

What is sexual and reproductive health equity and why does it matter for nurse practitioners?

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This article describes sexual and reproductive health equity (SRHE) and how nurse practitioners can apply this framework to improve research, policy, and clinical practice. It means that systems ensure that all individuals, across the range of age, gender, race, and other intersectional identities, have what they need to attain their highest level of sexual and reproductive health. This includes self-determining and achieving their reproductive goals. Government policy, health-care systems, and other structures must value and support everyone fairly and justly.

KEY WORDS: health equity, reproductive health, sexual health, racism, sexual and gender minorities, healthcare policy

Sexual and reproductive health (SRH) is a key component of people's lives and overall health. As defined by the United Nations, "good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system."¹ Persons of all genders have SRH needs related to information; the ability to have a satisfying and safe sex life, and the freedom to decide if, when, and whether to have children. This piece uses gender-neutral language to reflect the broad reach of SRH and to be inclusive of trans and nonbinary individuals.

Despite advances in technology and access, people face barriers to optimal SRH. These barriers are exacerbated by bias and discrimination in healthcare and policy, disproportionately affecting people of color, those living in poverty, those with disabilities, immigrants, LGBTQIA+ individuals, and others with (often intersecting) marginalized identities.^{2,3} The sexual and reproduc-



tive health equity (SRHE) approach is a solution to redress these issues. This article explores what SRHE means for nurse practitioners (NPs), how members of the profession can advance justice, and steps to take to uphold SRHE in research, policy advocacy, and clinical practice.

What is sexual and reproductive health equity?

Sexual and reproductive health equity means that systems ensure that all persons, across the range of age, gender, race, and other intersectional identities, have what they need to attain their highest level of SRH. This includes self-determining and achieving their reproductive goals. Government policy, healthcare systems, and other structures must value and support everyone fairly and justly. This definition is based on foundational frameworks like reproductive justice, health equity, and reproductive autonomy.⁴⁻⁶

In the United States today, SRH is treated differently from other health services, with real implications for patients. Sexual and reproductive health policy is also siloed, perpetuating harm. An SRHE approach necessitates breaking down siloes and seeing people's health in the holistic, integrated way that they experience it. It also means that policy, research, and healthcare center the needs of communities, especially those with greatest access barriers and most experiences of injustice.

What would it mean to center sexual and reproductive health equity?

Acknowledge histories of injustice

To center SRHE, it is important first to acknowledge and understand the historical context and how inequity has

structured the lived experiences of individuals with marginalized identities. Sexual and reproductive coercion have been used as a tool of racial and gender oppression throughout US history. All aspects of society were mobilized to deny the sexual and reproductive autonomies of enslaved Black people, as slave owners used forced procreation as a profitable vehicle and sexual assault to reduce the likelihood of resistance.^{2,9} Examples from the 20th century include oral contraceptive trials on Puerto Rican people without informed consent and the state-sanctioned eugenic sterilization of Black, Latinx, and Indigenous people, and those with physical and intellectual disabilities.^{10,11} Coercive sterilization practices have also continued into the 21st century in both detention and correctional settings.^{10,12} Racism, misogyny, and all other systemic forms of oppression are the elemental causes of SRH inequities, and NPs must understand and counteract these forces if SRHE is to be achieved.

Engage in individual and institutional self-reflection

Historically, nurses have played a role in perpetuating these injustices as participants and bystanders. We have also worked to dismantle oppression as whistleblowers, activists, and deliverers of respectful care.^{7,8} Nurse practitioners have a responsibility to name our own implicit biases and identify personal areas for growth by identifying harms that have occurred in our settings and reflecting on our experiences with patients and communities. Exploring these cases requires personal and professional self-examination, individually or in community.

Institutional reflection is also essential to center SRHE. Planned Parenthood's reconsideration of Margaret Sanger's legacy is an example of such an institutional practice.¹³ Institutional reflection also requires critical examination of the way members of our profession are educated and trained. Steps to make education and training more equitable include hiring teaching staff and faculty who are diverse and represent the communities served, experienced in SRHE work, invested in their own learning, and open to feedback. Training programs must invest in SRH education and consistently review and revise curricula to incorporate current events, tailor lessons to patients' holistic needs and preferences, and evaluate the extent to which training and education advance equity in care provision.

