

Evolving the Preconception Health Framework

A Call for Reproductive and Sexual Health Equity

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Over the past decade, increasing attention has been paid to intervening in individuals' health in the "preconception" period as an approach to optimizing pregnancy outcomes. Increasing attention to the structural and social determinants of health and to the need to prioritize reproductive autonomy has underscored the need to evolve the preconception health framework to center race equity and to engage with the historical and social context in which reproduction and reproductive health care occur. In this commentary, we describe the results of a meeting with a multidisciplinary group of maternal and child health experts, reproductive health researchers and practitioners, and Reproductive Justice leaders to define a new approach for clinical and public health systems to engage with the health of nonpregnant people. We describe a novel "Reproductive and Sexual Health Equity" framework, defined as an approach to comprehensively meet people's

reproductive and sexual health needs, with explicit attention to structural influences on health and health care and grounded in a desire to achieve the highest level of health for all people and address inequities in health outcomes. Principles of the framework include centering the needs of and redistributing power to communities, having clinical and public health systems acknowledge historical and ongoing harms related to reproductive and sexual health, and addressing root causes of inequities. We conclude with a call to action for a multisectoral effort centered in equity to advance reproductive and sexual health across the reproductive life course.

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The provision of health care during pregnancy has long been considered essential to optimizing

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pregnancy outcomes. Those invested in improving maternal and child health have increasingly recognized that focusing solely on the brief period between prenatal care and childbirth is insufficient, however. Rather, given the life course determinants of maternal and infant health, public health and clinical interventions before pregnancy—in what has come to be known as the “preconception period”—provide additional opportunities to improve birth outcomes, including preterm birth and infant mortality.^{1,2}

The movement toward preconception health advanced our understanding of how to improve health care to meet public health goals and increased attention to people’s health before pregnancy. In the decade since the preconception health framework emerged, however, social movements and changes within health care itself have resulted in substantial shifts in the understanding of peoples’ reproductive and sexual health needs. Specifically, there is ongoing and increasing discussion of the importance of and barriers to reproductive and bodily autonomy, the relevance of structural inequities and the social determinants of health, and the need for greater attention to gender and race equity. These developments have pointed to opportunities to evolve the preconception framework to center gender and race equity, as well as to recognize the multidimensional and intersectional context in which reproductive health outcomes occur.

The Reproductive Justice movement provides a valuable lens through which to motivate this evolution. First laid out in 1994 by Black women activists, and further elaborated by Black women, Indigenous women and other women of color, Reproductive Justice centers on the human right “to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”^{3,4} By focusing on the full scope of reproductive experiences, it moved beyond the traditional reproductive rights movement’s narrow focus on pregnancy prevention and abortion to a broader conceptualization of how to achieve social justice related to reproduction. It further embraced addressing structural inequities and dismantling intersecting spheres of oppression that constrain individuals’ ability to prevent pregnancy, access abortions, and ultimately create the families they desire. Explicitly founded in human rights principles, this movement prioritizes the experiences and preferences of people with the capacity for pregnancy while placing individuals within the context of their families, communities, and society and directly acknowledging the role these forces can have in facilitating or impeding reproductive autonomy. Through its emphasis on the interconnected nature of reproductive experiences, the

centering of race equity, and the structural and historical analysis it provides, Reproductive Justice is well suited to inspire evolution in the preconception health framework.

To facilitate a conversation about this evolution of the preconception health framework, the California Preterm Birth Initiative at the University of California, San Francisco, convened a multidisciplinary group of maternal and child health experts, reproductive health researchers and practitioners, and Reproductive Justice leaders in February 2019. This group was tasked with considering how to conceptualize the health and health care needs of nonpregnant people with respect to their potential reproductive outcomes, informed by both the values and goals of Reproductive Justice and maternal–child health perspectives. This commentary is a summary of the proceedings of this meeting and the recommendations of that body.

BEGINNING THE CONVERSATION

Our diverse group of stakeholders engaged in a 2-day conversation about the areas of alignment and tension between the preconception framework as currently conceptualized and a Reproductive Justice perspective. There was agreement that attention to the health of individuals when they are not pregnant is an important strategy for improving reproductive health outcomes that are aligned with Reproductive Justice. The group noted, however, that the existing preconception framework and the Reproductive Justice perspective were not completely in alignment given the frequent focus of prepregnancy messages and services on individual responsibility and behaviors, with limited attention to structural factors—such as racism, gender oppression, and economic deprivation—that circumscribe and influence these behaviors. There was recognition of efforts within some prepregnancy health initiatives, such as the Preconception Collaborative Improvement and Innovation Network on Infant Mortality, to integrate a greater focus on equity and a structural analysis.^{5,6}

The group also discussed how prepregnancy health has often been framed with respect to “women’s” health and how this overlooks the needs of individuals with the capacity for pregnancy whose gender identity is not as a woman. Finally, the group considered how the focus of prepregnancy health on people’s bodies primarily with regard to their reproductive capacity, rather than considering people’s health as having intrinsic value in and of itself, is inconsistent with Reproductive Justice’s grounding in human rights and focus on bodily autonomy.

