work through reflexivity, vulnerability, and transparency. In my work, I ensured the transparency of my research by providing a detailed overview of my methods and methodology in this chapter and of the analytic procedures undertaken to generate my findings. I also clearly outlined how my interview guide and research questions changed over time, which was shaped by my participants' narratives and emerging storylines. Additionally, I included details about the hurdles and setbacks I faced during the project such as unsuccessful participant recruitment during the initial recruitment phase and some of the difficulties I had conducting narrative interviews with some of my participants, which I outline below in my reflexive statement. As well, I am forthcoming about the integral role that the Obstetrics Justice Project played in the completion of this research. The involvement of the Obstetrics Justice Project in my recruitment has inevitably shaped the kinds of stories I collected and narrative findings I generated, given that the organization engages in advocacy for those who have experienced obstetric violence. This is considered in the Discussion chapter where I outline the interpretational boundaries of this work.

To reflect the feminist epistemology of my research, I also engaged in reflexivity throughout the entire project. Hence, my research was not only guided by women's subjective experiences of TL, but also my own experience as a young woman who was repeatedly denied TL. Reflexivity is the process by which the researcher introspects about their assumptions, experiences and motivations concerning the research and asks themselves about why they have chosen, and what assumptions they bring to, the research topic. I began to engage with reflexivity by keeping detailed notes during the interviewing process where I recorded the emotions and feelings that

came up in relation to the interview content. This reflexive writing also served as a place for me to be vulnerable and express my confusion and frustrations about the research process. For example, I frequently turned to my reflexive writing to work through my confusions about why women stopped requesting TL despite still wanting the procedure. I would also write about how I felt women's experiences related to my conceptual frameworks.

4.5.2.1 Reflexive Statement

I am child-free and wish to remain so. My interest in pursuing qualitative research on women's experiences of accessing tubal ligation as a form of permanent contraception was informed by my own TL denial almost four years ago. At that time, I was convinced that my research would center the experiences of child-free women and the ethics of TL denials. My interest was fueled, largely, by self-serving frustrations grounded in my physician's obsession to preserve my fertility. Following my TL denial, I wondered, what was so important about my fertility that it was deemed worthy to preserve? Who made the decisions about whose fertility was worth preserving? Why did my healthcare provider position the regret of not having biological children as the worst possible outcome for me?

I approached my doctoral research with the desire to speak to child-free women like myself and explore their experiences in seeking, receiving, and being denied TL. However, through my candidacy work and the early stages of my doctoral project I became aware of how many women sought TL as a means of ending their reproductive histories. Before beginning my doctoral program, I assumed that TL was a procedure that was primarily used by women who desired to never have children in the first place. Through my interviews, I learned that mothers also sought TL to end their reproduction often as a way to resolve their complicated and often traumatic reproductive histories.

I also approached my research with the assumption that TL denials were largely shaped by pronatalist discourses targeted at child-free women who dared to deviate from the expectation of compulsory motherhood. However, as my interviews progressed, I learned about the range and complexity of the barriers that women with children also faced while seeking TL. While prior to

my doctoral research I believed that only child-free women had difficulties receiving the sterilization services they needed, I came to realize that that view was very limited.

Since I approached my initial interviews with the expectations that I would be speaking primarily to child-free women, I was not entirely prepared for the complexities of the narratives I would encounter. In sharing their stories about their TL experiences, the women in this study also expressed their frustrations with the medical system, their husbands and partners, and drew attention to the various kinds of work they engaged in to receive TL. At times, the elicitation and recording of these stories proved to be difficult for me, both cognitively and physically. For example, during one of the interviews, my participant described in detail how their stitches had burst following a C-section. Her graphic descriptions sent my head spinning and I felt I was going to pass out, so I moved from my chair, where I was sitting during our interview, and laid down on the floor. I didn't want to interrupt the interview, so I quietly moved my recorder and my phone to the floor with me, elevated my legs to stay conscious, and kept the interview going. Many of the interviews were also interrupted by my participants' childcare responsibilities, with some of my participants' children becoming active participants in the interview recordings. In these instances, we paused interviews, rescheduled, took breaks, and listened to some very important inputs from some fussy babies.

At the beginning of my doctoral research, I never imagined the complexities of the reproductive choices that my participants would share with me. I was blissfully unaware of the hurdles that many women faced in Canada simply to access the reproductive healthcare they needed. The interviews often felt laborious, not only for me, but also for my participants who admitted to retelling these same stories many times before to friends, families, and healthcare providers. As the COVID-19 pandemic progressed, so did my understanding of the labour that went into managing contraception, pregnancy, delivery, and child-care, especially under the constraints of a global pandemic. Some of my participants shared that they were only a few days post-partum when they took part in their interviews and had little to no help from family members during the post-partum period. As my participants' stories illuminated these persistent efforts, and as their voices grew progressively more tired in telling these stories, my research focus expanded to include and make visible the work they undertook every day to manage their reproduction.

While I went into my doctoral work with a clear idea of who I wanted to speak to about their TL experiences, I'm glad that I was able to conduct interviews with a diverse sample of women across Canada. This dissertation is stronger and has greater implications for influencing reproductive healthcare through the inclusion of the many voices of the women in my study, and their complex and sometimes conflicting stories of TL. The diversity and complexity of these conversations led me down an unexpected path of exploration throughout my dissertation and I believe it has made me a more inquisitive and compassionate researcher in the end.

4.5.3 Credibility Through Trustworthiness and Multivocality

In my research, I established credibility through trustworthiness and multivocality. Trustworthiness is established when research findings are demonstrated as grounded in and supported by the research data (Tracy, 2010). Trustworthiness is established by linking researcher interpretations to interview and other research data. In my work, I establish trustworthiness by grounding my interpretations in a multitude of detailed, verbatim quotations from my interviews. Additionally, I presented my reflections of how participants' responses were elicited in relation to specific questions during the interviews in order to detail the communicative process between me and the study participants. Trustworthiness was also established during the analytic process by soliciting and receiving feedback from my doctoral supervisor, Dr. Polzer, and my advisory committee. This ensured that my findings were deeply grounded in my interview data, and helped to deepen my understanding of the emerging themes and the analytic process itself.

Credibility is also achieved through multivocality, which is defined as "the inclusion of multiple voices evident within the research context" (Tracy & Hinrichs, 2017, p.6). In this project, I provide quotations from multiple participants and present opposing viewpoints and experiences that participants shared during the interviews. By doing so, I attempted to include the varying experiences of the study participants into the research analysis and paid special attention to the accounts that challenged and contested dominant themes and threads.

Additionally, participant narratives, presented in the following chapter, were constructed to summarize and contextualize the stories specific to each study participant. These narratives

preserve the individual accounts of TL and provide the reader with snapshots of the stories that characterized and animated each participant's TL experience and trajectory.

4.5.4 Quality Appraisal in Critical Qualitative Research

Critical qualitative research is a form of social justice research (Denzin, 2017) that centers participant voices and amplifies these voices to bring attention to multiple social injustices (Denzin, 2017). Critical qualitative research can facilitate change by identifying areas for further scrutiny, advocacy and activism, which arise from conversations with research participants. In my research, I learned that the women in my study were already engaging in activism and advocacy, mostly through the Obstetrics Justice Network where many of them learned about my study, as well as in their personal lives in medical settings. My participants also engaged in informal social support by explaining TL to their friends and family. I came to understand that, by educating their friends and family about TL, they were performing the work that their healthcare providers failed to perform. This sort of informal and formal advocacy, including self-advocacy in medical settings, was extremely laborious and often left my participants feeling frustrated with the Canadian medical system as well as exhausted from what felt like an uphill battle. To help address this, the findings from my research will be disseminated through the Obstetrics Justice Network and may act as a resource for the already substantive advocacy the group engages in.

Second, by making the participants' critiques heard, critical qualitative work has the potential to influence policy and raise critical awareness and promote reflexive practice among healthcare providers (Denzin, 2017). Publications emerging from this thesis may be incorporated into pedagogical settings to inform clinical decisions and increase access to TL information for patients. In this regard, the findings from my doctoral work can facilitate discussion about reproductive justice and ethics of TL approval and denial, and potentially shape the ways in which reproductive health policies concerning TL are enacted in the future. To facilitate this, I will present my findings at interdisciplinary conferences for Canadian healthcare providers and feminist scholars and activists to continue to push for equity and accessibility in women's reproductive health and reproductive rights. As well, I will aim to publish a scholarly paper in the *Journal of Obstetrics and Gynecology Canada*, a professional journal for obgyns in Canada.

To begin this dissemination work, I've already presented my preliminary findings at the Congress of Humanities and Social Sciences which yielded a fruitful discussion about child-free women's experiences in requesting and receiving TL.

Chapter 5

5 Participant Narratives

In this chapter I present narratives for each participant that situate their experiences of TL within their unique reproductive histories. These descriptive narratives provide a concise account of how each of my participants arrived at their decisions to receive TL and how their experiences requesting and receiving TL intersect with their reproductive health histories and interpersonal relationships. As I conducted the interviews, it became clear that decisions about TL were often situated in relation to complex and often traumatic reproductive histories marked by long-standing and unsatisfying hormonal contraceptive use, miscarriages, and pregnancies. In keeping with the co-constructed nature of narrative inquiry, these summaries include direct participant quotations alongside my own analytic interpretations that arose during the interviews as well as multiple close readings of interview transcripts.

I begin by presenting the narratives of the women who requested and received TL to end their reproduction. For many of these participants, TL was narrated as a way to avoid future physical and emotional consequences associated with previous miscarriages and difficult pregnancies. I then move on to present the narratives of child-free women who sought TL as means of remaining child-free. These stories are marked by repeated TL denials and frustrations experienced by my participants. Interestingly, these are also the narratives that demonstrate the ways in which women leveraged sexist medical discourses to secure TL.

5.1 Jennifer

Jennifer is a journalist and lives in Ontario with her husband and two children. Throughout our interview, Jennifer responded to my questions in a curt and concise manner. Because this was my first interview, I attributed this to my lack of adequate prompting. However, her style of

narration was also consistent with her occupation as a journalist, a detail she disclosed while elaborating on her habit of always asking questions.

Jennifer first considered TL about a month before giving birth to her second child. She and her husband had long decided that they only wanted to have two children: “two hands, two kids”. She also mentioned that both she and her husband were soon to be forty and she couldn’t fathom having the energy for another child. Jennifer also laughed about not wanting to be outnumbered by children, especially in the mornings when everyone was trying to leave for the day. Jennifer was resistant to hormonal birth control options that were suggested by... and didn’t want an IUD because she wanted to prevent future complications that her friends had experienced with IUDs. As she put it: “I’ve had friends where it’s gone up and in and out and they’ve had to have major surgery anyway”.

Jennifer decided to have her TL following her C-section. Casually, she mentioned that since she was “having major surgery anyway” (the C-section) it made sense to have the TL “then and there”. Jennifer recalled the day of her C-section and TL as very hectic. She emphasized how she had to single handedly coordinate her care while she was in active labour. Although Jennifer was scheduled to receive her C-section on a Saturday, she went into labour on Friday and was rushed to the hospital. She recounted that, because the obgyns and nurses were changing shifts, she had to keep reminding everyone that she was scheduled to receive a TL following her C-section. Jennifer felt ignored by the doctors and nurses and that her TL would have “slipped through the cracks” if she hadn’t actively advocated for herself.

Performing self-advocacy in a medical setting wasn’t new for Jennifer. During the interview, Jennifer attributed her practices of self-advocacy to the tenaciousness and persistence she cultivated in asking questions as part of her career as a journalist. As well, she admitted that she doesn’t trust medical professionals and illustrated her distrust with a story about her daughter who needed her tonsils removed. After her daughter’s visit to the sleep clinic, Jennifer had to call the clinic repeatedly to get the results. When she finally received the results, the date indicated that her daughter’s results had been sent to the doctor’s office 6 weeks prior.

When I asked Jennifer about whether she regretted receiving her TL, she laughed and said “no”. Now in their mid and late thirties, she and her husband do not want to experience another pregnancy and the “newborn stage” since they’re “getting up there”.

5.2 Katie

Katie is married and lives in New Brunswick with her husband and nine-year-old daughter. Katie began her story about TL by remembering that, even as a six-year-old playing house, she never imagined having children. Cats and a husband, of course, but not kids. She never had the urge to procreate, to “have a baby,” and the notion of a biological clock still eludes her, even after having her daughter. After Katie got married, she got pregnant and, despite never wanting a child, decided to keep “it”. Others told her that once she was pregnant, she would want more and more kids, but that never happened. When I carefully asked Katie about whether she regrets having her daughter, she was slow to answer. After thinking about it she replied that she didn’t regret it and felt proud whenever her daughter hit a new milestone, like going to middle school.

Katie’s story is marked by ambivalence, shaped by the tension between her life-long desire to remain child-free and her having become a parent through an unplanned pregnancy. Katie reflected that her approach to life had a focus on adapting to unforeseen circumstances, like having a child. Never imagining herself as a mother has helped Katie avoid the “mother guilt” as she puts it; that is, the pressure that women place on themselves to be ideal mothers. Katie told me that she, her husband, and their daughter take it day by day and try to make decisions that make sense for all of them and help all of them become better people. This approach to day-to-day living aligned with Katie’s ethos of taking life as it comes.

Katie first began thinking and inquiring about TL when she got pregnant with her daughter in 2011. At that time she was denied TL by her obgyn. In 2018 she became pregnant again and, since she did not want any more children, Katie terminated the pregnancy. At the clinic, she recalls being forced to choose one of the many contraceptive options before she left the clinic. Katie chose an oral contraceptive with the lowest hormone dose hoping that she wouldn’t experience any side-effects. While she only tried the oral contraceptive for a few months, Katie experienced a series of physical and psychological side-effects including weight gain and mood

swings and quit the pill as soon as she was approved for TL a few months later. Katie recounts that, prior to taking the pill, she always felt that her hormones were “in balance”; she never had PMS symptoms and had predictable periods and “throwing” artificial hormones into the mix would “off balance them”.

Katie was approved for TL after a visit to her obgyn, who had gotten a TL herself. Katie recounts that she was approved for TL “within two minutes” of talking to the doctor. While the TL approval was straightforward, getting the TL procedure proved to be very difficult. Not only did Katie have to drive two hours to a hospital where the surgery could be performed (since the hospitals in her area did not perform TL), the surgery was rescheduled twice due to overbooking. Similar difficulties regarding access were described in the TL stories of the other women who lived in the Maritimes (Kristine, who briefly resided in New Brunswick, and Joy).

When Katie finally did receive TL, she recalls the procedure being very quick and painless. By the evening of the day of her TL, Katie felt pain-free and was ready to go back to work. She never explicitly stated where she worked but mentioned that it was in “the arts”, and with a lot of other “creatives”.

When I asked Katie if she had any regrets about TL, she said that her biggest regret is that she hadn’t received it sooner. While Katie didn’t regret having her daughter, she felt brainwashed, to an extent, that parenting would be a rewarding experience. At the time of our interview, Katie didn’t want any more children and was really glad she received TL. While she did express her frustrations with the medical system and how long it took her to receive the TL, she was happy with the overall experience. For Katie, being sterile was a natural state: “I feel like this is the way that my body is supposed to be... [...] kinda like the way I’M supposed to be is like... to not be fertile.”

Katie also described that the TL made her feel as though she could enjoy sex again without being worried about becoming pregnant. Katie mentioned that, before the TL, the thought of getting pregnant would “kill” her libido and following her second period (after the TL) she rejoiced “YES, IT’S WORKING, I’m not pregnant!”

5.3 Cathy

Cathy lives in Ontario, is married, and has three children. Our initial interview took place during the initial lockdown of the COVID-19 pandemic and Cathy's two-year-old often interrupted our interview as childcare services were suspended. Cathy began her TL story by emphasizing that she was "very young" when she received the procedure at twenty-seven. She recounted that, after having their second child, she and her husband decided that their family was complete and that it would be her husband who would receive a vasectomy. However, Cathy became pregnant before the consult for the vasectomy. Before her obgyn appointment, her husband casually "threw it out there" that Cathy inquire about TL since they knew she would be receiving a C-section anyway.

When Cathy inquired about TL, she remembers being approved immediately, without any further probing or additional information provided by her obgyn. Although she was informed about the permanence of the procedure, she felt that she was not told about the possibility of the long lasting, emotional consequences of TL that she later experienced. When our discussion circled back to this appointment closer to the end of our interview, Cathy insisted that, given how young she was, it was very careless for the obgyn to approve her for TL so easily.

Cathy's account of her TL was traumatic. During her recollection of the C-section and TL, Cathy sounded helpless and passive, her voice on the brink of tears. Going into her C-section, Cathy was informed of what would be done during the surgery itself and then asked again about whether she wanted the TL. While in retrospect Cathy remembers already having doubts about the TL, she told the surgeon that she still wanted to go through with the sterilization. During the interview, Cathy mentioned that she felt like she "promised" her husband that she would receive the TL and didn't want to "disappoint" him by backing out. While she recognized that her husband wouldn't be angry, she still feared disappointing him.

Cathy recalled the C-section and TL as a surreal "out of body" experience. She described feeling that the TL was something that happened to her without really experiencing control of the situation, and has led to her suffering intense emotional consequences. She described this as grieving for the various child's life stages that she wouldn't again get to experience with a child. After Cathy began to experience regret and "grieve" her TL, she conducted more online research

about the procedure and was shocked to learn about post-sterilization syndrome, which included headaches, changes in menstruation, and other consequences about which she was not informed by her obgyn. She described that the TL left her feeling “less of a woman”, “altered”, and as experiencing no sex drive. When Cathy approached her obgyn about reversing the TL, she recounted that the doctor made her feel “silly” for even considering this. She was informed that it was impossible and that attempting the reversal would be “astronomically expensive”. To process her “grief”, Cathy recounted going to counselling with her husband and relying on friends and family for emotional support.

At the end of our interview, when I asked Cathy whether there was anything else she wished to tell me that we hadn’t discussed, she lit up. She explained to me that, since the TL, she has been transformed from a “passive” and “amazing” patient who never asked any questions of their healthcare providers to an advocate who believes that there are no such things as “dumb questions” when it comes to one’s health and reproduction. Cathy wished that she had more people to talk to before she received the TL and has taken it upon herself to become “one of those people” for someone else: “I wish someone sat me down and said ‘Cathy listen, you... it’s a very like... wide and broad range of things that this might affect, it’s not just a few clips.’ I just wish I was more aware of that. Because I might have done things differently and if this helps someone just to... do more research or make their decision easier, I dunno, then that’s ...that would make me happy.” She described how she had dissuaded her friend from receiving TL by sharing her story of trauma and grief. Cathy’s experience with TL has also informed her desire to educate her children about bodily autonomy and self-advocacy.

5.4 Rachel

Rachel is 34, is in a long-term relationship, and lives in Ontario with her three children. Rachel remembered first being informed about TL when she had an emergency C-section with her first child and TL was suggested to her by her obgyn. She was only 25 at the time and was sure she would want to have more children, so she declined the TL. Rachel also recounted not being in an emotional or physical state to even consider the suggestion for TL seriously as she had been in labour for over 40 hours during the delivery and was exhausted when her obgyn mentioned TL to her. With some frustration, Rachel recalled that she found the suggestion very inappropriate at

the time. When Rachel turned 34 and was pregnant with her third child, she knew that she was content with her family size and would not want any additional children. She admitted that the third pregnancy wasn't a planned one, so she informed me that she was "extra certain".

