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Reconceptualizing Biomedical Paradigms for Contraceptive Care Through Feminist Poststructuralism

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Abstract

In the specificities of contraceptive care, sexual health is comprehensively defined as overall physical, emotional, mental, and social well-being related to sexuality, including experiences that are safe, pleasurable, and free of coercion. However, due to the predominance of biomedical paradigms that promote and espouse 'unbiased' and 'objective' contraceptive care practices, comprehensive, inclusive, and safe sexual health care remains limited. In this article, we argue that feminist poststructuralist knowledge is needed to reconceptualize sexual health care, ultimately promoting reproductive justice through social change and advancement of reproductive rights. We demonstrate how nursing as a discipline and profession can utilize feminist poststructuralist theoretical perspectives to challenge dominant discourses within contraceptive care and lead to the delivery of equity-owed contraceptive and sexual health care for cisgender women and people who can get pregnant.

Keywords

Feminist poststructuralism; contraceptives; reproductive justice; sexual health; equity

Contraceptive care – embedded within sexual and reproductive healthcare – is an essential contributor to health as the ability to manage one's fertility can influence education and employment opportunities, empowerment, and health outcomes among cisgender women and people who can get pregnant[1] (Society of Obstetricians and Gynaecologists of Canada [SOGC]; World Health Organization

[1] Although cisgender women have been primarily targeted as needing to manage their fertility, all genders have reproductive potential. We recognize the need for further work to unpack the gendered, sexist approach to sexual and reproductive healthcare, while still focusing on cisgender women and people who can get pregnant in this argument.

[WHO], 2025a). Contraceptives are used to manage fertility and can include short and long-acting hormonal and non-hormonal methods such as pills, patches, intrauterine devices (IUDs), condoms, and fertility awareness approaches (WHO, 2025a). The WHO (2025a) provides an often-cited, comprehensive, and nuanced definition of sexual health, consisting of "physical, emotional, mental, and social well-being" related to sex, gender, and sexual orientation, that is influenced by historical, political, religious, and cultural contexts (para 4). Sexual health includes a person's ability to have sexual experiences that are pleasurable and free of coercion and discrimination, and to be able to access equitable sexual and reproductive healthcare (WHO, 2025b). As such, we suggest that promoting sexual health, sexual and reproductive healthcare – including contraceptive care – must be equitably accessible and free from discrimination.

Western healthcare systems are grounded in biomedical paradigms positioning health and illness as oppositional binaries, reducing the body to the sum of its physical parts, and espousing 'unbiased' and 'objective' ways of knowing (Ashcroft & Van Katwyk, 2016; Crosschild et al., 2021). This grounding leads to narrow, reductionist, and risk-based understandings of sexual health, which limits the possibility for comprehensive, inclusive, and equitable sexual and reproductive care for cisgender women and people who can get pregnant – ultimately impacting contraceptive care (O'Sullivan et al., 2019; Ollivier et al., 2019). As such, the complexity of sexual health – as defined by WHO (2025a) – is often lost when addressed within Western healthcare systems, as aspects of sexual and reproductive healthcare outside of diagnosing and treating sexually transmitted and blood-borne infections and unplanned pregnancies are triaged as non-essential and therefore rendered invisible (Mitchell et al., 2021; Ollivier et al., 2019). Within biomedical paradigms, the bodies of cisgender women and people who can get pregnant are positioned as 'risky' in the behaviour (i.e., being sexually active) and in biological process (medical 'risk' associated with ovulating, menstruating, and being pregnant; Bertotti et al., 2021; Geampana, 2019; Gomez et al., 2018; Mann & Bertotti, 2024). Thus, unplanned pregnancies are medicalized as a condition that requires medical treatment. Contraceptives can be positioned by healthcare providers (HCPs) as a treatment for unplanned pregnancies, regardless of the sexual orientation, gender identity, social location, or age of those seeking care (Forsberg & Eliason, 2022; Higgins et al., 2019; Mann et al., 2022). This practice fails to account for nuances in human experiences and desires related to fertility management, instead prioritizing the use of the most effective contraceptive method above all else – including patient preference (Mann & Grzanka, 2018; Swan et al., 2025).