Although many involved in prepregnancy health interventions and policy have placed a high value on people's health and reproductive autonomy as basic human rights, "preconception care" as a label for these efforts insufficiently conveys these messages.

A NEW FRAMEWORK: REPRODUCTIVE AND SEXUAL HEALTH EQUITY

With this dialogue and discussion, we came to a consensus that, rather than explicating new principles within the existing preconception framework, the time was right to define a new framework of "*Reproductive and Sexual Health Equity*." The evolution to Reproductive and Sexual Health Equity can build on the strengths of the preconception work and its influence over the past decades while also reflecting the evolving understanding of its relationship to race and gender equity, structural and social influences on health, and bodily autonomy. By defining and promulgating this new framework, it is our hope that we can provide motivation and guidance for a new commitment to promoting reproductive and sexual health through health care practices and policies, including (but not solely) as individuals' health relates to their potential future reproductive outcomes. By including equity as a core tenet of the framework, we seek to center the needs and experiences of the most marginalized, recognizing that interventions and programs that do not explicitly focus on equity often have the effect, even if unintended, of exacerbating inequities.

DEFINING REPRODUCTIVE AND SEXUAL HEALTH EQUITY

This new framework articulates a commitment to meeting people's reproductive and sexual health needs, with explicit attention to structural influences on health and health care and grounded in a desire to achieve the highest level of health for all people and to address health inequities. Importantly, in this framework, individuals' health needs are not constrained to only those with the potential to affect future reproductive outcomes, but are more broadly conceptualized. To advance our understanding of how the Reproductive and Sexual Health Equity framework can inform interventions and priorities, we defined the framework's six principles in a collaborative, cross-disciplinary discussion. They are as follows:

- Center the needs of and redistribute power to marginalized individuals and communities. Most of health care and health care delivery systems reflect entrenched structures that prioritize the needs of those in power, both on a societal level and within the individual systems themselves. Health care

providers, administrators, advocates, policy makers, funders, and researchers must proactively work to redistribute power to communities most affected by historical and structural forces that limit their ability to achieve reproductive and sexual health equity. To enact this principle, both interpersonal and institutional power must be shifted. Interpersonal power dynamics can be reshaped through increased focus on person-centered models of health care,⁷ such as the shared decision-making model,⁸ and institutional power can be transformed through shared governance structures, such as the patient-led governing boards of Community Health Centers.⁹ In health-related research, funding Reproductive Justice and other community organizations to lead research informed by Reproductive Justice principles and increased community engagement, through such mechanisms as community-based participatory research,¹⁰ can change whose perspectives are prioritized in choosing research questions, conducting research, and interpreting findings. Social accountability approaches, such as the Community Score Card process, have also been used in low- and middle-income countries as a means to give voice and power to patients to improve health services^{11,12} and can serve as a model for more transformative approaches to refocusing attention and redistributing power in a transparent and inclusive manner.

- Acknowledge historical and ongoing harms, including those perpetuated by health care and public health institutions. There is a long history of women, and particularly Black women, Indigenous women, and women of color, experiencing trauma due to structural injustices and interpersonal biases. These traumatizing factors have manifested themselves in reproductive health care through such practices as coercive sterilization of women of color and women with disabilities throughout the 20th century,¹³ the systematic removal of Native American children from their families,¹⁴ unethical testing of the oral contraceptive pill in Puerto Rico in the 1960s,¹⁵ and targeted marketing of the contraceptive injection in the 1990s.¹⁶ The legacy of this history is evident in research documenting the understandable distrust of reproductive health care providers among women of color, including one study that found that more than 40% of young Black and Latina women believe the government promotes birth control to reduce birth rates in these communities.¹⁷ In addition, transgender, gender nonconforming, and gender expansive individuals frequently experience discrimination in the context of reproductive and sexual health care.^{18,19} Under the Reproductive and

Sexual Health Equity framework, this context is foregrounded. Public health practitioners and clinicians—and the institutions in which they work—must actively work to address the effect of this historical and social context to build trust and avoid perpetuating and recreating harmful dynamics and practices. The structural competency framework provides one approach for reproductive and sexual health programs and providers to both recognize these harms and engage in transformative practices and advocacy to rectify them.²⁰