Rachel relied on oral contraceptives when she was in university to prevent unplanned pregnancies. She recounted that she initially switched contraceptive methods as she became more and more uncomfortable with taking "artificial hormones". While deciding on a long-term contraceptive option, Rachel used condoms to prevent unplanned pregnancy. Although she heard "good things" about IUDs from her friends and decided to try it out herself, she became turned off of this idea after discovering that the company that made the IUD her doctor prescribed also manufactured chemo-therapy drugs. Because Rachel's first husband passed away from cancer, she felt conflicted using an IUD that was manufactured by supporting a company that she felt "profited off of people having cancer". While she admitted that there was no "scientific" evidence to support her decision she still felt like she would be giving up some bodily control if she were to use an IUD manufactured by the company.

When Rachel became pregnant for the third time with her second partner, she had to make a difficult decision about whether she wanted to keep the pregnancy. Since Rachel's second partner did not have any children of his own, he was worried that he would want to have a child in the future and so was hesitant to get a vasectomy and to terminate the pregnancy. Rachel expressed her hesitation for having a third child as she was just at a point of returning to her career and felt that it would be impossible to juggle the demands of childcare and work with a newborn: "I was worried that if I had a baby that that would then ruin everything I was working towards with my career and that I would no longer be able to get a job".

Rachel recounted that the longer she remained pregnant, the surer she became that she could "make it work" – that is, have another child and return to work as a teacher. Rachel also expressed a lot of guilt in "denying" her partner the opportunity of having a biological child.

When Rachel found out that she would need a C-section, she decided to have her TL "there and then" to avoid having to go in for another surgery. Rachel doesn't remember anything out of the

ordinary about the day of the C-section and TL. She received C-sections for the delivery of her other two children and this one didn't feel any different.

When I asked Rachel how she felt about her TL experience overall, she expressed that it was liberating to make this decision about her body and her reproduction. She felt that the last 10 years of her life, her body “belonged to her children”: while she carried them during her pregnancy, while she breastfed them, and as she raised them at home. The decision to have TL was empowering to Rachel; she made the decision “for myself and for my wellbeing” and she “doesn't have to justify it to anyone.”

Rachel expressed no regrets about the TL. She sometimes thought about being pregnant again and having another child so her youngest would have a sibling close in age, but then she thought about the added financial strain that would put on her and her partner. She was also glad that now her partner has a child that is “his blood”. Rachel never mentioned if she ever returned to work.

5.5 Angela

Angela is married, works as a doula, has four children, and lives in Ontario. Angela gravitated towards TL as a contraceptive option due to the largely negative experiences she had experienced with hormonal contraception since she was a teenager, including changes to her mood, weight gain, high and low blood pressure, and headaches. During our interview, she recalled having tried almost all available options, including an IUD, different kinds of hormonal contraception, and the Nuvaring. Angela also described using fertility awareness methods, such as charting her cycle, to prevent pregnancy, which have been effective for her.

Contrary to her early experiences with gynecologists who pushed hormonal contraceptives on her when she was a teenager, Angela felt that her current obgyn had a “holistic” view of fertility and reproductive health, meaning that they positioned reproductive health within a broader context of overall physical and mental health, which aligned with Angela's personal values.

During our interview Angela didn't disclose her age; however, given that she first had discussions about TL with her obgyn when she was 27 and has since had twins, she's likely in

her mid-30s. TL was suggested to Angela after the birth of her first child by her obgyn, but because she was still considering having more children, she declined. After her second child was born, Angela wondered whether TL was right for her; however, before she could make a firm decision, she became pregnant again, this time with twins. When Angela found out that she would need a C-section, she firmly decided that she would receive TL at the same time since she didn't want to go in for a separate surgery at a later date. Since Angela's pregnancy with twins was unexpected (she and her husband only expected to have one more child), Angela emphasized that their family was "extra full" at this point.

Angela recalled that most of her knowledge about TL stemmed from working in the reproductive health field for many years as a doula. She also had many friends who worked as doulas or in similar roles such as midwives and nurses, and she drew on them for information. Given her background, it was not surprising that Angela was informed of several ways in which TL may be done (e.g., removal of the fallopian tubes, clamping of the tubes, cauterizing of the tubes). She knew that the procedure wouldn't affect her hormones the way a hysterectomy might. Angela was also warned of the risk of ectopic pregnancies following TL and therefore suggested that her husband receive a vasectomy to eliminate any chance of ectopic pregnancy in the future.

Angela described the day of her TL as uneventful and expressed relief knowing that she would not become pregnant again. At the same time, she reflected that she experienced a "surreal" feeling following the TL. Angela contemplated that TL signaled an end to a "chapter in her life", with reference to her capacity to have children: "...part of my... life is, that chapter is closed and in a positive way, like I'm quite happy with my decision". Despite these ambivalent feelings, she quickly reminded me that she is happy with her decision to receive TL.

5.6 Rebecca

Rebecca is a stay-at-home mom in her mid-thirties living in Ontario with her husband and five children (between two and sixteen years of age). Rebecca began her TL story by telling me that she is a mom of five and has been requesting TL since she was twenty-three. At that time, Rebecca had two children, and after her youngest recovered from meningitis, she requested TL. Rebecca explained that the emotional toll of watching her youngest child suffer was

overwhelming and she didn't want to have more children and risk "witnessing another serious illness". Her doctor informed her that she was not eligible for TL because she was too young, and that she had to be at least thirty years old before she could be sterilized: "I requested to have my tubes tied and my doctor said that because I as only 23 I was not eligible that I... that she would not allow it that she said it was a bad idea and I have to be at least 30 to get my tubes tied..." Since her initial TL denial, Rebecca has made several attempts to get TL and has been denied TL every time.

Rebecca recalled her experience with contraceptives as largely negative. When she was sixteen and taking an oral contraceptive, she became pregnant and suffered a miscarriage. Rebecca was pregnant several other times while on birth control and was certain that hormonal contraceptives "do not work" for her. Before requesting TL, Rebecca had many discussions with her husband about permanent birth control. She suggested that he have a vasectomy, but he wasn't sure if he was ready to be sterilized as he might want more children in the future.

Since her last TL denial, Rebecca's husband has had a vasectomy. Rebecca informed me that his mind changed after she issued him an ultimatum that she would refuse sex until he was sterilized. Since her husband's vasectomy, Rebecca enjoys sex a lot more. She remembered how stressful sex felt when she worried about getting pregnant again; that worry is now gone. Due to the COVID-19 pandemic, Rebecca hasn't been able to see her doctor and ask about TL again. However, she insisted that when the pandemic passes, she would persevere until she gets approved for TL.

5.7 Joy

Joy is divorced and lives in Newfoundland and Labrador with her son. She began her TL story by recounting her difficult reproductive history: "...in 2014 myself and my husband decided that we were going to try for a baby. Um, so in the two years [...] my son was born in 2016, but within those two years I had had 6 miscarriages, um, two were in the second trimester so they were quite hard." Joy first began thinking about TL when she was sure that her pregnancy was "sticking". Because she had gone through traumatic miscarriages, she and her husband decided

that it would be too emotionally and physically draining for Joy to get pregnant again. Together, they decided that if they wanted to expand their family, they would adopt.

After hearing from her friends that vasectomies were not always fully effective at preventing pregnancy, Joy became convinced that she should be sterilized. At the time of our interview, five years after Joy's initial TL request to her obgyn, she had yet to receive the procedure. Despite asking to be placed on a cancellation list and for "anything" that would speed up the TL approval process, Joy has had no luck in receiving her TL. Joy's first TL denial provided a clear illustration of medical sexism and pronatalism when her doctor justified denial by insisting that Joy's husband may want to have more children in the future. Since then, Joy has been calling her obgyn every six months to see if they would approve her sterilization, she has been denied every time.

Joy's experiences with temporary birth control have been largely negative, especially during the COVID-19 pandemic. Since Joy had been laid off by her employer due to the COVID-19 pandemic, she no longer has health insurance that would cover monthly birth control and doesn't feel certain she would be able to pay for the monthly refills. Joy expressed doubts about the effectiveness of temporary birth control as it had proven ineffective in preventing unwanted pregnancy for her. After her son was born, Joy was on a low dose oral contraceptive and got pregnant, then suffered another miscarriage. Joy also recounted how she had used an IUD when she was younger and that it "fell out" after 6 months. When she had her second IUD, it "fell out" as well, and Joy was convinced that her body was rejecting the IUD. These experiences shaped Joy's skepticism about temporary contraception and she wanted a permanent option. During the time of our interview, Joy was taking the Depovera shot for contraception. Joy enjoyed the "peace of mind" she had for that time, knowing she wouldn't get pregnant.

During our interview, Joy repeatedly expressed her frustration with the accessing reproductive healthcare in Newfoundland and Labrador. Before we ended our interview, I asked Joy if there was anything else she wanted to share and, after a moment of silence, she left me with a sobering and disillusioned reflection of Canadian reproductive healthcare: "I'm hoping that, you know, uh some of the experiences you're going to discuss with other people are a lot more positive than

mine and put a little bit of hope in there for ya but um as of right now for women's health I have zero faith in uh in Canadian health [healthcare].”

5.8 Mary

Mary is married with two children and lives in Ontario. Similar to several other women in the study, she always knew that she wanted two children, so when she found out she was pregnant with her second and the pregnancy was healthy, she began seriously considering TL. While telling me her TL story, Mary casually mentioned that she had two miscarriages and two D&Cs. She didn't further elaborate on these experiences. When she recalled these events, her voice was “sing-songy” and I felt that her tone was aimed at easing my discomfort rather than her own.

Mary's husband was not able to get a vasectomy due to a pre-existing health condition, which made it difficult to undergo general anesthesia that a vasectomy required. Unprompted, Mary joked about her husband's “weird testicle”. This kind of humour was common in my interviews, often arising from women's reflections on how little of a role their partners played in their reproduction.

When Mary was approved for her TL which she recounted as being “no problem”, she was provided with information about the efficacy rates of the procedure as well as possible complications that she may experience as a consequence of surgery. Mary's obgyn reminded her that TL was permanent and wanted to make sure that Mary knew this before she proceeded with approving the surgery. The obgyn also informed Mary that if she wished to have another child in the future, she would be able to do this through egg harvesting. I found this interesting since egg harvesting was never brought up in any other of the women's stories about TL. After the conversation with her obgyn, Mary considered that she may have another child if one of her other children fell seriously ill. She called this a “designer baby”. To explain the meaning of the term, Mary described the plot of the film, “My Sister's Keeper” where the younger sister is conceived to provide organs and bone marrow to the older, sick sister. Mary didn't know how she felt about having a “designer baby” but was sure that that was the only circumstance under which she would want to be pregnant again.

To learn more about TL, Mary spoke to her family about the procedure and was surprised to find out that her mother had also been sterilized. Mary also spoke to some of her friends and was surprised to find out that most of her friends were sterilized (female friends through TL and male friends through vasectomies). None of her friends or family members actively discouraged her from seeking out the procedure and Mary attributed this to them knowing that she was content with her family size.

When I asked Mary about whether she regretted getting a TL, she pondered that she could grow to regret it, but that at this stage of her life this was the best choice for her. This was the first time that any of my participants explored the possibility of future regret in such an open way aside from Cathy. Mary completed her interview by stating that she was glad she received her TL when she did. Since she was homeschooling her children during COVID-19 while also working full time as a teacher, she couldn't fathom handling her day-to-day activities with even more children at home.

5.9 Annie

Annie lives in Ontario and is married with two children. When I asked Annie to tell me about her process of requesting and receiving TL, she began with an overview of her traumatic reproductive history. Annie had two miscarriages and one ectopic pregnancy before she had her first child. Throughout our interview, Annie reiterated several times the toll that the miscarriages, the ectopic pregnancy, and even the viable pregnancies took on her. While her pregnancy with her eldest was described as “pretty simple”, Annie had to undergo an emergency C-section with her second child. Annie described knowing at this point that she was “done” after this pregnancy: “My body was done. The stress, the anxiety, of the whole you know, okay you're newly pregnant, what's going to happen um... we already had gone through an ectopic”.

Annie's request and subsequent approval for TL had a very unique path that involved religious and medical authorities. Because her pregnancy was being overseen by an obgyn at a Catholic hospital, she explained that she required “permission” from the “Catholic clergy” to receive a TL and that this was a standard practice. She explained the request process as a simple one: her obgyn wrote a letter describing her reproductive circumstances and the “clergy” approved her

request for TL. When I asked Annie about her feelings about the process, she appeared indifferent, replying that she was fine with the letter. “I would have fought it more if they did say no because of all the things that I had been through previous to that um... but I... I... I’m alright when it comes to that kind of stuff so um... I felt fine with him writing the letter.” I wondered about an alternative story, one where Annie’s request was denied, and where she would have to advocate for herself within the constraints of the religious doctrine.

Annie couldn’t remember if she was provided any information about TL by her obgyn, and she narrated this fact briefly and in passing, without any sense of frustration. Most of what she knew going into the surgery, Annie recalled finding online through Google.

It was important to her that she felt as “normal as possible” after the procedure. In this sense, Annie didn’t want to go into what she described as “early menopause” or lose her menstrual cycle. Annie was also concerned about triggering early menopause if her ovaries were removed and hence opted for TL instead of a full hysterectomy. To her, the hormonal fluctuations she had grown to expect from her body were a symptom of normalcy. Annie’s experience with hormonal contraceptives had been largely negative, marked by both physical and psychological side effects. Hence, Annie was adamant about a non-hormonal contraceptive option following the delivery of her first child. Between her first and second pregnancies, Annie did not use hormonal contraceptives and instead relied on fertility awareness methods that involved counting days from her last period to assess if she was ovulating and would be more likely to become pregnant.

Prior to her delivery, Annie was nervous about the C-section due to a negative experience she had with her previous C-section when the epidural began to wear off and she could feel pain towards the end of surgery: “I could feel the needles and stitching and everything like that, I could feel them, I could feel my legs starting to, you know, when you get the nervous bounce and your legs do that bouncy...nervy..nervousy thing”. Annie remembered her second C-section and subsequent TL as uneventful and “good”. Annie was a little sad but relieved following her TL realizing that she wouldn’t have another pregnancy. While the miscarriages and ectopic pregnancy took an emotional and physical toll on her, Annie felt that being pregnant was “cool” when it was a “healthy pregnancy” and she got to connect with the baby while it was still inside

of her, but she was also relieved that she wouldn't have to go through any more miscarriages, including the stress, and other strong emotions associated with hoping for a healthy pregnancy.

Since having her TL, Annie said that she feels relieved and more at ease because she is certain she will never again have to go through the trauma of suffering a miscarriage. She explained that she doesn't regret her decision to get sterilized and doesn't really think about the TL that often.

5.10 Danielle

Danielle lives in Alberta and received her TL following the birth of her second child, which she delivered by C-section. Danielle began her story about TL with a preamble about how she and her husband always knew they wanted to have two children. In the year between her two successful pregnancies, Danielle experienced multiple miscarriages. During the year Danielle spent trying to get pregnant, she also lost her job and decided to become pregnant before she tried to look for a new one. She recalls this time as especially stressful both emotionally and physically when getting pregnant became her "top priority": "I mean it's stressful to put that much, to put that much pressure on your body and your system to get pregnant is always "ah... doesn't make life any easier (baby cries) um...so... yeah... it was... it was a lot, and it was just a lot of stress to put on myself on top of life that was already there". Unprompted, Danielle informed me that she had never had an unintended pregnancy. During the interview Danielle presented herself as a woman who always had control of her reproduction, which must have made the year she was unable to get pregnant especially stressful.

It was when Danielle became pregnant for the second time that she began to consider permanent contraception. Danielle's obgyn suggested TL during one of her appointments and she was receptive to the idea since she had already achieved her "goal" of having two children. Danielle recalled that, despite wanting a permanent contraceptive method, she would have been happy with continuing to use her Mirena IUD. Danielle had varying experiences with hormonal contraceptives. She was first put on the pill when she was a teenager to manage her polycystic ovarian syndrome, then the Depo-Provera shot, and finally, the Mirena IUD. She enjoyed the less frequent periods on the Mirena IUD and, at the time of the interview, she expressed that, even though she had been sterilized, she was considering getting the IUD just for that added benefit.

Danielle decided to receive her TL during her scheduled C-section as it “just made sense” to her out of convenience. When discussing TL with her obgyn, Danielle was provided with a pamphlet outlining some basic information that she describes during our interview as “clear and concise”. Danielle remembered being reminded frequently by her doctor that this was a “permanent decision” and that she had to be completely comfortable with it for them to proceed with the procedure. To learn more about TL, Danielle spoke with her friends and surveyed several online chats on Facebook to learn more about women’s first-hand experiences with TL. In her discussion with friends, Danielle was surprised to find out that several of them had been denied TL in their 20s.

On the day of her C-section and TL, Danielle was asked again by her obgyn if she still wanted the TL and she confirmed that she did. Danielle recalled a moment before her C-section was performed when she was overcome with a “daunting” feeling. Despite not wanting to have any more children, the idea of being sterilized seemed frightening: “Shutting the baby factory down was a little bit daunting and I...I don’t know why because I’m very comfortable, I’m very confident that I don’t want any more kids, but it was, it was a weird thing to have to say, that’s it, that’s, it.” Despite this, when I asked if she regretted receiving TL, Danielle insisted that she never reconsidered her decision for TL, replying with a definitive “no!”.

5.11 Natalie

Natalie is married, child-free, and lives in Ontario where she works as a civil servant in environmental policy. Natalie began her TL story by stating that she always knew she wanted to be child-free. She explained that not having a child was the “single most environmentally friendly thing you could do” and her decision to remain child-free aligned with her “zero-waste and vegan lifestyle” values. Natalie’s husband had gotten a vasectomy several years before the interview since he is also committed to remaining child-free regardless of whether they stay married.

In the summer of 2017 when her IUD was being replaced, Natalie asked her family doctor for a referral for a TL. Natalie recalled that her family doctor was supportive and provided her with several referrals to different obgyns; however, as of the time of our interview, none have agreed

to approve her for TL. Natalie expected the referral process to take a long time based on the experiences of her friend who was denied TL for years before eventually giving up on the idea.

Natalie reiterated her frustration about her TL denials several times during the interview, often unprompted. She cited her high paying job and her overall financial success as the main reasons for why she deserved being taken seriously by obgyns. She compared her experiences attending the obgyn appointments to those of a job interview where she presented her competence by wearing her government job ID badge and “professional” clothing and spoke in an “articulate” manner. Natalie described that she felt like a “show horse” who had to jump through many hoops and say the “right things” to be approved for her TL.

Throughout the TL-requesting process, Natalie has educated herself about the possible side effects and efficacy of the procedure. She specifically decided to have TL as she understood that it had minimal side effects and a short recovery time. Natalie was also relieved that TL was covered under OHIP and she wouldn’t have to pay out of pocket for the surgery.