Considering the dominance of biomedical paradigms in structuring healthcare systems, where the provision of sexual and reproductive healthcare is situated, there is a discord between the definition of sexual health provided by the WHO (2025a) and the provision of contraceptive care, where cisgender women and people who can get pregnant experience inequities due to healthcare encounters that are influenced by discrimination and coercion. For example, a HCP's ability to provide sexual and reproductive healthcare may be influenced by internal biases and discriminatory beliefs, mediated and/or moderated by racism, ableism, ageism, classism, homophobia, and transphobia (Åling et al., 2021; Bertotti et al., 2021; Dyer & das Nair, 2013; Mann et al., 2022; Tumwine et al., 2020). These factors can

manifest as gatekeeping and coercion that highly influences HCP's contraceptive care consultations, affecting the ability for cisgender women and people who can get pregnant to access their desired method or remove/discontinue their current method (Eeckhaut & Hara, 2023; Mann et al., 2022; Swan et al., 2025). These negative effects are particularly impactful for young, poor, and/or racialized women, who bodies are considered 'more risky' and thus triaged as needing 'treatment' via contraceptives with the highest efficacy (Gomez et al., 2018; Mann et al., 2022; Mann & Grzanka, 2018; Manzer & Bell, 2022). Ultimately, these tensions between structures – defined here as "economic, political, legal, religious, and cultural" social entities that influence individuals and groups experiences, perceptions, and views (Farmer et al., 2006, p. e449) – and individual agency can manifest and/or potentiate traumas in ways that impede reproductive justice. Reproductive justice focuses on the multiple structural oppressions that affect reproductive health, shifting the focus from a goal of choice to improving equitable access for all to sexual and reproductive health services (Ross, 2017; SisterSong, 2007).

In this article, we posit that a feminist poststructuralist approach can advance equitable contraceptive care as an element of sexual and reproductive healthcare by drawing attention to dominant discourses within biomedical paradigms. First, we present the political landscape in Canada influencing contraceptive care. Next, we identify discourses that are present in biomedical paradigms that restrict equitable contraceptive care. Following, we suggest that feminist poststructuralism offers an opportunity to reconceptualize contraceptive care and provide a more equitable approach to sexual and reproductive healthcare delivery. Lastly, we discuss the implications for nursing. Nurses are deeply implicated considering the discipline is situated within biomedical paradigms (Holmes et al., 2006) and that nurses are regulated providers involved in contraceptive care.

Politics of Canadian Contraceptive Care

Contraceptives are inherently political as reproduction and fertility are politicized and directly influenced by politics and public policy. Public policies overtly affect contraceptives by increasing or decreasing access to specific methods. For example, recent legislation in British Columbia, Canada enabled all residents to attain free access to specific prescription contraceptive methods (Government of British Columbia, 2023). As well, the federal government implemented a Pharmacare program that covers specific contraceptive methods for Canadians, as long as the provincial governments choose to sign on (Action Canada for Sexual Health and Rights, 2025). Provincial politics also play a role in regulating HCPs, which in turn determines who can prescribe or dispense contraceptives. In Canada, nurse practitioners and – in some provinces – registered nurses with additional certification can prescribe and/or dispense some prescription contraceptive methods (Canadian Institute for Health Information, 2020; SOGC, 2015). In Canada, cisgender women and people who can get pregnant need to consult a regulated HCP to receive prescription contraceptives (which includes hormonal methods and the copper IUD). Lastly, provincial, territorial, and municipal politics play a role in determining school curricula, which shapes the content and coverage of sexual health education (see Sousa, 2024), which can be delivered by nurses.

In more covert ways, politics can influence the type of knowledge and

practices that are culturally normed. Browne (2001) discusses the influence of (neo)liberal political ideology shaping the types of knowledges that are considered standard, and the discourses that are taken up as truisms (e.g., biomedical discourse). Neoliberalism is a resurgence of classic liberalism – a political ideology that privileges ideals including individualism, equal opportunities, capitalism, and neutrality (Browne, 2001). Within contraceptive research, public and institutional policy, and practice, unplanned pregnancies and failure to 'successfully' use contraceptives are routinely presented as an individual level failure (Bertotti et al., 2021; Mann & Bertotti, 2024; Mann & Grzanka, 2018). This perception is influenced by neoliberal ideologies where consequences of decisions exist as a sole responsibility of the individual, failing to acknowledge the structural influences and root causes of inequities that impact contraceptive access and reproductive decision making (Bertotti et al., 2021; Mann & Bertotti, 2024; Mann & Grzanka, 2018).