- Address the root causes of reproductive and sexual health inequities, including racism, patriarchy, and economic inequality. Reproductive and sexual health in the United States is embedded in a society in which racism, misogyny, and transphobia are a source of systemic oppression and in which resources necessary for health are differentially distributed. Attempts to improve health and advance health equity for those affected by these intersecting spheres of oppression must both recognize these root causes and work to eliminate them. In line with the socioecologic model,²¹ research and programs aligned with the Reproductive and Sexual Health Equity framework must shift toward multilevel interventions that address contextual factors, ranging from policies that reinforce oppressive structures to structures and social norms that perpetuate them. In addition, individual-level interventions must be appropriately contextualized with respect to these influences on health and health behavior to be effective and to avoid perpetuating injustices.
- Honor bodily autonomy for all people. A central aspect of reproductive oppression in the United States is a failure to honor the right to bodily autonomy, particularly among communities and individuals whose reproduction is devalued. The manner in which this manifests changes with the social and historical context, ranging from the explicit reproductive control of Black women subjected to enslavement¹⁶ to modern-day experiences of disrespectful maternity care and resistance to removal of long-acting reversible contraceptive methods by health care providers.^{22,23} In the context of the health of nonpregnant people, there is a risk of failing to honor bodily autonomy when clinical and public health efforts prioritize the health of a potential future fetus over the autonomy, health, and well-being of a nonpregnant person themselves and their existing familial unit. Efforts consistent with Reproductive and Sexual Health Equity hold the right to bodily autonomy as fundamental.

- Affirm and create conditions for healing; don't shame or (re)traumatize. As described, the health care delivery system has been a source of trauma and harm for many communities. It continues to give limited attention to the self-defined needs of individuals and communities. In the preconception health framework, this is reflected by the focus on individual behavior change, which shames or blames individuals, rather than focusing on the structural factors circumscribing these behaviors. Through partnerships with communities and attention to the historical context, interventions under the Reproductive and Sexual Health Equity framework instead promote engagement and healing.
- Create systems that meet people's needs inside and outside the formal health care system. The services and information people need to maximize their health are diverse, and people's preferences regarding this care are varied. At a minimum, these services need to be accessible and culturally appropriate. In addition, there is a need to expand the settings in which care can be received to meet individuals' specific needs and circumstances. Examples of nontraditional health education and health care delivery mechanisms range from providing hypertension care in barbershops and hair salons to using popular opinion leaders to disseminate health information in the community.^{24,25} Given the personal nature of reproductive health decisions and the history of reproductive oppression within formal health care settings, it is essential to have flexibility regarding how and when people can access care. Potential options for reimagining how care is delivered include group visits with health educators, personalized and interactive digital resources, and education in community settings from trusted community members. Research and policy—including regarding payment strategies for nontraditional care delivery strategies—can help to build the evidence base and capacity to meet people's needs for health information and care in flexible, responsive ways.

Taken together, these six interrelated principles provide a starting place for advancing the Reproductive and Sexual Health Equity framework. Acting on these principles can build and restore trust—on an interpersonal, community, and structural level—between those invested in advancing reproductive and sexual health and those whom they seek to serve.

CONTINUING TO EVOLVE

In describing the Reproductive and Sexual Health Equity framework, our aim is to catalyze further

dialogue to achieve a healthier, equitable society. We acknowledge that much work is required to operationalize the framework. Essential next steps include defining actionable ways for clinicians, health systems, and other structural entities, including funders, to apply the principles in research, practice transformation, and policy. For example, we anticipate this framework could be applied in quality-of-care initiatives in diverse settings (eg, health systems, Title X programs, Federally Qualified Community Health Centers). We welcome conversations and elaborations with a broad range of stakeholders to further develop and operationalize this framework.

We also call on federal agencies (eg, the Centers for Disease Control and Prevention, the National Institutes of Health, the Office of Population Affairs, and the Health Services Resource Administration) and professional organizations (eg, the American College of Obstetricians and Gynecologists; the American Academy of Family Physicians; the American Academy of Pediatrics; the American College of Physicians; the Association of Women's Health, Obstetric and Neonatal Nurses; the American College of Nurse-Midwives; and the American Public Health Association) to proactively change their language and the focus of their efforts from preconception health toward a Reproductive and Sexual Health Equity framework.

With cross-sectoral engagement and commitment from these groups and others, we have the potential to generate the momentum necessary to create a true cultural shift. It is our hope that our cross-disciplinary effort to reconceptualize preconception health and define the Reproductive and Sexual Health Equity framework will spark an intentional and focused movement toward equity, justice, and person-centeredness in the approach to reproductive and sexual health and health care across the life course.

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