Natalie was approved for TL before the COVID-19 pandemic; however, given that it is an elective procedure, the surgery was postponed several times and then cancelled altogether. The doctor who approved Natalie’s TL now no longer performs elective procedures. While Natalie expressed being discouraged and angry with her doctor for “letting her and other women down” by cancelling all elective procedures, she wasn’t dissuaded about pursuing TL. Natalie informed me that she would continue to request TL and will hopefully be approved soon.

5.12 Rose

Rose is in her mid-thirties, single, child-free, and lives in Ontario. Rose has received a TL, and then a full hysterectomy to manage her chronic menstrual pain. Rose began her TL story by telling me that she talks about her TL all the time. She wanted other women to know that it was possible for child-free women to receive TL despite the many hurdles she faced during the process. Rose was eighteen when she first requested TL, and although she knew that she never wanted to have children, she was told by her doctors that she would “change her mind” when she met the right man. Rose was discouraged after being denied TL; she recalled being laughed at by her family doctor and having her request dismissed because she was “too young to know” what

she wanted. Ultimately, Rose felt that her autonomy and wishes were not respected, and she described feeling that her body “belonged to a man” before she ever met him.

When Rose had an unplanned pregnancy in her early twenties, she decided to have an abortion. She recalled the day of her abortion as the “second worst day”, but also as the “second best day”, of her life. Rose remembered having to walk through a crowd of protesters outside the abortion clinic to get inside and teared up when she told me about a couple that was also at the clinic. Rose remarked that it was tragic to watch the couple get harassed outside by the protesters since they were “clearly grieving the loss of a pregnancy”.

Prior to receiving her TL, Rose tried several contraceptive options throughout her life. She first started taking oral contraceptives as a teenager and then transitioned to a copper IUD when her weight began to exceed the weight-limit of oral contraceptives. The copper IUD, as Rose described it, “fell out”. Rose then tried the Nuvaring, which never “fit right”, the patch, for which Rose exceeded the weight limit for, and finally the Depo-Provera shot which caused month long bleeding. Unsatisfied with all of these contraceptive options, Rose became frustrated that the contraceptive responsibility always fell on her shoulders instead of her partner’s.

When Rose moved from Alberta to Ontario, she was seen by a nurse at a community sex clinic. The nurse instructed her that acting like she was “too crazy to take care of a child” would help her get approved for a TL. Rose was convinced that following these instructions helped her to finally get approval for TL.

When Rose did receive her TL, she remembered the procedure as quick and minimally invasive; akin to “filling a tooth”, the surgery took less than 20 minutes and she was “done”. A year after her TL, Rose also received a hysterectomy to manage the symptoms of her endometriosis. Rose described that she felt “great” following her TL and hysterectomy, and that she was glad to never have to buy tampons, pads, or Midol again. She felt intense relief from knowing that she was not able to conceive and reported that the procedure significantly improved her quality of life: “I have peace of mind. I’m not an anxious wreck every time I feel ill.”

5.13 Kristine

Kristine is in her mid 40s and lives in Quebec. She's divorced and doesn't have any children. Throughout our interview Kristine swore frequently, usually when expressing her disdain for the medical community. Kristine began her story about TL by recounting an abortion she had in 2002 and her subsequent request to be sterilized, which was denied. Before her request for TL, Kristine had already tried most available contraceptive options except for the IUD. When I asked her about her reluctance to use an IUD, she told me a story she heard from a sexual partner about how his penis was damaged by a misplaced IUD; Kristine jokingly reassured me that her partner's penis was indeed "weird looking" to authenticate his story. Kristine also told me that she was "not a fan" of female condoms or sponges as she found them to be awkward. Most notably, Kristine suffered major health complications that she believed resulted from the oral contraception she had taken for ten years starting when she was a teenager. Following what Kristine described as a "major body shutdown", she was informed that her gallbladder had stopped working and needed removal. While her surgeon couldn't definitively conclude that her gallbladder complications were due to the pill, Kristine has abstained from taking hormonal contraception ever since; as she put it: "it wasn't worth risking my life".

Based on these experiences, Kristine felt that taking some form of chemical contraceptive for decades was "crazy". At the time of our interview, Kristine was relying on condoms to prevent pregnancy. During the interview, Kristine relayed that, in many of her sexual encounters, she felt that the responsibility to manage contraception was placed exclusively on her. This sense of responsibility was revealed when she recounted several times when her sexual partners would try to slip off the condom or convince her that they didn't need to use one. Each time, Kristine was adamant that her sexual partners needed to wear a condom.

Kristine felt that TL was the "simplest form of contraception" for what she wanted, which was to never have children. Kristine also described how her commitment to remain child-free has ended many of her relationships: "I.. lost so many boyfriends... because it became oh, you know, we get a nice thing going and we're serious and guys... were like well, I wasn't sure if you wanted kids and you don't want kids so... let's end it now instead of losing time, I was like WOW, that's rough". As she got older, Kristine found it easier to meet sexual partners who were not

interested in having kids. She has also found that nearly “a third of the men” she meets have had vasectomies but are quite shy about telling her. Kristine was also surprised to find out how many of her male friends had vasectomies, including some who did not have kids, and how easy it was for them to be approved for the procedure. Kristine attributes this double standard to “patriarchal discourses” that promote “that good old maternal image of the woman that, you know, of course, that’s the objective of our entire lives is having kids”.

Kristine joked about being unable to receive TL as she entered perimenopause, noting that: “it’s ironic to me that I managed to like... go through all my reproductive life without being able to get it [TL]...” She suspected that, at her next appointment with her obgyn, she would be told that she was no longer eligible for a TL since she is so close to being menopausal.

Kristine anticipated that this would present difficulties navigating sex with an “ex-boyfriend” with whom she reconnected during the pandemic. Similarly to some of the other study participants, her comments in this regard drew attention to the ways in which her desire for TL intersected with her sexual wellbeing and pleasure: “...We’ll want to have sex all day every day when we finally get to see each other again, but [...] with ah, condom all the time, it’s not gonna be the same thing. C’est la vie.”

5.14 Miley

Miley is 37 years old and divorced. She doesn’t have any children and lives in Manitoba. Miley first began thinking about TL when she was thirty. However, at the time of her first TL request she was still married and her doctor suggested that her husband may want children in the future. Miley reminded me that, despite the expectation that marriage and having children are synonymous / go hand-in-hand, she had always wanted to remain child-free. While Miley reflected on her own desire to never have children, she did not convey whether her former husband wanted children.

Like many of the other women in this study, Miley recalled her experiences with oral contraceptives to be negative as she developed several side-effects including mood changes, anxiety and depression, rapid weight gain, and changes to her blood pressure. Miley had been on several oral contraceptives and “just about every other” contraceptive option except for an IUD.

She added that she was notoriously bad at taking the pill every day and preferred something she didn't have to think about.

To Miley, the idea of TL was less intrusive than the IUD because an IUD would “stay inside of your uterus”. She also mentioned that keeping her period was something that was important to her, and she could “lose it” if she had an IUD. As she put it: “I’m a little bit of a hippie with the cycles thing [...] it’s still like a valuable part for me to like learn about myself.” Miley tried Seasonelle as a contraceptive option - a pill where you only have a period every three months - and hated it.

According to Miley, the turning point in her requests for a TL was the appointment where she disclosed to her doctor that she was in a polyamorous relationship. Miley laughed and said that the appointment was “extra awkward” after she disclosed her relationship status which caused her doctor to reluctantly approve her for a TL. Miley’s disclosure of her non-monogamous status resonated with the stories of some of the other child-free women who portrayed themselves as “deviant” to be approved for TL.

While Miley did get approved for TL, she couldn't remember whether she was provided with much information about the procedure aside from an “outdated” pamphlet. To learn more about TL, Miley discussed the procedure extensively with her friends. She learned that many of her female friends had been sterilized because their husbands, while being open to getting a vasectomy, never followed through with it. Miley also recalled reaching out to online communities on Facebook to learn more about TL to get an idea of what she could expect during and after the surgery. In her conversation with these online community members, she learned more about the surgery, including details about how the stomach cavity would be inflated with gas that would take some time to escape following the surgery.

After her surgery, Miley said the biggest changes that occurred in her body were her increasingly painful periods. However, despite the increase in pain, she didn't regret the procedure. Following her TL, Miley began to identify herself as someone who provided TL information to others. She explained how good it felt to be the one to convince her girlfriends that this was the right choice for them and to provide them with information about the procedure. Miley also felt that the TL

had positively affected her sex life because she no longer experienced worry about becoming pregnant. She disclosed that all those in her polyamorous relationship, who also wished to remain child-free, were happy with her decision to obtain TL.

5.15 Conclusion

In this chapter I presented descriptive narratives for each of my study participants, in order to situate their experiences of requesting and receiving TL in their complex reproductive histories. In each participant narrative, I presented an overview of that participant's reproductive history, how they arrived at their decision on receiving TL, and their experiences requesting and receiving TL. In the following section, I present the narrative threads that were generated from my analysis of all of the interviews. These threads are presented in relation to the concepts of relational autonomy, reproductive justice, and reproductive labour and health work.

Chapter 6

6 Narrative Threads

In this chapter, I present five narrative threads that describe the overarching themes that weaved across the participants' stories about TL. These narrative threads are: (1) TL as a resolution to complex reproductive histories; (2) forming and negotiating reproductive decisions within intimate and familial relationships; (3) negotiating medical authority and bodily autonomy; (4) TL and reproductive labour; and (5) complicating post-sterilization regret. While these narrative threads are woven through multiple participant narratives, the narratives of child-free women often included unique elements that were distinct from the narratives of women who had children. These counter-narratives provide valuable points of resistance that are distinct from those who were mothers. At the same time, analysis of the stories about TL also revealed some overlaps between the experiences of child-free women and women with children, such as experiences of reproductive labour and using TL as means of ending complex reproductive histories. These stories also suggest that both child-free women and mothers struggled with pronatalist discourses and had their reproductive autonomy constrained by medical paternalism.

Throughout this chapter, I use verbatim quotations from my interviews to present the narrative threads and to ground my interpretations in the narrative data. I use pseudonyms throughout to protect my participants' identities. As well, identifiers such as locations of where my participants received treatment or names of physicians are replaced with generic descriptors to preserve anonymity. Within the quotations, text presented in all capital letters signifies speech that was emphasized (e.g., by increased volume) by the participants themselves, whereas italicized text signals my own interpretive emphasis.

6.1 TL as a Resolution to Complex Reproductive Histories

The participants' narratives situated TL within long and complex reproductive histories marked by infertility, multiple miscarriages, pregnancy termination, and difficulties with hormonal and non-hormonal forms of birth control. Most of the narrative space during the interviews was occupied by participants' recollections of their complex reproductive histories, with TL positioned as the final "chapter" of or "resolution" to these complex histories by preventing the

possibility of future miscarriages, resolving the side-effects of hormonal birth control, and preventing multiple unwanted pregnancy terminations.

This was the case for Annie who, after having multiple miscarriages and one ectopic pregnancy, felt that her “body was done” and that the “stress, the anxiety” of subsequent pregnancies had worn her down physically and emotionally. Joy also recounted a traumatic reproductive history. In the two years of trying for a child she suffered six miscarriages followed by a difficult pregnancy. Joy also suffered through a traumatic birth experience due to obstetric negligence where she didn’t receive her planned C-section and instead delivered her son vaginally despite the risks it posed to her health:

In 2014 myself and my husband decided that we were going to try for a baby. Um, so in the two years [...] *my son was born in 2016, but within those two years I had had 6 miscarriages, um, two were in the second trimester so they were quite hard.* Um, and um, my son pretty much [...] the doctor said it was very lucky that we him, um, he [...] in the exact position that he needed to be in um to have a tilted uterus and um pelvis and shape and [...] I guess for like the laymens term of it. *So we were very very lucky to um end up with a child. Um, so within those couple years you know um that was...um extremely difficult couple of years trying to get pregnant and then losing so many.* Um while my girlfriends are all having kids and pregnancies are going fine I’m sitting here and just you know thinking ‘oh my god this is me’ every time [...] every time. *Um so my pregnancy with my son um was quite difficult, I was put on bedrest after 5 months [...] I developed three blood clots, um, had nerve and muscle damage from where he was positioned um as well as when he was born um my labour was um 36 hours um I was scheduled for a C-section knowing um how I have a tilted [...] uterus, and uh T-shaped pelvis. Um but they never, the OB at the hospital never took that into consideration.* [Joy]

Danielle experienced several miscarriages during her reproductive years. For her, TL was a way to manage pregnancy loss and to be certain that neither her husband nor she would go through the trauma of miscarrying again:

I have two children um... but this was my fifth pregnancy um... I had three miscarriages well two... a miscarriage before my first pregnancy with my daughter, so I guess, I've had two pregnancies, um... before having a live birth and then I had two more miscarriages between my daughter and my son so... *I was not interested in going through another miscarriage again, especially since we knew we were done having children. And... ah... yeah, I wasn't emotionally prepared to have to deal with loss again...so...this [TL] was a great way to... completely take that out of the equation. [...] neither myself nor my husband were emotionally equipped for more losses.* [Danielle]

For other women, TL was positioned in their narratives as the most favourable option for contraception given their previous negative experiences with hormonal contraceptives (e.g., depression, anxiety, weight gain, increased blood pressure). Mary, for example, recounts the extensive side-effects she experienced:

I had really awful side effects with anything hormonal um... like I had ah... *pretty big weight gain on one, I had extreme weight loss on another, um... like, sleeplessness um... weird brain stuff* (laughs) just every way they could go wrong they went wrong for me. And I'm also really bad at taking a pill every day, so it was sporadic (laughs) [Mary]

For Kristine, who wanted TL to remain child-free, sterilization was also a form of risk management following the life-threatening complications (and subsequent gallbladder removal) she experienced, which she believed resulted from prolonged use of hormonal birth control:

I started taking the pill when I was 14 and became sexually active and when I was 24 I got super sick. Ah... *Like a major body shutdown ah... fever, passing out, couldn't eat... ah... and... finally after months of going to emergency room at least once a week someone figured out that my gallbladder had stopped working.* Ah... so a surgeon actually removed my gallbladder, I had complications from it but it finally came back ah.. and that was in 2000. Yeah, that was in 2000 and... back then even before all the... odd cases and [...] against the pill makers my surgeon ah... *told me that he suspected that that was probably ah... consequence of taking the pill for 10 years and that he saw more and more women having issues with their gallbladder after taking the pill.* So, the thing

he said is... you know he was pretty straight forward with me and honest and said 'listen, I can't say that this was because you took the pill but... if I'd be you I wouldn't... I wouldn't continue taking the pill anymore' so at that point in 2000 *I think I was 24, I stopped taking the pill just because I figure... you know... this, this is not the risk I'm willing to take.* Like I don't think it's worth risking my health and especially now that I don't have any gallbladder anymore, like what's the next step you know. [Kristine]

Kristine's decision to discontinue taking the pill was shaped by her perceived risk of future health complications. By choosing not to "risk her health" with continued use of the pill, Kristine was placed in a difficult position of compromising her reproductive autonomy by risking an unwanted pregnancy.

In their stories about TL, some of the women shared their doubts about the effectiveness of hormonal contraceptives in preventing unwanted pregnancies. This included Joy who became pregnant with her son when she was on a low dose pill. For Rebecca, doubt in the effectiveness of the pill was grounded in her experience of having become pregnant twice while using birth control:

The first time I got pregnant, *I was 16 and I lost the baby. And I was on birth control, we were using spermicide and my husband was using condoms* so we've been together for a long time and we like... we still managed to get pregnant so I..I knew that if weren't like if it wasn't like an actual step that I would continue to get pregnant and I was on birth control when I got pregnant with my my daughter who... survived like.. who is alive like... I'm still on birth control, *so I knew that that [the pill] didn't seem like a valid option for me.* [Rebecca]

For the child-free women in my study, TL was positioned as a way to avoid terminating unwanted pregnancies. Both Rose and Kristine terminated unwanted pregnancies during their reproductive years. Rose assured me that she wasn't taken seriously by doctors as someone who wished to remain child-free until she had her abortion. Rose also expressed strong ambivalence towards her abortion; while the experience of accessing the abortion was traumatic, it also

validated her decision to remain child-free. In our interview, Rose was very forthcoming about the anger and frustration she experienced while requesting and receiving her abortion:

I had done everything up into that point to do what I could to prevent this from happening and it still happened. And *I was upset, I was angry, it was just the worst. I had to drive to this clinic in [city] and there was like these protesters outside and it was just a horrible experience. Just, all around horrible experience.* It was, I [...] second best day of my life though, just done and over with... [Rose]

Similarly, Kristine terminated an unwanted pregnancy and, through this process, was reassured in her decision that she did not want children. Both Rose's and Kristine's stories about pregnancy termination illustrate the difficulties and barriers to accessing reproductive health services for women who have to commute to receive their abortions or pay out of pocket:

I never really chose it [to become pregnant], but I became pregnant in ah...in... November 2002 and... so... I have you know, thought about it despite the fact that I was pretty sure that I didn't want children it's obviously, it wasn't planned um... ah... and decided to get an abortion and I was in [city], at the time *so it was super complicated because there was no abortion in public sector so...long story short, got the abortion, I paid because I had to go to a private clinic, [...]*, and at that point it became very clear to me *that I... would never want children like having been faced with the fact that I could have other children, a child, I didn't want it.* [Kristine]

The multiple perspectives presented by the women in my study suggest that TL was often sought as the means to ending complex, and, at times, traumatic, reproductive histories. It was also used as one of the limited options for women who experienced negative side-effects from hormonal contraceptives or for whom hormonal and non-hormonal contraceptives were not experienced as effective. Overwhelmingly, the women's stories illuminated the limitation of widely available contraceptive option and the scarcity of accessible reproductive health services, particularly by the participants who resided in the Maritimes. As Jennifer put it, when asked about why she chose TL over her other contraceptive options, she said:

You can either be on hormonal birth control or get an IUD or your husband gets the snip, you know? [sighs]. [...] Again, those are the options that are presented to women.
(Jennifer)

6.2 Forming and Negotiating TL Decisions Within Intimate and Familial Relationships

In my study, women often told stories about TL in relation to their intimate partners, families, and friends. These stories illustrated how the participants' partner's desires (usually husbands) often shaped their reproductive choices about whether to end reproduction and who would seek sterilization in the partnership. During the interviews, partners were often storied into the women's narratives of TL in a limited and fragmented way. For example, the women would recall having brief conversations about sterilization and family planning with their husbands. Within their narrations, these statements were often made in passing, after women talked at length about their own experiences and roles in family planning and they often felt like an afterthought to their responses.

When husbands were included in the women's stories about pregnancy, delivery, and sterilization, this was at times done comedically. For example, my participants often laughed or shrugged during our interviews while describing their partner's involvement in reproductive decision-making. As well, partners were noted in the women's narratives as providing instrumental support, such as driving my participants to medical appointments, but were rarely storied as providing emotional or informational support.

When partners were storied into the women's accounts of requesting and receiving TL, it was clear that they played important roles in shaping and influencing their reproductive decisions. For example, some of the women's stories pointed to their partners' inability and unwillingness to get vasectomies. In this regard, partners were often positioned in the women's stories as in need of being "spared" from medical procedures. This was the case for Mary who, after being sterilized herself, mocked her husband's medical condition that prevented him from seeking a vasectomy:

I went for the consultation and because of his underlying health condition... him going under... for anesthetic wasn't... like... necessary, wasn't like... it wasn't a good choice for him cause it could actually kill him. *So, like... he shouldn't have unnecessary surgery um... so... because of um... he's.... [does a comic voice] don't tell people about my testicles!* [Mary]

Cathy, who experienced intense regret following her TL, recalled feeling spiteful towards her husband as it would have been much simpler for him to receive a vasectomy, but instead he got to “skip it”. In drawing attention to this, Cathy points to the disproportionate reproductive labour women engage in that men get to avoid:

Researcher: You said that your husband “got to skip it”, ah... what do you mean by that?