Furthermore, pregnancy and childbirth may be influenced by the political acts of capitalism and commercial industries targeting specific populations (Gilmore et al., 2023). For example, the commercial determinants of health – defined here as the "complex and often negative links between the commercial sector and health" (Gilmore et al., 2023, p. 1194) – both disable and enable population growth as a means to profiteering. Indeed, there are entire industries specializing in reproductive health that profit from pregnancy prevention (e.g., pharmaceuticals), pre-conception and pregnancy (e.g., ovulation kits, supplements, lotions, clothing), and childbirth (e.g., post-partum supplies, formula, clothing, toys) highlighting the broad and multiple factors that may influence reproductive decision making.

Lastly, some bodies are more politicized than others (Dyck & Lux, 2016). In Canada, eugenic science shaped state legislation, policies, and practices that promoted forced and coerced sterilization as a means of social control to 'protect' society from the burden of those deemed as unfit to reproduce. Individuals who were Indigenous, racialized, disabled, poor, mentally ill and sexually and gender diverse were targeted (Lowik, 2018; McLaren & McLaren, 1986). In 1928 and 1933, Alberta and British Columbia, respectively, enacted Sexual Sterilization Acts, which were not repealed until the 1970s (Stote, 2015). This legislation disproportionately impacted Indigenous women who were often misled and coerced into sterilization under false pretenses (Canadian Senate, 2022; Dyck & Lux, 2016; Stote, 2015) Although forced sterilization and eugenic practices are often discussed in a historical context, these practices are ongoing (Cheng, 2023; Roberts, 2017).

Contraceptive Discourses within Biomedical Paradigms

The Clients: (Straight Cis) Women Only

Gendered compulsory birth control – a phenomenon first labeled by sociologist Krystale Littlejohn (2021) – explains how cisgender women are socialized to take primary responsibility for pregnancy prevention. This focus on responsibility at an individual level is, again, rooted in gendered, patriarchal, and neoliberal perspectives that exist in healthcare systems (Browne, 2001). Gendered expectations often privilege cisgender men and people with penises' pleasure above women's – if not ignoring women's sexual desires and sexuality completely (Le Guen et al., 2021; Littlejohn, 2021). Similarly, when HCPs are influenced by gendered norms, they can negate cisgender women and people who

can get pregnant as being influenced by multiple factors – including partners, HCPs, cultural norms and religious beliefs – instead perpetuating essentialist notions that all who can get pregnant want to control their fertility in the same way (Alspaugh et al., 2020; Grzanka & Schuch, 2020; Le Guen et al., 2021; Ti et al., 2022).

The Evidence: 'Unbiased' is Best

Biomedical paradigmatic understandings are rooted in Eurocentric, colonial, patriarchal, and neoliberal ideologies (Crosschild et al., 2021; Redvers et al., 2024). These ideological influences work to silence ways of knowing outside of what is believed to be 'true' within biomedical paradigms (Holmes et al., 2006). Within biomedical paradigms, 'unbiased' and 'controlled' evidence developed from randomized controlled trials (RCTs) are considered the *gold standard* for healthcare knowledge, which promotes an authoritative voice and hierarchy of evidence routinely discrediting knowledge from the social sciences, including embodied, subjective, and experiential knowledge (Crosschild et al., 2021; Holmes et al., 2006). However, those with reproductive potential may privilege narratives, experiences, and situated knowledge (Zeeman et al., 2014), creating a gap in evidence needed to aid in their reproductive decision making. As well, women, trans, nonbinary, racialized, older, and/or disabled people are consistently left out of research, highlighting racism, misogyny, sexism, ageism, and ableism imbedded within the production of knowledge (He et al., 2020; National Academies of Sciences Engineering and Medicine, 2022; Sardar et al., 2014; Stranges et al., 2023). Exclusion from research and knowledge production can have profound consequences, including the development of treatments that are ineffective or not appropriate for specific groups, challenges with trust in healthcare systems, and perpetuating health inequities (see National Academies of Sciences Engineering and Medicine, 2022). Within evidence creation, the experiences of cisgender women and people who can get pregnant have long been muted, and in the specificities of contraceptive care, the normative frame of biomedical authorities have failed to question this absence (Stranges et al., 2023). Although it may be argued that biomedical paradigms are not inherently bad, the creation of strict boundaries around what constitutes 'good evidence' and 'truth' – leads to ideologies that might be uncritically accepted as *normal*, conflating what is normative as the unitary truth (Crosschild et al., 2021; Holmes et al., 2006).