Interrogate and reform research practices

Nurse practitioners often lead or participate in research as principal investigators, research coordinators, and con-

sumers of research findings. When considering research in SRH, how the research is conducted is as significant as the design and content, especially given the history of research injustice in SRH. As part of a yearlong effort to develop a Priority Roadmap for Policy-Ready Contraceptive Research, the Coalition to Expand Contraceptive Access (CECA) developed a set of equity-informed research principles. These are listed here and described in greater detail on CECA's website.¹⁴

- Ground research in a holistic vision of SRH that centers justice, equity, autonomy, and choice.
- Interrogate and reevaluate the research practices that have guided us.
- Honor and embrace communities as equal partners throughout the research process.
- Understand and reflect the impact of historical, socio-cultural, political, and economic contexts that influence the lived experiences of community members.
- Design actionable research that can be used to impact the lives of individuals and communities through changes in systems, policies, and practice.

Develop and implement equitable policy solutions

Policy, when viewed through the lens of SRHE, means that all policies and programs are developed and implemented to deeply reflect the needs of communities and remove all barriers to full autonomy. This necessitates addressing a wide range of issues such as housing, environment, employment, paid family leave, childcare, and affordable healthcare.¹⁵ Across state and federal systems, existing programs should be audited to determine the extent to which they reflect equity and result in equitable outcomes.

Current developments include a range of legislative efforts aimed at ending preventable maternal mortality and morbidity and closing disparities in maternal health outcomes. Additional equity-oriented work focuses on seeking approval of over-the-counter status for oral contraceptives, which have a 40-year safety record and meet over-the-counter health criteria.¹⁶

Emerging policy directions include expanding access to digital health products and services; supporting expanded scope of practice for nurses, pharmacists, and community health workers; and broadening the availability of abortion care. Nurse practitioners can advocate, both individually and through professional organizations, for these efforts and others that can advance SRHE.

Redefine clinical practice

Redesign clinical structures: When clinical practice is designed with an SRHE approach, equity is not a performative afterthought but a direction toward repair. Increased equitable access to SRH care for all people is paramount, but it is even more important to create pipelines for those who have experienced harm in the healthcare system and face the greatest barriers to care.

Offering the full scope of SRH services in addition to broadening referral networks enables individuals to be well informed about the options available, autonomous, and able to attain their highest level of sexual and reproductive health. Beyond access to affordable and effective methods of contraception, the full range of SRH services also includes comprehensive sex education; maternal and infant healthcare; abortion services; prevention, screening, and treatment for sexually transmitted infections and HIV, including pre-exposure prophylaxis; prevention, detection, immediate services, and referrals for sexual and gender-based violence; cancer prevention, screening, and treatment; counseling, education, and treatment for infertility; and counseling, education, and treatment for sexual wellness and dysfunction.^{17,18}

Reform the delivery of care: Even with increased equitable access to full-scope care, it is important to acknowledge that clinical spaces have not been physically or psychologically safe, particularly for individuals with marginalized identities. Integrating a comprehensive trauma-informed approach to organizational culture and clinical practices can begin to help them feel safe accessing SRH services.

Examples of trauma-informed changes to organizational culture include involving patients in all aspects of planning (eg, establishing advisory boards and compensating patients who participate); training all staff members; hiring a diverse workforce; creating opportunities for staff to explore their own trauma histories; incorporating mental health off days; and auditing policies, procedures, and practices for biases and re-traumatization. Examples of clinical practice changes include screening patients for trauma (but avoiding frequent rescreening), encouraging support people and strategies (eg, focused visualization and breathing exercises), developing a trauma-informed referral network, and engaging referral sources and partner organizations.¹⁹

Conclusion/call to action

As individuals called to this field, and as a community of NPs committed to improving outcomes for all patients, we have an ethical responsibility to continue our learning and

to build and maintain equitable systems. There are several ways to stay engaged in this work. One way is to stay connected to colleagues and share the most up-to-date resources and best practices around SRHE from organizations engaged in the work, including the National Birth Equity Collaborative and Nurses for Sexual and Reproductive Health. Schools and training programs should improve systems for receiving and integrating feedback on curriculum content from students and alumni. Both new and seasoned nurse practitioners would benefit from more structured, guided spaces to share cases and reflect on obstacles to SRHE with an eye toward brainstorming solutions.

To fully meet patients' needs, provide compassionate care that helps our patients thrive, and to create the best health outcomes possible, it is important to make SRHE a priority in our practice. There are numerous opportunities for NPs to advance SRHE. The recommendations above serve as a starting point for improved implementation, continued conversations, and further research. ■

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