Cathy: Well just that he... he didn't have to... like you know...*women... they go through the pregnancy, the labour, the delivery, the C-sections, the TLs,* and he... he didn't have to do the vasectomy and I was kind of a little bit spiteful about that.. cause I was like... just because of HOW I reacted after having it done but not handling it the way I thought I would. By having an issue with... I never thought twice beforehand...but afterwards... when your...my mind was really thinking about it... I was like I REALLY regret doing that... and he...*he didn't have to get his procedure done... so I don't know.. It's sounds juvenile, believe me I know, but I was just kind of like... oh, kinda bummed, that you didn't even have to book your appointment and the now I'm going through X Y and Z .*
[Cathy]

While my study participants rarely included their husbands in their stories about TL, they often justified their sterilization decisions in terms of “us” and “we”. The most striking example of this comes from Rachel's story of how she decided to keep her pregnancy with a new partner even though she was already content with her family size of two children from a previous marriage. In the passage that follows, Rachel's trepidation about having more babies and her desire to be free from nurturing infants is outweighed by her consideration of her partner's desire to experience biological fatherhood and her apprehension about “depriving” him of this opportunity:

My children are 7 and 8 now and I really like parenting children that age. They're different than having... infants and uh and uh I thought that my partner, although I, y'know I had a new partner and he was actively involved in parenting my children, *I thought that uh if we stay together and didn't have any more kids we would have more opportunity to do things together like travel and uh pursue our own interests. So, I felt like having another child would add another like ten years to that part of our lives that we could experience.* So, when I first found out I was pregnant I considered having an abortion and I actually did, I did book an abortion. Uhm and then this was earlier this year and we went away and the abortion was supposed to be after we came back and then COVID-19 started at the same time and so and I came back I couldn't go to the procedure because I needed to isolate for 14 days *and as I spent more time being pregnant and looking into my options about my job I felt more confident that I could keep the baby and that I wouldn't, it wouldn't negatively impact my career in the way that I feared and although my partner was uh leaving the decision up to me and he said he was OK if I didn't want to have the baby, I just feel badly that I would be taking that opportunity away from him who....has two babies and then I I know what it's like uh to care for a child...and did feel like it would be selfish of me to deprive him of that.* And so, I canceled the abortion when I came back because of uh COVID-19 and I didn't reschedule it and then *we decided to keep the baby and now there's a baby.* [Rachel]

The way in which Rachel switches her voice from “I” to “we” throughout this story captures the relational aspects of her reproductive autonomy, noting the complex ways in which reproductive decisions are embedded within and shaped by partners, and further complicated by COVID-related circumstances. Rachel's reference to being “selfish” points to the gendered perspectives of reproduction and the weight and responsibility women feel while making reproductive decisions. In her switching between *I* and *we*, this story effectively illustrates the ambivalence she is negotiating between her wishes to not have more children and focus on her career and her fears about “denying” her partner the experience of parenting an infant and raising a biological child. Following the birth of her third child, Rachel did receive TL in 2020.

The women's narratives also illustrated how their TL decision-making was embedded within and influenced by their relations with family and friends. Many of the women decided to request TL after learning that many of their female friends were sterilized postpartum, often right after their C-sections. Danielle noted that learning about TL happened through "casual comments" between friends, a finding that was echoed by my other participants. These stories are suggestive of the centrality of women's friendships and social groups in reproductive decision-making and illustrate the ways in which women form their reproductive decisions relationally:

Well, just in the fact that like, *we all have a friend that was done having kids so we'd talk about that she'd have it [TL] done and, you know, just a lot of casual comments, you know, we're talking about our various reproductive systems* and be like oh, not an issue for me [monitoring reproduction]! or I had this done! or... for most of them it wasn't really pointed out as being... *a lot of them seemed to be like me. They had a C-section and they had it done at the same time. I probably only have probably about half a dozen friends [sound of baby cooing] that deliberately went to have it done surgically. Um... instead of sending their partner in.* [Danielle]

In their recollections, the women noted how these friendly and informal exchanges provided guidance about ending reproduction and that ,these shared stories also helped them to prepare for the barriers and hurdles that they might encounter when requesting TL. Natalie, a child-free woman who had not yet been approved for a TL at the time of our interview, remembers adjusting her expectations that she would be approved for sterilization easily based on stories about her friend's experiences requesting the procedure:

Uhm, uhm one of my best friends who um is also a public servant um *we're similar in basically every regard. We're well educated, well-employed, you know. Uhm, she sought sterilization for four years before she gave up for good and just kind of resigned herself to a life of [hormonal] birth control.* And um this particular friend is older than I am. She's in her thirties so she's been going at this for a lot longer than I have. Um, which is why I went into this whole endeavour a little bit jaded because *I had heard all of her stories and all of her rejections and um if I'm being completely honest, I thought she*

might have been exaggerating a little bit when she told me some of the outrageous things that doctors told her. [Natalie]

Natalie was skeptical of her friend's experiences with TL denials and admitted that these stories shaped her "jaded" attitude towards her TL requests. As such, Natalie's friend's experience of being denied TL prepared her for her future disappointments. However, as someone who is still pursuing TL, Natalie distances herself from her friend who "resigned herself to a life of [hormonal] birth control" despite their similar status in education and income. It is hard for her to believe that someone so "similar" to her - "well-educated" and "well-employed" – would experience so much resistance from healthcare providers.

Similarly, Miley, a child-free woman who received TL in 2020, was surprised that she received pushback from physicians when requesting the procedure. In contrast to Natalie's story, Miley noted that her girlfriends did not have problems getting approved for TL, and so she was convinced that her TL denial had something to do with her specifically. However, she quickly corrected herself to suggest that the denial was supported by her doctor's "old fashioned" and pronatalist assumptions:

So, it was frustrating, I'd say, frustrating (laughs) and I kept, you know, I had other girlfriends who had requested it through other doctors and they didn't have any problems but I for some reason, *I had my doctor since I was 18 and I just trusted her so there must be a reason that I SPECIFICALLY shouldn't get this done but turns out she was just really old fashioned* and thought that I would change my mind about wanting babies.
[Miley]

Some of the participants recalled how their familial experiences and relationships shaped their decisions about fertility and reproduction. Negative childhood experiences associated with growing up with separated parents, or the experience of growing up as a middle or only child, shaped the women's ideas about what their ideal families would "look like", and TL was often sought and used as a way to secure that desired family. Rebecca, for example, informed me about her and her husband's decision to only have children with one another regardless of how

their marriage worked out. This choice was informed by their respective family histories of divorce and their complicated relationships with stepsiblings:

We've been friends since we were 11 so he was kinda there when my parents' marriage ended and when we had started dating we had...like talked and [...] we both come from broken marriages so we both knew that we had to talk more than most to make sure that we lasted kind of thing and... we had addressed that [kids in the background] like he comes from a family that has like a... combined like um.. his stepmom and stepsiblings kind of thing and like, you know, my parents situation had- we had discussed that like we wouldn't be trying to... the effort of trying to make two families work for Christmas [...] *we had talked about all that and how difficult it was on him growing up and how like it didn't go well with my family growing up and that we didn't ever want to do that to our kids so at the time we had discussed, you know, that... whether- whatever happens with us [...] we would only be the only people we would have kids with* [kids in the background] [Rebecca]

As well, Mary's childhood experience of growing up as a middle child shaped her decision to have two children and seek sterilization following the birth of her second child. While asserting that her childhood "wasn't traumatic", Mary nevertheless did not want to force anyone else to go through the experience:

It sounds pathetic (laughs) Um... I'm the middle child and I hated it! And it doesn't mean I had this traumatizing childhood or whatever, I just remember... feeling that three was too many for my parents. And... I... I didn't want to do that. I wanted... *I wanted the one-to-one ratio. [...] I was never abused as a child, I was raised in a lovely home, I just... middle child syndrome, stuck hard with me (laughs).* [Mary]

Mary also justified her decision to have two children in terms of what she could handle: a "one-to-one" ratio. This sentiment was also echoed by Jennifer who expressed her desire to have two children as "two hands, two kids". These examples suggest that women often knew, based on their childhood experiences, how many children they could manage both timewise and financially.

Similar to Mary's experience growing up as the middle child, Annie shared that her experience of growing up as an only child was a lonely one. This experience, in conjunction with financial considerations and history of miscarriages, shaped her decision to have only two children:

You know, I come from a small family, he comes a relatively small family, and I just didn't want an only child, because I was an only child and I know it sometimes it can be lonely um... when you're growing up and stuff like that especially in these times when you are supposed to stay home and ah... so we ah... we knew right away that we wanted two for financial reasons and...and um... after I had my two miscarriages, I didn't want to keep going for more... [Annie]

The stories presented in this narrative thread illustrate the complex ways that reproductive decisions, generally, and decisions about sterilization, specifically, were often made by the women in and through their relations with partners/husbands, friends, and in ways that were informed by their own experiences of family when they were children. In the following narrative thread, I present stories to illustrate how autonomy and reproductive autonomy were shaped by women's relationships with their healthcare providers.

6.3 Negotiating Medical Authority and Exercising Bodily Autonomy

Stories of negotiating and contesting medical authority were common across almost all the women's narratives. Stories about how the women retained bodily control in relation to their experiences with birth and reproductive health care came up during the interviews in different ways. Relationships between women and their healthcare providers were complex and were often storied with tension embedded in them. Women recalled negotiating relationships with their obgyns and other healthcare providers in relation to their reproductive needs and wants and often spoke about how they contested medical authority to retain control over their reproduction and their bodies. In their stories, TL was often positioned as the "final step" in these negotiations and was shaped by women's pre-existing relationships with medical professionals. Some of the women in my study recalled having good relationships with their healthcare providers, often noting that they trusted their physicians' decisions about their care. However, others expressed

distrust towards their physicians, including the child-free women who experienced multiple TL denials and the women who experienced extensive barriers to their reproductive health care.

The narratives suggest a variety of ways in which the study participants negotiated medical authority and exercised their bodily autonomy. For the participants with children, these narrations of retaining bodily autonomy in relation to medical authority were often presented in relation to their experiences of pregnancy and childbirth. Danielle, for example, involved a midwife at her first birth and during her later pregnancies because she felt the midwives focused more on her choices and provided her with a comprehensive overview of her option as compared to obgyns:

I think it's just I find the appointments a lot more involved and a lot more... concerning *what's going on with the pregnancy and what your intentions are with delivery, and you know, it's a little more about YOUR wants and how YOU see things going rather than what the medical... options are.* I guess. [...] Like the midwifery care does a very good job of explaining what the options are but at the same time, I find that they are a little but more involved with their care. And ah... *it's a bit more conducive to just having a baby... like the fact that they come see you after the baby is born as opposed to you having to trek into a hospital to the OB's office* [Danielle]

Rachel also worked with a midwife during her first pregnancy and was planning a home birth to exert control over her delivery in light of her knowledge about unnecessary induction for hospital births. However, she was also cognizant of keeping her options “open” if things “didn’t work out” and that she could deliver her child at a hospital with the midwife still providing care:

From what I researched [...] found about childbirth *midwives seemed to be the best option for having more control over the options that were presented* and I wasn't uh keen on the idea of having a hospital birth and *having a midwife would be the only option to be able to plan for home birth and uhm also have the flexibility that if things didn't work out at home I could go to the hospital and my midwife continued to care for me then. I was only transferred care once I was sent for a C-section but like my midwife continued to monitor me after and I was able to do my aftercare follow-up with baby and them.* [...] I

had read about hospitals and the rates of induction and the rates of intervention it seemed like as soon as you opt to have a hospital birth or plan to have a hospital birth the chances of having a natural childbirth or one free of intervention seemed to be uh dramatically decreased so I didn't at the time of my life I- *I was- hadn't had a baby yet and I was pretty sure that it was something my body could do and uh I thought it would be safest done in my house with my family and a midwife caring for me at not be uh cared for by different team of people every 12 hours in a hospital setting.* [Rachel]

In their narratives, both Rachel and Rebecca shared their experiences of how they made concessions and accepted medical interventions to retain as much bodily autonomy as they could. For example, Rebecca praised her new family physician and contrasted her positive experience of medical intervention in the form of a D&C to her sister's "natural" miscarriage after listening to her doctor:

Like, the doctor is very 'women's rights'! Like they're very like... um... like before when I had talked to...like when I miscarried before the doctor at the time is like 'okay well you should just let your body do what's just naturally gonna happen', but *my sister had miscarried um... not long before me and she almost died.* And I have kids...I had kids at home so I was kind of like, I... I wanted to have a D&C procedure and whereas my sister let everything happen naturally, she ended up needed a blood transfusion cause she almost died so I was kind of like no, and the doctor was like, oh well, 'we can just let the body work itself out' and I... they weren't as like... you know... friendly about me making a choice regardless of what their belief was. So... and then like... the new doctor like, I... like...had a little bit of mental health struggles and... um... the doctor was all about like 'okay let's find the right one [medication] for you so you can keep breastfeeding if that's what you want to do', like, that, *I just feel like the doctor that I have now is very much like... about me being a patient instead of like them being the doctor.* [Rebecca]

As suggested here, Rebecca also expressed her desire to retain bodily autonomy through her decision to breastfeed her child while continuing to medicate for her "mental health struggles". In this case, medical intervention in her postpartum care (finding the "right" medication) enabled

her to retain bodily control by being respectful of her wishes to continue to breastfeed her child. Her story illustrates that bodily autonomy is not necessarily opposed to medical authority, but is rather an active negotiation between women and their healthcare providers.

For my participants with children, receiving approval for TL was often straightforward and was decided on by the women and their obgyns before a scheduled delivery and C-section. These conversations were often described by the women as “nonchalant” and “matter of fact” as though they did not expect any resistance from their healthcare providers. Angela, for example, recalled that TL was offered to her following each of the two pregnancies she had and did not anticipate any “pushback” from her obgyn:

So it didn't come up at all um... almost my entire pregnancy and I had planned um... on my own to mention it knowing that *I wasn't going to have um... any pushback especially since it's been offered to me um... multiple times in the past by the same obstetrician and then a few weeks prior to my expected due date um... the obstetrician just said you know, ah... while we're in there (laughs) would you like us to do the TL?* Um... they went over the ah... the consent stuff with the...you know, it's permanent, the method that we use, um... the potential side effects, the...not side effects... the benefits and risks and that sort of thing and um... I had already had my mind made up prior to that so that um... yeah that's they mentioned at that appointment, I signed the waiver of consent and he asked me again at the surgery to make sure that I still consented. [Angela]

Similarly, Danielle recalls that her obgyn offered her a TL as a routine and convenient option since she knew that she would need a C-section for her delivery given her history of previous miscarriages:

I got about half-way through my pregnancy, it was most likely that I would need a scheduled C-section um... so when I met with the OB ah...he went through all of the general questions and all of the stuff like that and then... actually out of nowhere he said to me, um... is... *if we have to go in for an induced surgery, would you like to have a tubal done at the same time. And I honestly have not thought about it until that point.* And I was like, actually, *yeah, yeah, I definitely would like to have one!* [...] *Honestly,*

just seemed really matter of fact, routine kind of thing, just sort of that... since we're in there anyways, is this something that you have interest in to save yourself um... possible surgery down the road, um... so yeah... didn't...it didn't bother me at all...I'm actually really glad he thought of it and... ah... I was...I was pleased with the suggestion [laughs].
[Danielle]

While participants with children recalled experiencing very few hurdles in receiving TL, these stories were contrasted by the stories of child-free women, whose stories about requesting and acquiring TL almost exclusively focused on contesting medical authority. Katie recalls with frustration how her desire to be child-free was not honoured by her physician the first time she expressed her desire to receive TL. However, following a successful pregnancy and termination of a subsequent unplanned pregnancy, Katie was adamant that another pregnancy is something she definitely did not want. She expressed her frustrations with the pushback she received despite being sure about her decision:

I just brought it up with her [physician] when she was talking about me taking the pill or going on an IUD and I was just like... *I'm sure now that I've been pregnant that I don't want to do it again.* I was very ah... sick through the pregnancy like not anything... serious like... but absolutely nauseous and useless for 8 months. Like I don't want to go through it again... it's not worth it... if I don't want any more kids...so I went... I want something permanent... and again... yeah... *I got kind of like... arguments from her, it's funny because she's very open minded she's not like old school at all... she's very liberal minded but I still got these, what I felt like, were old school arguments, well this is the...you know the man's responsibility, he can get a vasectomy and that can be reversed. If you get a TL it can't be reversed and you're still young, you might change your mind and.... ah.... yeah... it just seemed like the least likely of options after talking to her. Like getting the tubal ligation seemed like the least likely of all the contraception options available.... [sighs] [Katie]*

Katie's reflection suggests that she placed her trust in her healthcare provider and subsequently was "talked out of" having TL. Her recollection of the conversation is riddled with disappointment in a physician she believed to be very "liberal minded". Interestingly, Katie's

physician reinforced her male partner's responsibility for contraception by suggesting that Katie's husband receive a vasectomy. Simultaneously, however, this effort by the physician to shift responsibility for permanent contraception onto Katie's husband is interpreted as restricting her bodily autonomy as she was denied TL. While Katie did end up pregnant again, she decided to terminate that pregnancy since she did not want to experience pregnancy again nor have another child. It was only after the termination of this second pregnancy that she was approved for TL. Similarly, Rose, a child-free woman was approved for her TL only after she terminated an unplanned pregnancy:

Like I knew what I wanted and no one cared. And you know what? *They didn't care until I was fucking you know pregnant and had an abortion, I was like look if this happens again, there's not going to be a life for me.* But it shouldn't take that far to get it done. That doctor shouldn't have laughed at me and I won't forgive her for it anytime soon.
[Rose]

Both abortions played an important role in receiving an approval for TL and seemed to "prove" to physicians that the women did not want to have (more) children. For the child-free women who never had an abortion, additional reproductive labor was needed to "convince" healthcare providers to approve sterilization. Often, despite this additional labour, the requests for sterilization were still denied.

6.4 TL and Reproductive Labour

In this narrative thread, I present stories about the reproductive labour the women engaged in to seek out and secure approval for TL. In this sense, I use reproductive labour to include and acknowledge the efforts and activities that the women engaged in to manage their reproductive lives (e.g., taking contraceptives, going to doctor's appointments, childcare). The women's stories revealed three forms of labour: (1) the activities they engaged in to seek out and acquire information about TL and to compensate for inadequate information provided by physicians; (2) the work involved in self-presentation during medical appointments to optimize their desired outcome of getting sterilized; and (3) the work involved in advocating for themselves and others during medical appointments and by informing friends and other women about TL.