The 'Treatment': Efficacy Over Everything

The tiered model of contraceptives is the dominant approach to contraceptive care (Bertotti et al., 2021; Brandi & Fuentes, 2020). In this model, HCPs consider long-acting reversable contraceptives (LARC) at the top of the hierarchy because these methods are the most effective at preventing pregnancy (see Options for Sexual Health, 2025). At contraceptive care appointments, HCPs prioritize a discussion of LARC as the first-line approach prior to discussing second (oral contraceptives) and third tier (withdrawal, fertility awareness) methods (Brandi & Fuentes, 2020). Feminist scholars have challenged this hierarchical approach arguing it is influenced by a discourse of risk that may conflate efficacy and safety (Bertotti et al., 2021; Mann et al., 2022; Swan et al., 2025). For example, contraceptives that may have more side effects as a *method* (e.g., oral contraceptive pills), are considered more safe than methods with fewer side effects (e.g., condoms) because the focus is on the safety

or risk associated with a *pregnancy* versus with the method itself (Bertotti et al., 2021).[2] Because cisgender women and people who can get pregnant also consider aspects outside of effectiveness when deciding on a contraceptive method (Alspaugh et al., 2020; Grzanka & Schuch, 2020; Le Guen et al., 2021; Ti et al., 2022), when HCPs prioritize LARC methods this approach may contribute to misunderstanding, confusion, and reproductive coercion for those with reproductive potential leading to unmet needs for managing their fertility (Bertotti et al., 2021; Swan et al., 2025).

Addressing Challenges in Contraceptive Care

Improving Access to Choice

Current recommendations related to improving contraceptive care engage reproductive justice by focusing on increasing contraceptive choices (Senderowicz, 2020). However, the concept of choice has been critiqued as it is rooted in Western ideology, placing responsibility at the individual level and assuming that all individuals have the same ability to 'choose' (Morison, 2021; Solinger, 2007). This construction of choice is influenced by neoliberal beliefs and fails recognize the power dynamics, structural factors, and coercion that may be imbedded within reproductive choices, again, assuming all cisgender women and people who can get pregnant have access and the ability and opportunity to 'choose' (Mann & Bertotti, 2024; McKenzie, 2022; Solinger, 2007). For example, there is power inherent within healthcare interactions (HCPs positioned as authoritative experts), ability to access services, coercion in relationships (including intimate partner violence), and gendered norms that influence the right to choose (Morison, 2021).

Furthermore, social class, racism, ageism, ableism, and reproductive choice are heavily implicated as public policies privilege women with resources as the most suitable to make choices related to reproduction, meaning only those with access can 'choose' to take specific contraceptives (Solinger, 2007). Although essential in reducing cost barriers, free contraceptive programs may satiate choice discourses, however barriers including social location(s), availability of other resources, and interactions with HCPs still exist. As such, we argue that to continue advancing reproductive justice, it is necessary to reconceptualize contraceptive care. In the following section, we discuss feminist poststructuralist theoretical perspectives and how these can challenge biomedical paradigms, ultimately expanding the ability to provide contraceptive care in comprehensive, inclusive, and equitable ways, creating opportunities for agency – wherein the "socio-culturally mediated ability to act and decide on contraception" is contingent on multiple factors that contribute to reproductive decision making outside of the control of the individual (Morison et al., 2022, p. 229).

Feminist Poststructuralist Theoretical Perspectives

As an approach, poststructuralism falls under the umbrella of postmodernism, focusing on discourse and power while providing critiques of truth and objectivity (McCormick & Roussy, 1997). McCormick and Roussy (1997) describe central features of poststructuralism as the rejection of grand narratives and essentialism; emphasis on difference and multivocality, focus on language, discourse, and the link between

[2] In the current article, by focusing on sexual and reproductive health and contraceptives, we acknowledge but do not formally compare or discuss the various impacts pregnancy can have on health.

knowledge, power, and discourse; and an emphasis on how disciplines represent discourse that produces power through knowledge and subjectivities (p. 271). In feminist poststructuralist theoretical perspectives, these central features remain with an additional focus on dismantling and disrupting constructs of gender and patriarchy (Willett & Etowa, 2023).