6.4.1 Information Gathering About TL as Reproductive Labour

Many of the women I spoke to engaged in independent information seeking about TL through online sources (i.e., through “Mommy Groups” and “Facebook Groups”) or through friends and acquaintances. When I asked Rachel about how she learned about TL, she replied that she found information about TL through using Google, other Internet searches, and reading whatever sources she deemed to be “credible”:

Uhm mostly just *Internet searches and Googling different things and reading what whatever [...] results there were that I felt came from like hospitals or research settings or credible sources for things that I deem to be credible [...]* I just went with my instinct on that one rather than anything that is scientifically or in a journal or anything like that.
[Rachel]

Like Rachel, many of the women took it upon themselves to learn about TL from online resources. I often had to use directional probes to elicit recollections of this form of reproductive labour, which suggests that the work of internet searching for information about health is an everyday part of their lives instead of an extraordinary exercise. Danielle describes what “she knew before she received TL” as a combination of the information provided to her by her doctor and information that she found online through her “independent research”:

Um...that I’ve had several friends that have been through with it that most of the cases, *I did a little independent research just online just to find out*, it seems like the [baby cries] the... side effects, outside of obviously not being able to get pregnant seems to be rather minimal um... compared to like a full hysterectomy or some other birth control options that might have been out there and ah... yeah... I...me... *I basically there was a lot of mix of their [doctor’s] information and my information* [Danielle]

Like Danielle, many women actively sought information about the potential side-effects of TL, as well as recovery times and the efficacy of the procedure. For Miley, this involved asking her girlfriends who had received TL about the procedure in lieu of the outdated pamphlet her doctor provided her:

I've had girlfriends that have had it done maybe six months before me um... and then *asking them everything about you know, how did it feel? how was your recovery? how was the time in the hospital? how long were you under? How did the drugs feel? Like, and just also getting an idea of what to do the day of, cause I was given an information pamphlet* um... when I got approved for it and after my initial consultation with the surgeon *and it was like... totally out of date...*[Miley]

Miley's story of information gathering illustrates the ways in which women leveraged their social circles to learn more about TL, particularly when information that they were provided with was viewed as inadequate or obsolete. As well, Miley's account provides insight into how little information is provided by physicians to women during and after the TL approval process to support their informed decision-making about the surgery. Annie, as well, had difficulties recalling what sorts of information she received from her physician; however, was quick to add that she learned most about the procedure from Google:

Um.... oh shoot! Um... I believe... I'm ... I must have gotten some information sheet from my OB just to explain how...how it happens. Um... I feel like I read that there's different ways of having it done, like it's whether it's you tie your tube or you...you cauterize it? Maybe? Um... I can't remember... *I feel that that's... I feel like there isn't tonnes of information about it, but I just said hey, can I get my tubes tied and um... then he wrote the letter and everything like that so maybe I got a brief pamphlet on it, but not tonnes of information on it, if anything I Googled what actually happens...*[Annie]

When we discussed the information Annie received from her physician, she was unphased by the lack of information she received, almost uncaring. This unphased attitude was shared by other women in my study suggesting that my participants accepted their roles as information gatherers and rarely expected the physicians to educate them about TL.

6.4.2 Self-Presentation as Reproductive Labour

Child-free women, specifically, shared many stories of the work of self-presentation they engaged in to be approved for TL. Natalie explained that she made a purposeful effort to appear as “professional” as possible to convince her doctor that she was a competent and autonomous

decision maker. Natalie expressed that her doctor visits often felt like job interviews where she attempted to showcase herself in the most competent and professional light, leading to her feeling like a “show pony”:

I would show up to these meetings typically there on a workday, so *I'd be in business attire and I would be presenting myself in the most favorable way possible* [...] I'd be showered, clean, um my hair is dealt with in some capacity whether I styled it or just put it in a bun or ponytail or something like that. *I'm wearing some form of work clothing whether that's you know a sheath dress or a suit or you know a nice cashmere sweater and some flats you know.* [...] And then, then I have these appointments with the doctors and always sure to mention all of the, the things that are considered favorable? *So you know I will tell them that I'm a university graduate, that I have a fancy job, that I own a house, that I'm married. I have all of the things that are considered...cultural milestones or social milestones.* All of the things that are typically looked upon favorably by, you know, society, medical professionals and [...] Very sure to physically present myself in the most favorable light, but also showcase all of the other desirable positive accomplishments in my life. [...] It's hard. Because...*you basically have to, like, treat it like a job interview. Like, you're a show pony and you're presenting yourself in the most favorable light* you can to these doctors, like not literally prancing around but you know, think you are simply prancing around and showing how great you are [Natalie].

Natalie's story demonstrates the labour involved in presenting herself to her healthcare provider as someone who is deserving of reproductive autonomy given her economic and professional success. Also, Natalie expands on her “interview” simile by explaining the ways she censors herself when meeting with physicians. In this regard, she is careful not to tell them about her lifestyle choices of zero-waste living and veganism, which she feels may be perceived by doctors as “crazy” and “radical”, thus compromising her chances of being sterilized:

I usually didn't tell them about any of my more radical views because I'm generally aware that the world at large sees vegans as crazy people [...] ...anything that goes against the social norms, so like living the zero-waste lifestyle, or um yeah not buying

fast fashion anything that can be *considered radical or outside of the norms or social conventions*. [Natalie]

As such, Natalie presents a carefully cultivated image of herself as someone who is traditionally successful and deserving of respect. Contrary to Natalie's professional and "socially acceptable" self-presentation, Rose was instructed by a nurse practitioner to appear as "crazy" as possible so as to convince the doctor that she would make a poor mother and maximize her chances of TL approval:

My doctor said 'go to the sex clinic in town in [...] and talk to the nurse' I said 'OK'. So I booked an appointment at the sex clinic, I went in, and the nurse said 'OK so why are you here?' and I told her, I said 'I want a tubal' and she's like 'How much do you want it?', and I told her the story and she like 'OK' and she's like 'this is what you gotta do' and I was like 'OK' and *she's like 'you need to convince them that you are so crazy that it is in their best interest to sterilize you based on the fact that you wouldn't be able to take care of chi- take care of children.'* And I was like 'um, OK?' and she's like 'don't mention boyfriends, don't mention wanting or not wanting kids, don't mention anything. Just convince the doctor that you are just like flat out insane' and I was like 'um, ok?' and she's like 'I know it sounds stupid, it sounds crazy but' she's like 'if you really want this that's literally what you're gonna have to do'. [Rose]

From here, Rose went on to tell me how she convinced her healthcare provider to approve her TL by acting "crazy" and saying that she would kill herself if she got pregnant again:

I was 24 at the time, I didn't have kids, I didn't have a boyfriend, I was at my mental s- I was hanging on by a thread, so anyways, so my um family doctor gave me an appointment with a gynecologist named, um...his name was XX and he was out of [city], and he just happened to be the ethics professor at [university] where my doctor went to school. So, I go into this guy's office and he's like 'OK' so why are you here and I'm like I- I want a tubal. And he's like 'OK'...and I'm like if- and *I told him the story so if I get pregnant again, I'm just gonna assume that this is the rest of my life and just literally kill myself and he was like 'OK' and I'm like so your choices are to allow me to possibly*

regret it in the future or to this now and save my life and he's like, and he thought for a moment and he was like 'OK'...I guess my only question is if were at a point where you were medicated to the point of you know a normal thinking person, are you gonna regret this decision? And I'm like no. I'm like this has just been the [...] and he's like 'OK, OK yeah, I think we can do that for you'. [Rose]

Unlike Natalie, who aimed at presenting herself as a competent and successful woman in order to be approved for TL, Rose's self-presentation was aimed at appearing as "unfit" for childbearing as possible, even suggesting that she may kill herself if she were to become pregnant. Given Rose's successful TL approval, her account suggests that some healthcare providers may be more willing to sterilize women who present themselves as mentally "unfit" for childbearing. Similarly, Miley who is also child-free, recalled being denied TL several times. She finally convinced her doctor to refer her for the procedure after declaring her polyamorous status, which made her doctor "very uncomfortable":

It [medical appointment] was EXTRA uncomfortable...it was... I'd been separated for about a year and a half at the time um... and... I was being as blunt with her as possible, like, I'm divorced, I am never remarrying, under no circumstances, under threat of death and like I am... I am polyamorous and dating multiple people right now and a pregnancy would be like... I didn't say death sentence, but I did say like the worst thing that could happen right now, like I did not want it, and she like got very uncomfortable and said well okay, it sounds like you know what you need and then you know...referred me from there. [Miley]

6.4.3 Narrative Labour: The Work of Advocacy and (Re)Telling

Many of the women in my study engaged in narrative labour by having to re-tell their TL requests and TL stories in their efforts to become advocates for themselves and others. This labour was talked about at length throughout my interviews. Among the study participants who had undergone a TL, six women shared stories about taking on the role of advocates following the procedure. As such, these women became sources of TL information within their social networks. While expressing their roles as advocates for TL, many child-free women recounted

this role with pride, stating how “happy” they were and how “good it felt” to be spreading information about TL. This was the case for Miley who recalled how good it felt to provide this information to her girlfriends as well as support them in their decisions about whether or not to receive TL:

I've had girlfriends ask ME about it since I've had it done and like just reassuring them that it's, you know, not as bad as you might think and... you know, just giving other people these like... it's okay. It's a thing you can ask for and get, so that feels really good because that's something I've wanted for so long and I took so long to make happen that now that it's done like, I dunno... encouraging other girls to do the same feels good.

[Miley]

Natalie, as well, reflected on her self-advocacy as she continued to seek medical approval for TL. In this reflection, she recounts the labour she has done to advocate for her choice to remain child-free and recognizes her privilege to engage in this labour:

I have the ability to be my own advocate, which um I don't think most women do have? Um, but despite that, I don't think my outcome is any better [laughs] than someone of less privilege because ultimately I still haven't gotten what I've wanted? Um, but I imagine if I wasn't able to...well one, take off all the time to visit all of these doctors and get so many referrals and that um...someone might not even get this far in the process because they've burned all of their sick time and their vacation time and they simply can't get off of work to seek all of these appointments. Um, but beyond that, a lot of other women may not have the ability to understand their rights and advocate for their rights.

[Natalie]

In addition to being able to dedicate the time required for self-advocacy, Natalie also positions herself as a knowledgeable advocate for other women. The labour involved in self-advocacy was also revealed in some stories where extreme vigilance was required to ensure that the TL procedure was performed after it had been approved. For example, Jennifer contextualized the hyper-vigilance and self-advocacy required to receive her TL within her distrust of the “medical community” and her occupation as a reporter where she is trained to “ask the questions”. In the

passage that follows, Jennifer highlights how this vigilance and self-advocacy were necessary to manage her own care in the context of multiple shifts and changes in care providers:

Ah.... just.... [sighs]....[long pause]... *it was definitely odd to have to ask so many different people so many different times and to remind them that that was supposed to be happening cause it was all... cause the anesthesiologist at one point changed and the ...the surgeon changed about three different times so then oh, the time that I went arrived at the hospital to the time it actually happened the person who was gonna be doing it changed and ah... at least three times and the nurses changed shifts and everybody you know, was all, different people different people, and it seems like no one was, no one had written it down or anything. So that was um... weird...[Jennifer]*

As well, Jennifer illustrates how her self-advocacy for her TL is grounded in her role as a mother where she had to engage in a laborious process of requesting her daughter's medical results:

I don't trust, um... them... so much, because they you know, I, I'm... I'm a reporter, a newspaper reporter, so it's like [sighs]. You ask, you ask the questions, right? So, I would ask you know, did you know this? Oh, no. Oh well that's, you know, did you know that I, wanted this? Um... tubal? And they, oh no, I didn't see that, you know? You know I need that. Oh yeah yeah... Right? Cause they know [sighs] for my daughter. Um... it, it took a lot of uhh... doctor's appointments and a lot of fighting and a lot of calling... to get things for her done. She needed her tonsils out um... so she you know, had to go to a sleep clinic, and all this stuff in order to get them to have them out. And you had to get the results and you had to, keep calling and calling and calling and calling to get these results and nobody seemed to keep up on it unless you were on it. [...] You know? So... if you want something with the medical community you can't exactly assume that it'll all happen in due course because you know? For that despite that I've been calling doctor's office every Friday, for six weeks. When I got the test results they, the date, on the fax for the report was four weeks before I got it [Jennifer]

The hyper-vigilance presents an extreme example of the efforts that some of the women had to make in order to realize their bodily autonomy and self-advocate. Advocacy also took forms of

cautionary tales. Cathy, informed by the intense regret she felt following her own TL, felt a tremendous responsibility to act as a role model of self-advocacy. Cathy recalled how she acted as a source of information for her girlfriend who wanted to receive TL. While she acknowledges that her experiences may not be shared by her friend, Cathy shares her own “story” about TL as a cautionary tale to advocate that her friend become fully informed about the permanence of the procedure and the possible consequences:

Um... I... I did have a friend who was considering getting it done if she needed a C-section she was having twins and she was young like me and I just, I just want to put it out there, that everyone’s experience is different and *I’m not saying that everyone is going to have the same mental blocks or anything like that, that was MY story*, but I...I just... I guess I...I’m more open about it now, *just to really do the research and truly think about it especially if you’re young because it is SO permanent and anything can happen* and it’s just, it would... I don’t know where I’m going with that. I’m just glad to share it, it was kinda helpful too to walk through it and if it helps someone else, it’s all I can wish for. [Cathy]

In addition to modelling the importance of self-advocacy with her friends, Cathy took it upon herself to educate her children about medical decision making and self-advocacy in medical settings:

I need to lead by example for my kids, *it’s your body, your rules and you need to advocate for what you want*. And ask the questions [Cathy]

Other forms of narrative labour were prominent in the stories of child-free women who spoke about the work involved in telling and re-telling their reasons for requesting TL as they were denied the procedure repeatedly and had to continue to search for a physician who would approve them for TL. All the child-free women in my study recalled the multiple tellings of their TL requests, often without getting any closer to being approved. These recollections were marked by a profound sense of frustration with the medical system that failed to honour their reproductive autonomy. Child-free women also told and re-told their TL stories to their friends as part of the advocacy they engaged in following their TL. This act of re-telling was especially

salient for Rose who began the interview by acknowledging how often she shares her TL story to encourage women who believe that TL will never be approved for them. As the passage unfolds, the effort and tenacity that Rose had to engage in to have her reproductive choices acknowledged is made clear through the multiple requests she made over several years:

Ah [sighs] well *I honestly tell this story a lot because I, there's a lot of people out there who just think there's absolutely no hope to get it done* so my starting point would probably be when I turned 18 I went to my family doctor and asked her if I could get a tubal and she thought, I don't know, she thought I was joking or is she, she kind of made a mockery of it, like 'oh you're young, you don't have kids, you don't even have a boyfriend like how dare you think that's like OK' [...] *I asked to get one when I was 20 and then again when I was 21 and then I asked pretty much every year, like, right after my birthday which is [in December] and always got uhm denied.* [Rose]

The remainder of Rose's interview is a detailed history of her reiteration of TL requests to one physician after the other. One aspect that is central to Rose's retellings is how medical sexism served as the basis of her TL denials and the distress she experienced as a result. Similarly, some of the other child-free women's accounts of their TL requests echoed the intensity of this narrative labour. This was the case for Natalie, who further narrates the frustration of having to speak with several physicians in order to secure access to TL. This quotation illustrates the ways in which women are passed from one healthcare provider to the next, each time having to re-tell their TL story:

And so um after I got my IUD placed that's when I got my first referral um...that one was...not so bad? Um the doctor just said "no I don't do that" and I moved on. But they didn't really, I don't know, impose their personal beliefs on me or say anything shoddy and illegal. Um so that was the first rejection. And um so I went back to our private care doctor to get another referral because that's how you gotta do it and you can't just hop from obgyn to obgyn. You have to go back to primary care doctor to get a new referral for a new obgyn. Luckily my primary care doctor has a kind of live and let live view of the situation. He's like "yeah sure do whatever you want" and he luckily helped me get the referrals I asked for, even though I probably looked like a crazy person to him. Um

so the next referral, uh, that one was ...bad. *Um the doctor lied to me. Um on many fronts. She said that she's not allowed to do it, which is not true, obviously. It's perfectly legal in Ontario, and not only that it's covered by OHIP. And then when I tried to push back on the lie, she quote unquote said she "wasn't allowed to do that".* She said that I was young and um like why not just ask my husband to get a vasectomy? *And I had a lot of really bad "big no's" of her trying to invalidate my beliefs and my reasoning and my decision-making skills. And um that particular part was crushing.* Um and when, so after she refused me based on false grounds, I went back to my primary care doctor to get another referral. Um, this referral was also terrible. Um this particular doctor also lied to me. *They said it was going to be really expensive, which is not true. It's covered by OHIP. Um, that there's all these hurdles, that I needed my husband's permission, again not true.* That I would change my mind, um, just kind of a series of um inflammatory statements after. Inflammatory statements about why I can't or shouldn't or I'm unable to seek the procedure... *So I went back to my office and uh emailed my primary care doctor. Again! For another referral.* [Natalie]

Both Rose's and Natalie's stories about re-telling their requests to different doctors highlight the ways in which women have to repeatedly justify their reproductive desires as they are passed from one healthcare provider to the next, following each denial. In this way, these women perform a great deal of narrative labour in order to self-advocate and "convince" their healthcare providers that they should be sterilized. These negotiations are often shaped by medical sexism (i.e., suggesting that the women would change their minds about having children, questioning women's relationship status, and requiring their partners to provide permission for them to receive TL) and contribute to the reproductive labour associated with getting a TL approval.

The work of re-telling was not limited to child-free women. Some of the mothers in my study also expressed discomfort and strain with having to tell and re-tell their TL requests to their physicians. Rebecca explained that changing doctors was overwhelming because it required her to re-tell her entire life story. Her mentioning of the personal file that doctors have on their patients conveys the unnecessary burden she felt of having to re-present her life story:

When my doctors were switched over I was nervous and... like I knew that the other doctor knew my history all this other stuff so for... me to be able to like.. um.. be okay with this new person is huge for me. And.. I think speaks volumes about how wonderful they [the doctor] are [...] Um.. just that... um.. I don't know like.. *having to explain my life over to someone else even though they have the file is.. you know.. Is..is..[kids yelling] kind of overwhelming to me.* [Rebecca]

As Rebecca explained this change in doctors to me, I heard fatigue in her voice. She often lost her train of thought and trailed off. Her five children were ever present in the background and were clearly heard during our conversation. I couldn't shake a guilty feeling that I was labouring her further with my probing, initiating another "overwhelming" act of re-telling.

6.5 Complicating Post-Sterilization Regret

In my conversations with my participants, regret rarely came up unprompted. When I probed and asked about it explicitly, most participants clearly articulated that they did not regret their TL, often responding with a resounding "No!". This was followed by their justifications as to *why* TL was the right choice for them. I found these responses unsurprising given the time and effort that the participants had spent and made to research TL as permanent contraception, decide whether TL was right for them, and, in some cases, attend multiple medical appointments to get approval.