When knowledge is viewed from feminist poststructuralist theoretical perspectives, there is a value placed on multiple realities and the social construction of knowledge and categories (Willett & Etowa, 2023). Herein, power is "relational, in flux, continually being produced and resisted in everyday interactions" (Willett & Etowa, 2023, p. 6). As such, there is an additional layer of attention to how one's gendered experiences have been influenced by power dynamics. Feminist poststructuralist theoretical perspectives add the potential to reconceptualize contraceptive care by focusing on privileging knowledge that promotes multivocality, challenges binaries, and attends to power. These changes will center those seeking to manage their fertility as well as their desires, pleasure, experiences, wants, needs, concerns, considerations, and perspectives. Similarly, these perspectives can provide opportunity to shift focus to control of fertility and family planning for everyone with reproductive potential over strictly preventing unplanning pregnancy for cisgender women.

Multivocality

Multivocality necessitates privileging multiple voices and centering the narratives of those often silenced (McCormick & Roussy, 1997). Considering the unethical testing of the first oral contraceptive pill (Liao & Dollin, 2012) and the eugenic basis for implementing contraceptives (McLaren & McLaren, 1986), centering the voices of those with lived experience – particularly those with intersecting experiences of racism, classism, misogyny, ableism, and sexism – is imperative. As well, there is a lack of research related to the reproductive health of Two Spirit, trans, nonbinary, gender nonconforming people, highlighting a much-needed centering of voices (Forsberg & Eliason, 2022; Lowik, 2020). Conducting research with the intent of multivocality creates evidence to inform more relevant policies and practices. For example, Cook et al. (2022) – in their examination of youth's condom preferences – highlighted that although HCPs often approach condoms from a risk prevention standpoint, participants' preferred approach to condoms was playful, viewing condoms as a fun accessory. Inclusion of multiple voices also breaks with the patriarchy of sexual pleasure being contingent on specific constructs, for example condomless erection, penetration, and orgasm in heterosexual, cisgender, monogamous configurations, making available a diversity of relational mutualities and sexual pleasures and practices. Ultimately showing that when additional perspectives of lived experience are valued, new ways of approaching sexual health and contraceptives may be uncovered.

Furthermore, multivocality creates opportunities for transformational research that is empowering and reflexive without seeking an essentializing perspective. Evidence generated outside of biomedical hegemony can offer value to participants and knowledge production, providing opportunity for participants to enact agency (Galman, 2021). Similarly, incorporation of privileging the voices of those that are generally not heard offers additional ways of knowing, including research driven by and directly shared with community, highlighting how multivocality can create opportunity for additional impactful forms

of dissemination (Jull et al., 2017). Co-creating knowledge could improve development and implementation of interventions, ultimately reducing the knowledge-action gap, and leading to more relevant, applicable, and effective interventions.

Challenging Binaries

When viewed from feminist poststructuralist theoretical perspectives there is a focus on addressing and disrupting the binaries that are prevalent within dominant discourses, drawing attention to how binaries are used to create social hierarchies (Ollivier et al., 2019). Additionally, as feminist poststructuralist perspectives challenge the idea of essentialism (McCormick & Roussy, 1997) – or the view that social categories are fixed, uniform, and shared by all members (Pinho & Gaunt, 2021) – this perspective can be used to disrupt normative ideologies prevalent within contraceptive care. For example, a dominant essentialist belief within contraceptive care is that all cisgender women and people who can get pregnant have the same fertility intentions and plans, and all want to use the same LARC due to their efficacy (Grzanka & Schuch, 2020; Mann & Grzanka, 2018; Swan et al., 2025; Ti et al., 2022). Approaching care from a feminist poststructuralist theoretical perspective challenges these ideas, makes no assumptions about contraceptive desires or fertility plans, and centers the individualized and relational wants and needs of those with reproductive potential. Similarly, feminist approaches aim to disrupt sex and gender binaries and essentialist perspectives, while challenging the idea of what is claimed as normative within society, allowing for full expression of human experience commensurate with intersectionality (Willett & Etowa, 2023).