Some of the women acknowledged that they may come to regret their decisions in the future but recognized that it was the right decision for them at the time of their sterilization. Mary suggested, for example, that she is open to the possibility of regretting her TL in the future but also expressed that TL was the right choice for her when she received the procedure. In our interview, this was articulated in a story about advice she gave to her friends:

I have other girlfriends debating, 'would I have my third [child] or should I have my second?', you know. I'm pushing 40 and whatnot' and... I'm like 'you just need to do what's right for you and your family', they're like, 'how did YOU know'? And I'm just like, *I have always known. I said you can go five years from now and regret it, not having a second or third or a fourth child um... so you need to do what is right for you, I was*

always just *two and through*, so [I] just mainly feel better [knowing] that I wouldn't have... I wouldn't get pregnant again. [Mary]

Similarly, Rose, a child-free woman who had her TL in 2020, acknowledged that she may regret her decision to get sterilized in the future and added that not having children is “not the worst thing in the world”. For her, this future regret would be less painful than the alternative of having children and not being able to care for them:

And like I said *I'd rather regret not having kids then have one and be like 'shit I can't do this'*. Like, there are worse things in the world than choosing not to have kids. [Rose]

However, Cathy, a mother of four, described having tremendous regret following her TL. Having received the procedure at 27, almost four years before our interview and after the birth of her twins, Cathy felt that she had undergone TL too young and that she wasn't fully informed about the potential emotional consequences when she consented:

So... I feel like women especially if they're younger in my personal experience... *I do have a lot of regret doing it... and it's not that I want more children... our family is SO FULL and we are SO BLESSED I just... there's something always there in my mind that I just feel I don't know... it's a process and I felt like I... was grieving that after, if that makes sense, just the fact that you can't have any more kids... even though I never wanted to... it's just a very permanent thing and because I was only 27 when I got it, it really affected me emotionally after getting it done um... yeah... that's sort of... I never really dove into that part, I just thought it was a simple... and it IS... it's just a simple clip once they're already in there especially doing a C-section, it's two extra minutes kinda thing but I just think that the long-term lasting effects...mentally just for myself, I was just not prepared for that and didn't really consider that beforehand.* [Cathy]

For Cathy, regret was not attached to wanting more children. Rather, Cathy described her regret as “grief” for the loss of her femininity that she closely related to her fertility. She also recounted that, following her TL, she lost interest in sex as she simply did not “see the point” of engaging in sex if she was unable to get pregnant:

I feel like my ah... again, this might be too much information... I feel like my sex drive is completely depleted like since getting it done and I know... I contemplated...I know we have young kids, right? It's all these other factors too but I... I... I just...I guess in my mind I don't really see... the point if that makes sense... of having... I don't know... I guess somewhere in my mind I feel that just leads to children and that's all over with now again... even though I'm very content... I just... it's always just kinda there... that's it's such a permanent like... THING [Cathy]

Furthermore, Cathy's experience with receiving TL deeply influenced her sense of self including feeling like "less of a woman" following the surgery:

I feel like... my periods have been a little different after getting it done um... I don't know, it's hard to really say I... just... I feel like it would have been easier for him to just get it done versus me cause I've been struggling... I feel like less of a woman if that makes sense [...] [Cathy]

Cathy's experience challenges current medical conceptualizations of post-sterilization regret, which focus on a woman's potential desire to have children. Cathy's regret, or "grief" as she describes it, arose from her construction of womanhood, which, for her, is bound up with the capacity for fertility; hence, the loss of her fertility challenges her experience of herself as a woman.

Notably, Cathy's regret about TL was shaped by the loss of bodily control and autonomy she felt during her C-section, when after changing her mind about the procedure, she did not have the "courage" to speak up. Cathy describes this frightening moment as an "out of body" experience where she was unable to act. She also positions her inability to speak up in relation to her husband, further complicating her experience of regret receiving TL:

Cathy: I remember it all, but it was like an out of body experience, if that makes sense, because I just felt like... I was just... I couldn't talk... I was just there... I was not experiencing it I was just physically there not... mentally or emotionally at all...

Researcher: Right... you mentioned before that ah... you changed your mind.

Cathy: I did. *I remember sitting there being like, I don't want this done and then I was also...I didn't want to... upset my husband [laughs]... as bad as that sounds... like... like I said yeah... and I didn't... I know... I just let it happen if that makes sense... I didn't have the courage to say, my change of heart really.*

Researcher: You said you didn't want to upset your husband, what do you mean by that?

Cathy: I think he thought okay, sweet! I don't have to get the vasectomy done [...] and that was kinda the deal, and I was like, is there any way, what's the big deal, and I didn't want to, yeah, no, YOU'RE getting it done, you know, you know what I mean? [...] Even though I know he would have never been upset, but in the moment, it was just such a split-second decision, and I should have aired on the side of caution and said no, but I did not.

Cathy's regret can be interpreted as a double loss of autonomy; first, by being unable to speak up during her surgery and stop the sterilization and, second, through the sacrifice of her bodily autonomy to avoid upsetting her husband. Her story complicates current conceptualizations of regret that are rooted in simplistic understandings of how women experience TL. While post-sterilization regret is often positioned as an explicit regret of becoming sterile, Cathy's experience points to a regret of *how* her TL unfolded. Cathy's loss of autonomy during the TL led to a traumatic experience marked by a loss of autonomy. Eventually, Cathy did "move past" the "grief" after seeking therapy and leaning on friends and family for support. As such, I believe, by actively taking steps towards resolving her regret, Cathy reclaimed a part of her autonomy.

This storied space, in which womanhood is conflated with fertility, was challenged by Kristine who attributed her TL denials to the "the good old maternal image of the woman" and sarcastically contested this construction when she noted, "of course that's the objective of our entire lives is having kids". Kristine further challenged the paternalistic attitudes that accompany these pronatalist norms of compulsory motherhood, critiquing the restrictive gendered roles and feminine ideals about appearance and domesticity that underpin these sexist attitudes:

We always get that good old image of you know, being, being the goal of every woman is to have kids and *even if she doesn't know, she'll know one day. She will figure it out. One day she'll want kids, like we, you know, that whole image that we are supposed to be thin, and cute, and nice, and have nice hair, and no career* [Kristine]

Like Kristine, Katie never wanted to have children, but felt she was “kind of brainwashed by society into thinking like children is the best thing ever in your life.” When Katie got married, however, she became pregnant, decided to keep the pregnancy and gave birth to her daughter. Despite her desire to be child-free, Katie regretted neither her decision to have a child nor her decision to get a TL. When I carefully asked Katie about how she felt about having her daughter, she took a while to respond, and then reflected that her approach to life involved adopting an “attitude” where you do your best in the face of uncertainty and unforeseen possibilities, like having a child:

And with having a child now... [sighs]... I guess you know, and not regretting it, a lot of it comes from the attitude I have you know? Life is always going to throw you curveballs and... you...and you don't have complete control of where your life is going or where your career is going and just to... accept something that ah... comes into your life... um... like a child and to do the best possible that you can do. [Katie]

In contrast, when I asked Katie about regret about her TL, she was very quick to answer that she had no regret and to assert her frustrations with a “medical system” that prevented her from receiving the procedure sooner:

No, no, absolutely not. I wish it hadn't taken so long, but that was out of my control... *I don't have any regret about that, I have frustrations with that. With the medical system.* [Katie]

She insisted that, following her TL, she became “the way she was supposed to be”, that is to say, infertile. Katie's experience having her daughter marks a distinct shift from her identity as a “child-free” woman to a “mother” and shaped her outlook on regret following her TL. I interpret Katie's absence of regret here as a reconciliation of her experiences and her identity before and

after she had a child. Katie's story, similar, to Cathy's, places regret in conversation with ideas of personal identity (i.e., child-free, motherhood, womanhood) and the transience of these identities over time.

In their narratives, the women in my study provided several reasons as to why they did not regret their TLs, including being certain that they never wanted children in the first place, ongoing financial constraints, and not wanting to experience more miscarriages. For example, Joy, who received TL following several miscarriages, a difficult pregnancy, and the birth of her son recalled that, even if she and her husband might want more children, they could always adopt, suggesting that she doesn't connect her identity as a mother to her ability to bear biological children:

Me and my uh husband discussed it um saying, you know, if we did want more kids there's you know we could adopt there's plenty of children out there that need good homes. But we decided that uh that my health the health of the baby isn't worth...you know...and it uh stress and pain that you go through when you having miscarriages after miscarriages [Joy]

Some of the other women's reasons for not regretting their sterilizations were rooted in financial reasons and time constraints that would be impossible to handle if they had more children. Annie, for example, responds that she would doubt her decision to receive TL if she were to "win the lottery" or be able to "hire a nanny", thus suggesting that her decision for sterilization was financially driven and not necessarily a result of her desire to stop having children:

Researcher: I'm wondering if at any point when you know, you were waiting for your TL if you've ever reconsidered or doubted your decision?

Annie: No! Nope! Never doubted it, unless I won the lottery! [laughs] I could hire a full-time nanny? Nope! We never doubted it. Um... Ah... Yeah... I knew I wanted it like I said pretty much ow! Excuse me! As soon as we knew we were having a healthy baby and we knew it was a C-section I said yup! Yup! Yup! Let's, let's get it done and I don't regret it. And I didn't regret it...or have any doubts during that time. [Annie]

When asked about whether she regrets her TL, Mary replied that she doesn't regret her TL and explains how "crazy" her situation already is with two children, especially during the pandemic as she home-schooled her kids while also working as a teacher:

Nooo! I'm home schooling my own children, I definitely do not regret (laughs) [...] It's crazy! It's crazy, my kids are 7 and 4 and I'm actually currently also a teacher and it's.... it's like teaching them...sorry, getting them to a computer and teaching my own kids and... running around the house like a chicken, I can't imagine having 3 or 4 kids at home trying to do that at the same time. [Mary]

Mary's story illustrates the ways in which the constraints presented by the pandemic intensified women's reproductive labour (Cohen & van der Meulen Rodgers, 2021) as she struggles to homeschool and care for her own children while also performing her duties as a teacher. In this way, by ending her reproduction through TL, Mary was also able to manage the reproductive labour associated with childrearing.

One of the women I spoke to, Rebecca, was never approved for TL even after several requests. When I asked her about whether she regretted spending so much time pursuing TL she responded that she didn't and her decision to be sterilized crystallized even further every time she was denied; with every subsequent denial, she became more and more certain that TL was something she wanted:

I think regardless.... I think regardless of me asking and not receiving I know that every time I asked, I became more sure that this was what I wanted so it really made me like, like, certain and made me become more certain and more certain that when I want something I'm allowed to request things so like as time went on, no this IS what I want, this IS what I'm after, whatever, it happens to be. [Rebecca]

Similarly, despite being child-free, Rebecca didn't change her mind about children as she was repeatedly denied TL, but rather became even more certain that this was the right choice for her. While Rebecca has successfully avoided pregnancy without being sterilized, she continues to seek TL as means of ending her reproductive years. This suggests that TL is more than a

permanent contraceptive method and can be a way for other child-free women, like Rebecca, to affirm their identities as child-free women.

Chapter 7

7 Discussion

The purpose of my doctoral work was to explore women's experiences requesting and receiving TL in relation to broader discourses of pronatalism and medical sexism. Guided by the conceptual frameworks of reproductive justice, relational autonomy, reproductive labour, and health work, and using a critical narrative methodological approach, I collected and analysed interviews with fourteen women and constructed five narrative threads that situated women's requests for TL within their complex reproductive histories and their decisions about TL within intimate, familial, and medical relationships. These narrative threads illuminate the complexities of women's experiences of requesting and receiving TL and challenge current biomedical constructions of post-sterilization regret. They also highlight the labour that women engaged in to request and receive TL and exercise their reproductive autonomy to ultimately cease their reproductive capacity.

In this chapter, I put my findings in conversation with the conceptual frameworks of reproductive justice, relational autonomy, health work and reproductive labour to further interpret and explore my findings in relation to broader social discourses about pronatalism and medical paternalism. As well, I discuss how my findings contribute to and challenge the existing research on voluntary TL (Chapter 2) and articulate the implications of my research for women's reproductive healthcare. I begin by discussing the ways in which my findings extend understandings of women's reproductive labour to include the labour involved in information gathering and in self-presentation by expanding on Mykhalovskiy and McCoy's (2002) notion of health work and Goffman's notion of identity management, respectively. Then, I highlight the ways in which my findings contribute to the existing body of literature on TL by challenging the current medicalized conceptualizations of post-sterilization regret. In so doing, I illuminate the meanings that my participants attributed to their sterilization through their narratives. I then discuss how my narrative methodological approach contributes to scholarly discussions about VTL by centering women's perspectives and creating rich and nuanced understanding of their experiences of requesting and receiving TL. Using this approach, I was also able to explore the ambivalences and seeming contradictions of women's feelings towards TL and complicate

existing constructions of post-sterilization regret by exploring the relationship between identity, autonomy, and sterilization decisions and drawing attention to the medical institutional discourses that shape TL approvals and denials. I conclude by exploring the relational nature of reproductive decision making and how women exercise medicalized agency to achieve their unique reproductive goals.

7.1 Entrenched Normalization of Women's Reproductive Labour

The narrative findings of my doctoral research extend the notion of reproductive labour by drawing attention to the work that my participants engaged in to manage and end their reproduction. Requesting and receiving sterilization included multiple forms of reproductive labour, often in response to institutional failure to provide women with the information and support they need to make informed reproductive health decisions. As the participant narratives and narrative threads illustrate, this labour included seeking and gathering information about TL, attending medical appointments to request TL, presenting and advocating for oneself to optimize one's chances of TL approval, and advocating for the reproductive freedoms of others by informing other women about TL. The reproductive labour associated with information seeking and gathering, specifically, was often assumed by women who described their healthcare providers as failing to provide adequate information about TL as well as referrals to other healthcare providers for sterilization. As well, much of the narrative space in my interviews was dedicated to describing the forms of labour that women engaged in to get approved for TL. Often, women recounted this labour without questioning why they had to engage in this sort of work. This is suggestive of the way that reproductive labour, generally, and the labour associated with contraception management, specifically, is normalized for women, and is deeply engrained in their everyday lives.

These findings illustrate the extensive work that is required by women to access TL and extend an understanding of how contraceptive and fertility management is socially normalized for women as a form of reproductive labour. As others have noted, women typically assume responsibility for managing contraception in heterosexual relationships. This labour includes attending medical appointments, selecting the right contraceptives, and paying for contraceptives

(Kelly et al., 2017; Lowe, 2005). Women also bear the health-related consequences of contraception, including unwanted side-effects of hormonal birth control, and the anxiety and work associated with managing unplanned pregnancies (Campo-Engelstein, 2012; Kimport, 2018). Even when women desire to get pregnant with the assistance of reproductive technology, they are often responsabilized for ending infertility treatment when such technology repeatedly fails (Carson, 2019; Carson et al., 2021).

Similarly, normative assumptions about women accepting responsibility to engage in labour required for TL were revealed in the ways that the study participants talked about their decisions about sterilization in relation to their husbands and intimate partners. This was suggested, for example, in the ways they described TL as something that “just made sense” for them and as “sparing” their hesitant or unwilling partners from receiving a vasectomy. For example, Mary made the decision to be sterilized to spare her husband of having to undergo surgery and Rachel kept an unplanned pregnancy so that she wouldn’t “deny” her partner the chance to have a biological child despite already having two stepchildren. Similar to research on the emotional labour women engage in to “convince” their male partners to use contraceptive options (Kelly et al., 2017; Kimport, 2018; Lowe, 2005), my findings show how women manage their emotions and expectations about their partners through the responsibility they assume for sterilization.

7.1.1 Building Informal Networks of Care Through Reproductive Labour

Another form of reproductive labour that occupied much of the narrative space in many of the interviews was the labour the women assumed to gather information about TL, suggesting a further responsabilization of contraceptive management. For example, many of my participants conducted their “own research” in lieu of being provided with sufficient medical guidance. This resembles Mykhalovskiy and McCoy’s (2002) analysis of how HIV-positive patients were responsabilized for managing their diagnosis and treatment despite numerous existing structural barriers that prevented them from doing so effectively. Similarly, the women in my study compensated for medical failure to provide accurate and updated TL information by gathering TL stories through their immediate social networks and online communities. The labour associated with their information seeking/gathering was extensive and involved seeking out sterilization information across various sources such as social media, online searches, and

through their social networks of friends and family. This form of independent information gathering is prevalent and has also been observed in other areas of reproductive health, for example, by pregnant women looking to learn more about fetal development, nutrition, and childbirth (Bjelke et al., 2016; Grimes et al., 2014; Sayakhot & Carolan-Olah, 2016).

By engaging in these forms of information gathering and dissemination through the collection and sharing of their experiences and stories, the women in my study can be perceived as participating in informal networks of care to compensate for the shortcomings in their reproductive health care and respond to the pronatalist assumptions that shape these service gaps (Carmone et al., 2020). To make decisions about ending their reproduction, my participants drew on these informal spaces to learn more about TL from others' lived experiences and, in turn, contributed to these spaces by sharing their own experiences and advocating for others. Interestingly, and in keeping with Sherwin's (1998, 1999) assertions that autonomy is situated in relation to others, these findings highlight the ways that women challenged individualized frameworks of autonomy and decision-making by turning to their communities to make their own reproductive decisions and to support others in their reproductive decision-making.

Interestingly, these informal networks of information sharing resonate with women's health movements of the 1960s, 70s, and 80s that advocated for greater participation of women in all levels of healthcare (Boscoe et al., 2004). These informal networks were mobilized to challenge the notion of women's health as a "neutral" and apolitical topic, and emphasized gender as a central determinant of health. However, contrary to women's health movements, my participants generated these informal networks of information to realize their autonomy and not to mobilize collective social action as previous movements have done.

7.1.2 Leveraging Class and Reproductive Fitness Assumptions Through Self-Presentation

The stories about the labour involved in self-presentation further illuminated the ways in which pronatalist discourses shape medical encounters and create barriers to sterilization, especially for child-free women. This labour included strategic forms of self-presentation to achieve TL approvals. In many instances, self-presentation labour happened in medical settings where

women had to navigate the power imbalances between them and their doctors. In this sense, my participants engaged in what Erving Goffman describes as “impression management”, that is, the performance and negotiation of one’s identity to shape others’ impressions of them (Goffman, 1990). For example, three of my child-free participants (Kristine, Natalie, Miley) engaged in impression management to present themselves in ways to convince their healthcare providers that they could be trusted to make important decisions about their reproduction, including sterilization, and were thus deserving of reproductive autonomy. Some of these narratives clearly suggest how women feel compelled to present to their doctors an image of respectability associated with their social class by demonstrating their economic success, symbolized by their income, education, and achievement of traditional economic and social milestones, such as occupation, home ownership and marriage (Natalie, Kristine). In this sense, these child-free women’s narratives echo Sherwin’s (1998) insight about the illusion of personal agency for privileged women who, because they are “taught that they need only to apply themselves in order to take advantage of the opportunities available to them, most learn to think of their successes as self-created and deserved (p. 25)”. Hence, by presenting their economic successes, both Kristine and Natalie positioned themselves as “deserving” of autonomy that is unbounded and unconstrained. However, despite their attempts to present themselves as economically successful, these participants were denied sterilization repeatedly.

Stories about self-presentation from my child-free participants also draw attention to the ways in which women position themselves as competent decision-makers in relation to classist, ableist, and sexist imaginings of reproductive fitness. These findings further suggest that women seeking to realize their reproductive autonomy have a very limited range of discourses available to them to support their positionings, thus reinforcing stratified visions of reproduction. For example, while Natalie and Kristine strived to present themselves as responsible through references to their social class (e.g., job, home ownership), Rose’s narrative suggests how she had to present herself as unfit for motherhood (“crazy”) in order to be approved for TL. Her story provides insights into the ways in which eugenic discourses about who is fit to reproduce circulate in and through medical encounters and animate women’s understandings of who is more likely to be granted permission for TL. Notably, Rose recalled that once she positioned herself as “crazy” she was granted TL without experiencing any further barriers. In a similar way, another participant

(Miley) recalled being approved for TL after she disclosed her polyamorous relationship to her doctor. Thus, in contrast to Natalie and Kristin who narrated their competence in decision-making and reproductive autonomy through their appeals to social class (and who were repeatedly denied TL), Rose and Miley's narrations suggest that they were granted reproductive autonomy and their wishes for sterilization once they engaged in forms of self-presentation that positioned them as unfit for responsible motherhood. These narratives are reminiscent of the ways in which TL's eugenic history continues to animate women's narratives of their efforts to secure TL, a history whereby thousands of women who were deemed "unfit" to have children (i.e., disabled, poor, mentally ill, racialized, and unmarried) were subsequently sterilized (Amy & Rowlands, 2018; Ladd-Taylor, 2014; Lopez, 1998; Novak et al., 2018; Page, 2019).

In contrast to the stories of these child-free women who felt they had to prove themselves as deserving of TL (either by narrating themselves as competent decision-makers or as incompetent and unfit mothers), the study participants who were already mothers and who sought TL (or were offered TL) to end their reproductive histories were generally met with little resistance when they requested TL and did not narrate their medical encounters as requiring them to engage in the labour of self-presentation in order to have their autonomy realized. This suggests that healthcare providers' decisions about sterilization are shaped by pronatalist discourses in ways that approve sterilization for women who have already fulfilled their motherhood roles. Furthermore, I argue that the denial of TL to child-free women is enacted as a disciplinary action for exercising their autonomy in ways that resist dominant pronatalist norms. By denying access to TL, healthcare providers discipline child-free women to accept their procreative roles as mothers, in the paternalistic guise of protecting them from future regret, by allowing them the opportunity to "correct" their misguided intentions and behaviours. The consequences of these TL denials are twofold. First, child-free women are kept reliant on other forms of contraception even when they experience significant physical and psychological side-effects. Second, it increases the extensive reproductive labour that child-free women engage in to be sterilized. As such, child-free women's counter-narratives illuminate deeply entrenched pronatalist and paternalistic discourses that inform medical denials of TL as well as the harms associated with these denials.

These findings expand on existing discussions about reproductive justice (Roberts, 2015; Ross & Solinger, 2019) by making visible the range and extent of reproductive labour that women engage in to end their reproduction through the use of TL and to resist the pronatalist discourses (such as medicalized constructions of regret) that constrain their reproductive autonomy. In illuminating the various forms of labour the women must do to exercise their reproductive autonomy and have it recognized by medical authorities, these narrative findings also raise questions about women's access to reproductive healthcare services in Canada. This was particularly pronounced in the stories from the participants in the Maritimes and Alberta who experienced difficulties accessing abortion and other reproductive healthcare services. These stories raise questions about reproductive healthcare availability in the Canadian context and suggest that the impact of pronatalist discourses take shape differently as they filter through territorial healthcare management. For example, the clause of "conscientious objection" based on religious beliefs has been used by healthcare providers in Alberta to significantly reduce the reproductive healthcare services they provide (Stevenson, 2017). right that is often constrained through medical paternalism.

As such, these discussions go beyond a consideration of reproductive rights, which focuses on upholding women's individual reproductive freedom through the legal system. Rather, by applying the relational autonomy and reproductive labor frameworks to my research, I was able to explore the ways in which reproductive decisions and the ability to exercise reproductive freedom moves beyond the individual. Specifically, I was able to illustrate how women's pursuits of TL are shaped by and embedded within their relations with family (partners) and friends and constrained by broader social discourses of pronatalism. Additionally, I was able to situate the desire to remain child-free as an under-researched reproductive right that is often constrained through medical paternalism.

7.2 Challenging Current Biomedical Constructions of TL

The counter-narratives elicited during this study challenge the individualized biomedical constructions of TL by situating TL decision-making within the context of women's complex reproductive histories and within broader discourses of pronatalism and medical sexism. Within this body of literature on VTL, most of the research focuses on TL success rates and the safety of

the procedure as well as discussions of possible secondary health complications in the form of “post-sterilization syndrome” (e.g., Cibula et al., 2011; Gentile et al., 1998; Harlow et al., 2002; Howard et al., 2017; Jahanian Sadatmahalleh et al., 2016; Kelekçi et al., 2005b; Lethbridge, 1992; Madsen et al., 2015; Nichols et al., 2013; Shobeiri & AtashKhoii, 2005; Shreffler et al., 2016a; Ylikorkala, 2001). This lack of attention to the complex dynamics involved in accessing TL is reflective of the post-positivist assumptions that inform most TL research and the reliance of this research on structured surveys and statistical analysis. As I reviewed earlier, much of the qualitative research that is available is also conducted from a post-positivist position in the sense that it is not informed by an explicit theoretical framework and relies predominantly on thematic analyses to generate descriptive research findings of the barriers women face when requesting TL. The current study expands this body of research to consider how women exercise their reproductive autonomy, negotiate reproductive expectations, and form their identities through their experiences requesting and receiving TL and in relation to institutional discourses of pronatalism and medical sexism.

7.2.1 TL as Negotiating Reproductive Expectations.

The findings of this narrative study provide insights into how TL was a preferred means for women with children to end traumatic reproductive histories and to negotiate the sort of families they wished to have. These stories are suggestive of how TL was used by my participants in complex ways to shape and manage reproductive expectations and complicate the reductionist understanding of female sterilization a simple and safe surgical procedure reserved for women who have achieved their desired family size. This reductionist understanding was countered by narratives that contextualized decisions to pursue TL against a backdrop of multiple miscarriages before achieving desired number of children. For these women, TL was a means of ending reproduction and of sparing themselves and their partners from the potential for future emotional and physical damage associated with miscarrying. My narrative methodology thus brought into light the ways in which some of the women’s decisions about TL are embedded within their embodied knowledge of suffering associated with miscarriages and experience of the pain and recovery associated with childbirth. By using a narrative methodology, I was also able to incorporate this embodied knowledge into my analysis by allowing stories about pain and

childbirth to inform my interpretations of these stories. These findings regarding TL as a way to cease and manage future reproductive trauma in my participants' narratives were also informed by my sample of study participants, many of whom were members of the Obstetric Justice Network, an online group for obstetric violence survivors.

For the participants in my study who were already mothers, TL was at times positioned as something they did for themselves and as a reclamation of their body. Because they already had children, these women were ready to move on to the next "chapter" of their lives, where they could focus on personal growth and ambition such as career goals. This was the case for Rachel and Mary whose counter-narratives challenged the pronatalist assumptions that childbearing and motherhood are the penultimate goals for women and instead used TL to transition into a different phase of their lives where they could prioritize their own wellbeing without the constant worry and work of managing their reproductive capacity.

The stories from my research also indicate that TL was used by some women to attain a desired family size and was informed by the women's family histories and patterns in their upbringing. In this sense, women used sterilization not only to prevent future unwanted pregnancies, but also to guarantee a specific experience of childhood and family for their children, which was illuminated in their stories about their own childhood experiences of feeling overlooked (e.g., because they were the middle child (Mary)). These examples illustrate the ways in which women made their reproductive decisions relationally, relying on their previous experiences of family and their own upbringing.

Finally, for the child-free women in the study, TL was used as the ultimate resistance to the pronatalist values and as a way to enforce their own reproductive expectations. These women spoke at length about how they were unwilling to compromise their personal fulfilment by having a child. Several of my child-free participants (Rose, Kristine, and Katie) terminated unwanted pregnancies to retain their child-free status, demonstrating an unwillingness to adjust their reproductive expectations according to the constraints imposed by medical denials of their TL requests. For example, Kristine terminated an unplanned pregnancy because she was unwilling to compromise a career opportunity that arose during the same time she found out she was pregnant. Kristine admitted to me that while she could have balanced both a pregnancy and

her career in the long-term, given her social supports and her stable financial situation, she simply was not interested in having a child and passing up on the immediate career opportunity.

7.2.2 TL as Resistance to the Hormonal Imperative

The findings of this study also provide rich illustrations of the ways in which women voluntarily pursued TL as a challenge to the hormonal imperative of birth control. In light of Tone's (2012) work on the normalization of hormonal birth control in the 1960s due to its simplicity and efficacy, the current findings draw attention to ways in which my participants did not experience hormonal contraceptives as simple, convenient, nor efficacious and often challenged the hormonal imperative by seeking sterilization. As many of the stories in this study suggest, TL is positioned as directly challenging the hormonal imperative of women's contraception and as additionally relieved women of the labour of managing their contraception in the future.

These stories of resistance to hormonal contraception were prevalent among the child-free women in this study and often focused on their views that hormonal birth control was an unnecessary and often ineffective means of remaining child-free. Some of the women countered the hormonal imperative by positioning sterilization as an effective way to reduce the amount of reproductive labour they had to engage in to manage their reproductive lives and realize their reproductive autonomy. In this way, my findings expand an understanding of how the hormonal imperative permeates women's reproductive decision-making and autonomy by drawing attention to the labour involved in managing hormonal contraceptives and in resisting it as a form of contraception.

With rare exception, for the women who already had children, TL was the "obvious" contraceptive choice, since they were certain that they were finished with childbearing. While counter-narratives to hormonal contraception were most pronounced among the child-free women, all of the women in this study shared that they were dissatisfied with hormonal birth control at some point during their lives yet continued to take it due to a lack of contraceptive options. This was pronounced in stories that detailed long histories of negative physical and psychological side-effects from oral contraceptives, unsuccessful experiences with IUD fittings, and that spoke to the unintended pregnancies while taking hormonal birth control. In one

extreme case, Kristine attributed the removal of her gallbladder to her long use of hormonal contraceptives. As well, the women's stories about their decisions to pursue TL were often elaborated in relation to their desires to put an end to their traumatic reproductive histories and their reliance on birth control. Several of my participants experienced multiple miscarriages and had to undergo abortions to end unwanted pregnancies.

Interestingly, many of my participants expressed relief and a newfound enjoyment of sex following their TLs that they did not previously have while using hormonal contraceptives. While most participants used some form of reversible contraceptives before their sterilization, TL provided a sense of definitive wellbeing and "peace of mind" by enabling the women to avoid the physical and emotional consequences of an unwanted pregnancy. In this sense, sterilization re-introduced a degree of sexual enjoyment that was previously absent from my participants' lives. These experiences further challenge the hormonal imperative of female birth control by highlighting these unsuspected benefits of sterilization for women.

These stories additionally illustrate how women navigate their decision-making for tubal ligation in relation to powerful cultural discourses. Specifically, these experiences highlight the ways in which the hormonal imperative operates as a pervasive cultural discourse that constrains women's options in accessing other forms of non-hormonal contraceptives. The discourse of the hormonal imperative is detrimental because it greatly reduces the number of contraceptive options that are easily available to women. Furthermore, it responsabilizes women for their contraception by making more traditional methods of contraception (e.g., rhythm method, female condoms) difficult to learn and acquire and curtailing innovation in contraception options (e.g., development of male contraceptives) (Tone, 2012).

7.2.3 TL as Identity Affirmation and Disruption

The findings from my study also illustrate the ways in which TL was viewed and enacted as a form of identity affirmation. For child-free women particularly, TL was positioned in their narratives as a sure way to avoid unplanned pregnancies and thus as a way to affirm their child-free identities. Many of the child-free women effectively relied on temporary contraceptives while they waited for their TL approval yet continued to advocate for themselves (often for a

number of years) to be sterilized. Given the work that many child-free women had to engage in to be approved for TL, while repeatedly being denied the procedure by medical professionals/gatekeepers, I expected that the child-free women in my study might express regret about their decisions to pursue TL. In contrast, the narratives illustrate how child-free women grew more certain that TL was the right decision for them the more they pursued (and were denied) the procedure. All of the child-free women described the importance of sterilization as a means to align their reproductive capacity with their desired identity. In this sense, their decisions to pursue TL went beyond preventing unwanted pregnancies. Rather, receiving TL held specific meaning for them as it signified a recognition of their bodily autonomy and their desires to affirm their self-understanding and become the way they were “supposed to be”; that is to say, infertile.

As well, my narrative methodology allowed me to elucidate the ambivalences and seeming contradictions of some of the women’s narrations of identity that are typically rendered invisible in descriptive, post-positivist qualitative research. Katie’s story, in particular, provides a telling example of the complex relationship between TL and identity affirmation. As the sole participant in my study who identified as child-free and who also had a child, Katie’s story challenges pronatalist discourses by disentangling culturally engrained ideas of womanhood from fertility. By positioning TL as a means of reconciling her current identity as a mother and her identity as someone who never desired to have children, Katie’s story echoes Richie’s (2013) argument that “the feeling of making a commitment to a lifestyle through a permanent procedure [i.e., sterilization]... can be essential to self-identify, satisfaction, and peace of mind” (Richie 2013, pp. 38-39). Hence, while Katie was already a parent and did not regret having a child, acquiring TL was simultaneously a way to reaffirm her child-free identity and reclaim her bodily autonomy.

In their narratives, child-free women also connected their decision-making about TL to other aspects of their identities. For Natalie, remaining child-free was positioned as a moral extension of her politically-motivated, eco-friendly, “waste free” identity, which she enacted through specific lifestyle decisions, such as not owning a car and working as an environmental policy analyst. For Miley, remaining child-free supported her polyamorous relationship in which none

of her partners had nor wanted children. Thus, in these ways, the decision to be sterilized was shaped by the women's desires to demonstrate their commitments to a range of identities and lifestyles, including being child-free.

The critical stance of my research also allowed me to examine how one participant experienced a marked disruption of identity following her TL. Cathy, who experienced intense regret following her TL, felt that she had become "less of a woman" because she was no longer fertile. Her experience of disrupted identity illustrates the ways that internalized pronatalist discourses that conflate femininity, fertility, and womanhood can negatively impact women's identities, which I explore further in the following section. However, after some time and support from her husband and close friends, Cathy was able to reconcile her new identity as an infertile woman. In this way, Cathy's experience demonstrates how identity and its relation to fertility can be transient and subject to change.

7.3 Challenging Current Conceptualizations of Post-Sterilization Regret

My findings contribute to the existing body of literature on TL by providing detailed and nuanced understandings of the meaning that women attribute to TL and the reasons for seeking sterilization. By addressing the ways in which women attributed meaning to TL and constructed their identities in relation to TL, my narrative findings facilitate an important discussion about the ethics of TL approvals and denials, both for child-free women looking to affirm their identities and for women looking to end their childbearing years and traumatic reproductive histories. In this way, my findings suggest that TL denials can subject both child-free women and women with children to greater reproductive harms than TL approvals and subsequent sterilization. While post-sterilization regret is often cited as the primary reason for TL denials (Ehman & Costescu, 2018b; Kelekçi et al., 2005a; Mertes, 2017a; Moore, 2021; Serrano Cardona & Muñoz Mata, 2013; Shreffler et al., 2015a, 2016a), my work illustrates that the notion of regret is more complicated than its current conceptualizations. My findings suggest that denials rooted in the notion of post-sterilization regret can simultaneously deny women their reproductive autonomy and expose them to greater physical and emotional consequences of experiencing unwanted or difficult pregnancies.

The stories from my doctoral work challenge the construction of post-sterilization regret, which is currently represented in the biomedical literature as a condition that should be avoided (Curtis et al., 2006; Hillis, Marchbanks, et al., 1999; Jamieson et al., 2002; Platz-Christensen et al., 1992; Shreffler et al., 2016b). In contrast to this medicalized construction, regret rarely appeared in my participants' narratives even when I probed them directly with questions about regret. Only one participant (Cathy) expressed regret during the interviews. Interestingly, and as I explored in the previous section, for Cathy, regret was storied in relation to the loss of her fertility that she closely attached to her experience of femininity. As well, Cathy's regret stemmed from the loss of bodily autonomy she experienced during the sterilization procedure, which was conducted during a C-section. Counter to assumptions that inform current constructions of post-sterilization regret, Cathy did not story her experience of regret in the desire to have more children, and quite often she reminded me that she was happy with her family size. However, the regret and "grief" for her lost fertility and femininity persisted for several years after her TL.

This experience draws attention to the ways that pronatalist and sexist discourses that conflate femininity with childbearing, fertility, and the overarching notion of womanhood restrict women's identities and worth by rooting them in essentialized narratives of women's procreative capacities. As such, Cathy's decision to put an end to her fertility challenged her ideas about her femininity as she closely identified her femininity with her fertility. This essentializing effect of pronatalism was also evident in the narratives of participants who expressed regrets about not being sterilized sooner and who felt "brainwashed" by society, as was the case with Katie when she went through her first pregnancy despite never wanting a child. While Katie recalls that she is happy with having a daughter now, in hindsight she believes that the only reason she did not terminate the pregnancy was because from a very young age she was conditioned to believe that having children was "just something you did".

Additionally, my findings provide empirical grounding for the critical theoretical work undertaken to examine the ethics of TL denials, specifically for child-free women (Campbell, 1999; Ehman & Costescu, 2018a; McQueen, 2017; Richie, 2013b). Specifically, the narratives from my research illustrate how many women were cognisant that they may come to regret their

sterilization decisions later in life; however, they were also certain that sterilization was the best decision for them. These reflections are indicative of the introspection that women often engage in before seeking sterilization, which McQueen (2020) argues should be the primary prerequisite to being approved for TL as it demonstrates the competence necessary to consider the potential consequences of sterilization. This introspection was glaringly apparent in my participants' narrations of how TL provided them with the means to reclaim a sense of their bodily autonomy, which had been threatened by their former experiences with multiple miscarriages, by avoiding the possibility of pregnancy and difficulty of carrying a child to term. In this way, sterilization increased my participants' well-being by reducing their worries about future reproductive trauma and reclaiming their bodily autonomy. These narratives also challenge the paternalistic view that informs medicalized notions of risk for regret in which women are assumed as in need of medical protection from an undesirable future and highlight the ways in which women thoughtfully consider such potential outcomes in their reproductive decision-making.

These findings also align with Richie's (2013) argument that regret "is a competent women's burden" (p. 39) and that the possibility of post-sterilization regret should not be used as a justification for sterilization denial. As well, McQueen's (2017) arguments for women's rights to sterilization as a form of permanent contraception focus on valuing women's present desires over the possibility of future regrets. This position was reflected in some of the women's narratives when they clearly articulated how, even though they may grow to regret their TL in the future, sterilization was the right decision for them. As Rose's narrative suggests, for child-free women especially, the possibility of future regret may be inconsequential as compared to the possibility of having a child that they did not want or having to undergo future abortions to terminate unwanted pregnancies, which many of them had undergone in the past. As well, for women who were looking to receive TL to end their traumatic reproductive histories, sterilization itself was a means of "sparing" themselves from future trauma.