Attending to Power

Feminist poststructuralist theoretical perspectives contest the power differentials that exist, focusing on the links between power, knowledge, and discourse, where dominant discourses perpetuate truth (knowledge) that benefits those with power. Research highlights that HCPs produce and maintain power dynamics across a range of care activities, including discussing sexual health (Åling et al., 2021), prescribing contraceptives (Mann et al., 2022), and deciding if a client's identity makes them worthy of care (Tumwine et al., 2020). As such, utilizing feminist poststructuralist theoretical perspectives to address how power exists within healthcare systems at the individual, organizational, and structural levels can provide opportunities for disrupting and transforming the status quo within contraceptive care. For example, feminist poststructuralist theoretical perspectives provide opportunities to critique how institutions exercise power over patients related to contraceptive prescribing based on classist, ageist, and racist biases (Mann et al., 2022; Manzer & Bell, 2022). Thus, by acknowledging this power, seeking to find the origins and beginning to disrupt some can create opportunities for the provision of sexual and reproductive healthcare to more closely align with the comprehensive definitions. Additionally, feminist perspectives can contribute to advancing understandings of power with regulatory agencies, funding bodies, and public policy makers, which affects contraceptive promotion and use (Bertotti et al., 2021; Mann & Grzanka, 2018).

The Role of Nursing

Although nursing has been underutilized in providing sexual and reproductive healthcare (Bungay et al., 2017) and continues to contend with the racist,

colonial, upper class, and apolitical influence of its history (De Sousa & Varcoe, 2022; McGibbon et al., 2014; Wilson et al., 2020), nursing as a discipline and profession offers unique contributions to mitigate the challenges existing within a biomedical paradigmatic view of contraceptive care. These contributions align with nursing's mandate to provide health promotion and equitable care. Although the valuing of additional perspectives is needed at the paradigmatic and structural levels, incorporation of equity-oriented care aligns with feminist poststructuralist perspectives within organizational and individual levels.

Drawing on the evolving work of Browne et al. (2024), equity-oriented care includes awareness and reduction of the effects of trauma in healthcare experiences, bringing attention to power differentials and actively countering discrimination with the goal of social justice. Practice and policies grounded in equity-oriented care can provide unique opportunities to address racism, ageism, and classism that are inherent within the *structures* influencing contraceptive care while countering implicit biases. At the time of writing this article (March, 2025) the Canadian Federation of Nurses Unions has an advocacy movement urging nurses to write to their political representatives highlighting the importance of Universal Pharmacare, which would cover the costs of some prescription contraceptive methods for patients (Canadian Federation of Nurses Unions, 2025).

Nurses can also improve health literacy – the ability to "access, understand, and apply health information" – which can fit within an equity-oriented approach (Hasnain-Wynia & Wolf, 2010; Nesari et al., 2019, p. e268). Improving health literacy can include nurses working to educate themselves on sexual health from a lens of reproductive justice, as well as educating the patients they work with. This approach can also involve nurses unpacking their implicit biases related to sexual health, which can contribute to stigma and discrimination (Hussein & Ferguson, 2019; Manzer & Bell, 2022). Nurses have the responsibility to improve health literacy through practices in all patient interactions, including using accessible language, meeting patients where they are at, providing opportunities for patients to ask questions, and creating spaces where patients feel comfortable asking questions and engaging with HCPs (Hasnain-Wynia & Wolf, 2010; Nesari et al., 2019; Wilandika et al., 2023).

Lastly, an equity-oriented approach can be utilized across multiple aspects within nursing – including research, education, and practice – resulting in the ability to influence social change at individual, organizational, and structural levels. Dehlendorf et al. (2018) encourages reflexive practice when engaging with sexual health research and ensuring that questions asked and methods use align with a reproductive justice approach. Nurses have the ability to view evidence around side effects, efficacy, and risk, while simultaneously exploring narratives including patient desires, experiences, and challenges.

Conclusion

Contraceptive care is currently dominated by biomedical perspectives, creating challenges for those with reproductive potential, particularly those who are considered to be at risk of unplanned pregnancy. Although, in theory, sexual health may be defined comprehensively, in research and practice it often defaults to biomedical paradigms promoting a reductionist lens that fails to acknowledge the complexity of nuanced human experiences. Feminist poststructuralist theoretical perspectives can provide opportunities to enhance the

creation of evidence that can better inform practice, public and institutional policy, and future research. When viewed from feminist perspectives, specific challenges can be addressed by embracing multivocality, rejecting binaries and essentialist categories, and drawing attention to the power that healthcare systems exert, ultimately reconceptualizing sexual and reproductive healthcare, promoting justice through social change. Considering nurses operate within, reinforce, and challenge systems, nursing as a discipline and profession can use a feminist poststructuralist theoretical perspective aligned equity-oriented lens to address the challenges that contraceptive care.

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