7.4 Exercising Medicalized Agency to Uphold and Subvert Medical Authority

As I have suggested thus far, the study findings illuminate the ways in which women engage in relational decision-making about ending their reproduction, whereby their decisions are viewed

as shaped by both immediate (i.e., family, friends) social relationships and in relation to broader social discourses (Sherwin, 1989b, 1998b). Within this relational view, my findings illustrate the ways in which women negotiated and navigated the use of medical means (TL) to achieve their desired reproductive goals. Most of the co-constructed narratives presented in this thesis demonstrate the ways in which women sought and relied on TL as a medical intervention to exercise their reproductive autonomy, either to end their reproduction or to prevent it altogether. These research findings challenge the individualistic model of autonomy by drawing attention to the ways in which women's reproductive decisions are made relationally, and are informed, enabled, and constrained by pronatalist discourse, personal ideologies (e.g., zero-waste lifestyle), and the influence of information networks and informal social networks of care (e.g., lived experiences of family and friends).

These findings illustrate the ways in which women exercised “medicalized agency” (Morgan, 1998), in which they actively internalize and negotiate medical technologies, language, and discourse in order to enact their reproductive autonomy. As such, many of my participants often used medical jargon in their interviews in a way that signaled their familiarity with this highly specialized terminology. For example, Mary proudly introduced the term “designer baby” to explain the circumstances under which she would have another child following sterilization and to explain the intricacies of genetic manipulation and the ambivalence she felt towards this form of medical intervention. Most of the participants also talked about how they willfully accepted medical interventions in the form of C-sections, with some even electing to have a C-section without the explicit suggestion of an obgyn.

In keeping with this notion of medicalized agency, my participants' stories illustrate how women exercised their reproductive autonomy through an active negotiation with medical discourses and were provided with multiple, but always medical, options as part of their reproductive health care (e.g., hormonal contraceptives, IUDs, induction, C-sections). When women exercise their medicalized agency in ways that are consistent with existing discourses of personal responsibility, control, self-management, self-determination, and medical authority, they become what Tasha Dubriwny (2013) calls “the vulnerable empowered woman” whose autonomy is encouraged as long as she embraces medical interventions and medical authority and the

traditional gender roles that these endorse (Dubriwny, 2012). However, when these same women adopted less medicalized views of their reproductive health, such as when child-free women pursued sterilization and women with children explored non-medicalized options for pregnancy and birthing (i.e., doulas, midwives), they were met with scrutiny.

Interestingly, resistance to medicalized views of contraception, and to pronatalist views of women, was also achieved through my participants' desires for medical, technocratic intervention in the form of sterilization. In this way, my findings extend the understanding of how medicalized agency can be exercised to achieve non-medicalized ends and subvert the power of medicine in reinforcing pronatalist agendas. While Dubriwny (2013) argues that, by exercising medicalized agency women inadvertently reinforce biomedical norms and, in the case of this thesis, responsibility for reproductive management, my findings suggest that women pursue TL to subvert medical authority over their reproductive lives. This is especially pronounced in the stories of the child-free women who leveraged medical means (sterilization) and discourse to secure their own non-medicalized ends (remaining child-free). These findings challenge the individualistic frameworks of autonomy and also illustrate the ways in which women can exercise their medicalized agency to uphold, subvert and resist medical authority to make reproductive decisions that are "best for them".

7.5 Strengths and Interpretational Boundaries

There are several strengths to this study both in regard to its methodological approach and in its methods of data collection. First, by using a critical narrative methodology, I was able to elicit rich narratives of women seeking and receiving TL, an area that has yet to be reflected in the scholarly literature on sterilization, and contextualize these narratives in relation to broader social discourses of pronatalism. Notably, the inclusion of child-free women in my sample creates the first qualitative empirical study of child-free women's experiences of sterilization to the best of my knowledge. The critical component of my narrative methodology allowed me to situate the women's stories of requesting and receiving TL in broader social and institutional discourses and interpret their meaning through a theoretically grounded analysis. Second, my

study sample included women who sought out TL for different reasons and whose stories illuminated the diversity in their range of experiences requesting and receiving TL. In this regard, the sample included women who sought sterilization to remain child free and women who wished to put an end to their reproduction after having children. By exploring this range of experiences, my findings challenge notions of TL as a simple and isolated surgical procedure as it is often depicted in clinical literature, and the homogenous portrayal of TL experiences. As such, I generated findings that explored the complexities and tensions of requesting and receiving TL, and contribute to the literature by expanding our understanding not only of TL, but also of how women make reproductive decisions and the labour associated with this decision-making and approval.

My study sample also included participants from different Canadian provinces, which lends insight into how personal experiences of requesting and receiving TL can be shaped by provincial healthcare policies. By extending my recruitment strategy to include women who resided throughout Canada, these findings shed light on how women's experiences of TL were shaped by access to reproductive healthcare in different regions. While universal healthcare theoretically provides access to healthcare services across the country, in reality, access and availability of these services are often constrained. This was reflected in the narratives of two of my participants who resided in Alberta and New Brunswick, respectively, and who faced barriers in accessing abortion care.

There are several interpretational boundaries to my research. First, the findings of this study are bound by my own interpretations of the participant narratives and the analytic lenses I used for my analysis: reproductive justice, relational autonomy, and reproductive labour. Future research may examine experiences of requesting and receiving TL through other analytic lenses and produce different interpretations of the data. Second, because my study sample was limited to the TL experiences of women residing in Canada, it did not reflect the realities and complexities of women's reproductive healthcare in countries without universal healthcare or with different arrangements of universal health care (e.g., United Kingdom which has a nationally and not a regionally organized healthcare).

Because I did not use a demographic questionnaire to assess my participants' social identities, my interpretations are bounded by the ways in which the participants narrated their identities in the context of the interview situation. This was a deliberate decision made in consultation with the thesis advisor and with an expert in narratively based health research. This approach allowed my participants to story aspects of their identities in ways that they felt were most salient and important to their experiences of TL. For example, in contrast to structured definitions of social class typically included on demographic questionnaires, as operationalized through socioeconomic status, education, and/or occupation, markers of class position and economic privilege were narrated through references to occupation (e.g., policymaker, journalist) and hobbies (e.g., traveling to remote locations). In the women's narratives, alternative or non-normative social identities (e.g., women's references to being "polyamorous" or an "environmental warrior") were often presented as motivations for remaining child-free. For example, Natalie justified her decision to remain child-free as "the most environmentally friendly thing to do". None of the participants narrated themselves as marginalized in relation to ethnicity, race, Indigeneity, or disability, suggesting that they likely occupy dominant social positions along these axes of difference. Because the goal of critical, interpretive qualitative research is not to generalize specific findings to entire populations, the purpose of this study was not to correlate women's narratives with external demographic information. While this information may have been helpful in quantitative studies, it may have also detracted from the ways in which narrative data is interpreted by constraining the ways that women can choose to narrate their identities in relation to their TL experiences.

7.6 Implications for Future Research and Reproductive Healthcare

Building on the methodology employed in this study, future research would benefit from taking an explicitly intersectional approach in both recruitment and analysis. Specifically, critical narrative approaches that center the perspectives of marginalized and racialized women who request and receive TL voluntarily would help illuminate the ways in which these women make decisions about ending their reproduction and how these decisions are shaped by broader social discourses. Currently, the perspectives and lived experiences of disabled, poor, and queer/non-

binary persons are largely missing from scholarly literature on VTL and the perspectives of racialized women are rarely discussed outside of forced sterilization and provide an important and timely avenue for exploration.

My findings demonstrate that, despite the presence of universal healthcare, many of my participants still experience barriers to accessing TL. An exploration of how reproductive healthcare is accessed across different Canadian provinces would be of value, specifically with emphasis on how TL is restricted through medical gatekeeping. Building on that, critical narrative methodologies can be a fruitful approach to explore healthcare practitioners' experiences providing reproductive healthcare, and their experiences of and decision-making about TL approvals and denials. By placing healthcare providers' narratives about TL access within broader discourses of pronatalism, racism, classism, and ableism, researchers can gain a deeper understanding of how implicit institutional discourses shape healthcare providers' decision making, and how these directly impact women's reproductive health experiences, outcomes, and medical encounters.

Future investigations into the labour women must take on to compensate for lack of medical support and comprehensive information can similarly build on the notion of health work in order to identify invisible barriers to accessing healthcare. The findings from this study illuminate the ways in which women engaged in various forms of labour to request and receive TL. Given the overall dissatisfaction with current contraceptive options described by most of my participants, future work can also examine women's experiences with using temporary contraceptives through a critical narrative methodology and can shed light on the labour associated with these contraceptive health regimes.

My findings also suggest that institutionalized pronatalist, sexist, and classist discourses shape the ways in which women must navigate their decisions to pursue TL as a form of permanent sterilization. Medical institutions can benefit from creating open forums by which these institutional discourses and barriers are discussed and challenged to draw attention to the implicit biases of many healthcare providers and the barriers these present to respecting women's reproductive autonomy. The burden of reproductive labour performed by women in making decisions about TL may also be alleviated by developing institutional supports to provide them

with a variety of updated, inclusive, and comprehensive information about their reproduction. By challenging and shifting these institutional discourses and increasing access to both services and medical information, healthcare providers can be better equipped to provide equitable and non-judgmental reproductive healthcare to all their patients.

The narrative methodology of my research yields itself well to a number of media outlets for the dissemination of findings, such as podcasts and radio shows. These media outlets provide a fruitful avenue for research dissemination and social change by challenging the pronatalist discourses that currently shape women's decisions and experiences of ending their reproduction. These outlets often function as social sites for resistance of pronatalist discourses. For example, one of the ways in which discourses around childbearing are shifting, especially for child-free women, is through media content such as podcasts, created and disseminated by women who are child-free themselves (e.g., *The Child-Free Girls*) or who challenge our ideas of motherhood by providing a "real" and "imperfect" look at the realities of parenting (e.g., *One Bad Mom*). Due to their wide reach and uptake, these informal avenues for research dissemination show promise in bridging the gap between academic research and the public and align well with critical research tenet of spurring social change. Distributing the findings of this dissertation through academic journals targeted at healthcare practitioners and researchers (e.g., *Journal of Obstetrics and Gynecology Canada*) can also challenge medicalized constructions of post-sterilization regret, and begin to change the institutional discourses that govern women's reproductive healthcare and constrain reproductive autonomy.

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Appendices

Appendix A: Screening Telephone Script to Determine Study Eligibility

Participants will be screened after they indicate interest in the study in order to confirm study eligibility and to maximize variability in relation to where they are at in relation to the process of requesting/receiving tubal ligation (TL has been requested and approved but not yet received; TL was requested and denied; TL was requested and approved but was discontinued; TL was requested, approved and received).

E-mail Process:

If potential participants initially contact me via e-mail, I will respond and thank them for their interest and attach the participant letter of information and consent form (see attachment B – Email Response). At that time, if they have any further questions they will be invited to email or telephone me. Those who indicate interest in participating in the study will be asked for a telephone number where they can be reached. The following telephone script will be used to determine each person’s eligibility and to arrange an interview time.

A - General Script:

Caller: “Hi, I am calling about the tubal ligation (TL) study”

Researcher: “Hi. Thanks for calling- my name is Anna. This project is part my PhD research. Would you like some more information on the study?”

Caller: “Yes”

Researcher: “The purpose of this study is to learn more about what it’s like to request or receive tubal ligation. We are interested in hearing from people with a range of experiences related to TL. If you decide you would like to participate, you will be asked to take part in an interview that will be audio-recorded and transcribed word-for-word to ensure accuracy. Because we are interested in learning about a diverse range of experiences, these interviews will be open-ended which means that the questions are worded in way that will allow you to answer in your own words. Before any data is collected, you will read a detailed letter of information that reviews your rights as a research participant and the potential harms and benefits of taking part in the study, and you will be asked to sign a consent form indicating that you agree to participate in the study. You can refuse to answer any interview questions and you can withdraw from the study at any time. Do you have any questions?”

Caller: [caller will ask any questions they have about the study]

Researcher: [researcher will respond clearly and openly] “Does that answer your question?”

Caller: "Yes."

Researcher: "Great. Are you interested in participating in the study?"

Caller: "Yes." → see B

B- Screening Question to Determine Eligibility for those Interested in Study

Researcher: “Ok great. I first have to confirm that you are eligible to participate. Are you currently in the process of requesting tubal ligation, or have you requested or received tubal ligation in the past 5 years?”

Caller: “Yes” → Go to C

“No” .”→Go to D

C -Screening Questions to Maximize Variability in Study Sample

Researcher: “You are eligible to participate in the study. I’d also like to ask you one more question because I’m interested in speaking with people who are at various stages of their tubal ligation process. Can you tell me, at which stage of the process are you?”

Caller: [potential participant will respond accordingly]

Acceptance Script:

Researcher: “You are eligible to participate in the study. Now we can go ahead and decide on our first interview time. What day/time is best for you?”

Participant: [date/time/location is negotiated with the researcher]

Researcher: “Excellent. Before I let you go, I need to get your name and some contact information- either a phone number or an e-mail address where I can reach you”

Participant: [provides name and contact information]

Researcher: Ok great I will see you on _____(date)!

Waiting List Script:

Researcher: “Unfortunately, we cannot schedule you for an interview at this time. This is because I am trying to recruit participants who are at various stages of their tubal ligation process. I already have individuals in my sample who are at a similar stage as you and am looking for participants who are at a different stage. Would you be okay with being placed on a waiting list? I will keep your contact information on file and contact you in a month to let you know if participation is a possibility at that point. This information will be kept confidential and will be destroyed after recruitment is completed. You are also welcome to follow up with me at any time. If no participants who are at a different stage than you are recruited in the next month, would it be alright to contact you to schedule an interview?”

(if caller does not agree to be wait-listed)

“Thank you for your interest in this study. Your personal information will be destroyed.”

D - Rejection Script (if caller responds ‘no’ to eligibility question, above):

Researcher: “I’m sorry but you are not eligible to participate in the study. Thank you for your interest in this research”

Appendix B: Interview Guide

Study title: Exploring Narratives of Voluntary Tubal Ligation

Thank you for agreeing to participate in this study. As you know, the purpose of this study is to learn more about your experiences requesting or receiving tubal ligation (TL). To do this, I will ask you some open-ended questions and you are welcome to answer any way you like. In order to ensure accuracy for the data analysis, I will be audio-recording this interview. I will let you know when we start recording. There are no right or wrong answers and you are free to refuse to answer any questions that you don't feel comfortable with. You decide how much you want to share. Please also know that you can take a break or stop the interview at any time. Do you understand? Do you have any questions before we begin?

I am now going to start the recorder and begin the interview.

1. In as much detail as you can, tell me your story of requesting or receiving TL. Feel free to start wherever you want and end wherever you want – it's completely up to you. You are more than welcome to take some time to think about it before you begin.
2. What was it like to request TL?
 - a) When did you know you wanted to pursue TL?
 - b) Who did you first speak to about obtaining TL?
 - c) What reasons did you provide for requesting TL?
3. Where are you at in the process of requesting/receiving TL?

If TL was obtained:

4. What was it like to get TL?
5. What has it been like since you've received TL? How do you feel?
6. Have you ever reconsidered or doubted your decision to get TL? Can you tell me about that?
 - a) Would you say that you regret getting TL? Can you say more about that? What do you regret, specifically? What does regret mean to you in this case?

If TL was denied:

7. What was it like to be denied TL?
8. Can you describe what the process was like? How were you informed that your request was denied? What was that like?
9. What has it been like since you've been denied TL? How do you feel?

If TL was approved but never received:

10. What made you pause or stop your pursuit of TL? How have you changed your mind about TL?
11. At this point, how sure are you that you'll dis/continue your pursuit of TL? Why do you say that? Are there specific things that you are (re)considering ?

- b) Would you say that you regret pursuing TL? Can you say more about that? What do you regret, specifically? What does regret mean to you in this case?

Non-Directional Probes

That's interesting. Can you say more about that? What do you mean by that?

Thank you for taking the time to participate in this interview. Would it be alright if I contacted you in the future to briefly talk more about some of the things you've mentioned in this interview?

Participant responds.

Thank you. I am going to turn off the recorder now.

Appendix C: Guiding Questions for Participant Summaries

Demographics (if the participant has expressed any):

1. What is the participant's age, marital status, number of children, location, occupation?

Experience of TL:

1. When did the participant first begin thinking about TL?
2. Who has the participant spoken to in their pursuit of TL?
 - What information was the participant provided about TL?
 - What did the participant know about TL before pursuing it?
3. How did the participant decide on TL?
 - What is the participant's prior experience with other contraceptive options?
4. What was the outcome of requesting TL?
 - What was it like when the participant was approved/ was denied TL?
 - What reasons, if any, were provided to the participant when TL was denied?
5. What was it like to receive TL?
6. How has the participant's experience been since receiving/being denied TL?
 - Have there been any emotional or physical changes since the TL/being denied TL?
 - Have there been any changes in the participant's relationships since the TL/being denied TL?
 - Has TL impacted the participant's sex life? How so?
7. Does the participant regret TL, if so, what has it been like for them?

Other Questions:

1. How has COVID-19 impacted the participant's TL experience?

Appendix D: Initial Story Codes

1. Stories about advocacy
2. Stories about being childfree
3. Stories about being denied TL
4. Stories about community
5. Stories about contraceptive experiences
6. Stories about COVID-19
7. Stories about doubt
8. Stories about fear
9. Stories about feelings
10. Stories about femininity
11. Stories about “things that didn’t fit neatly into a category”
12. Stories about seeking information about TL
13. Stories about justifying TL
14. Stories about loss
15. Stories about medical failings
16. Stories about menstruation
17. Stories about pain
18. Stories about partners
19. Stories about pregnancy
20. Stories about pronatalism discourses
21. Stories about receiving TL
22. Stories about recovery
23. Stories about relationships with healthcare providers
24. Stories about sex
25. Stories about terminating a pregnancy

Appendix E: Ethics Approval



Date: 13 October 2020

To: Dr. Jessica Polzer

Project ID: 116310

Study Title: Exploring Narratives of Voluntary Tubal Ligation: Pronatalism, "Regret" and Reproductive Autonomy

Short Title: Exploring Narratives of Voluntary Tubal Ligation

Application Type: NMREB Initial Application

Review Type: Full Board

Meeting Date: 07/Aug/2020 12:30

Date Approval Issued: 13/Oct/2020 11:14

REB Approval Expiry Date: 13/Oct/2021

Dear Dr. Jessica Polzer

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Curriculum Vitae

Name: Anna Sui

Post-secondary Education and Degrees: University of Toronto
Toronto, Ontario, Canada
2009-2013 BSc.

The University of Western Ontario
London, Ontario, Canada
2016-2018 M.Sc.

The University of Western Ontario
London, Ontario, Canada
2019-2022 (anticipated) Ph.D.

Honours and Awards: Ontario Graduate Scholarship
2019-2020, 2021-2022

Mitacs
Postdoctoral Fellowship
2022-2024

Related Work Experience

Research Assistant
The University of Western Ontario
2019-2021

Co-Investigator
University of Western Ontario
2019-2021

Research Assistant
Parkwood Institute
2016-2018

Publications:

Sui W, Morava A, Tsang J, **Sui A**, Rhodes RE. Describing the use of behavior change techniques among the most popular home workout channels on YouTube: A quantitative content analysis. *J Health Psychol.* 2022 Feb 4:13591053221074584. doi: 10.1177/13591053221074584. Epub ahead of print. PMID: 35114825.

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