

Community-Engaged Curriculum Development in Sexual and Reproductive Health Equity Structures and Self

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BACKGROUND: Inequitable outcomes in sexual and reproductive health disproportionately burden communities minoritized by systems of oppression. Although there is evidence linking structural determinants to these inequities, clinical learners have limited exposure to these topics in their training. We developed a curriculum aimed to teach clinical learners the structural determinants of sexual and reproductive health.

METHOD: We implemented Kern's six-step method for curriculum development. Through literature review, we identified structural competency as the foundational framework and explored community priorities for clinical training.

We assessed learner needs regarding structural equity training, articulated goals and objectives, and chose video modules as the primary educational strategy. We collaboratively developed content with community scholars and reproductive justice advocates. For phase 1 of our curriculum, we created pillar videos with reflection questions, resources, and a visual glossary of key terms. All materials are available through an online educational platform offering open-access, evidence-based curricula.

EXPERIENCE: We launched our curriculum with a social media campaign and presented our videos at several national convenings. We implemented videos with clinical learners with positive preliminary evaluation results.

CONCLUSION: With rigorous development rooted in community engagement, our curriculum contributes to the tools promoting structural equity training in obstetrics and gynecology.

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Inequitable outcomes in sexual and reproductive health are pervasive.¹ Marginalized communities are disproportionately burdened with these poor outcomes—the same communities minoritized by racism, classism, heterosexism, and other systems of oppression. Historically, researchers investigating these inequities misclassify social constructs of identity—such as race—as biologic or genetic determinants.^{2,3} However, community narratives and community-engaged research consistently name structural factors as root causes for inequity, such as neighborhood level segregation⁴ and insufficient maternal health policy.^{5–7} Clinical learners have limited exposure to these topics in their formal education and few resources exist teaching recognition and analysis of these injustices in practice. In the midst of a global pan-

democratic and persistent state-sanctioned violence perpetuated against marginalized communities, clinical learners continue to call for more formal structural equity training.⁸ Educators have a professional and ethical obligation to meet the needs of not only learners, but also of patients, communities, and greater society.⁹

We developed a curriculum to teach clinical learners about health equity in sexual and reproductive health. *Structures and Self: Advancing Equity and Justice in Sexual and Reproductive Healthcare* provides historical context for inequity, tools for critical self-reflection, and an analytical framework of structural health equity. Here, we describe our curriculum development process, experience with implementation and dissemination of our innovation, and implications for continued innovation in community-engaged structural equity training in obstetrics and gynecology.

METHOD

We used a rigorous development process, employing Kern's six-step method.¹⁰ Our foundational framework was structural competency: the learned ability to identify and understand how upstream decisions, policies, and practices dictate the inequitable conditions that result in health disparities.¹¹ We then identified the needs of learners and call for greater community accountability in clinician training; and created aligned goals, objectives, and educational strategies. Figure 1 illustrates the key stakeholders, inputs, and outputs of each step, highlighting community stakeholder engagement. In the following sections, we describe Kern's steps 1–6 in more detail.

Foundational Frameworks and Learner Needs (Steps 1–2)

We performed a literature search identifying the dominant educational frameworks around equity and social medicine: cultural competency, cultural humility, and structural competency. Most widely applied in medical education settings, cultural competency implies the trained ability to identify cross-cultural expressions of illness and health on the basis of race, ethnicity, social class, religion, sexual orientation.¹² However, this approach assumes that culture is fixed and universal amongst members of the same community. Assuming a person can gain competence in someone's culture leaves clinicians vulnerable to stereotyping, bias reinforcement, and further marginalization of patients.¹³ Cultural humility,¹⁴ however, encourages trainees to develop lifelong self-critique, readdressing power imbalances in the patient-clinician dynamic, which in practice is often minimized.

Despite utilization of cultural competency or cultural humility in clinician training, patients continue to report discrimination in health care settings and inequitable health outcomes persist, suggesting these frameworks alone are insufficient. Structural competency¹¹ represents a shift toward a lifelong analysis of how upstream decisions affected by systems of societal power and oppression lead to inequity, independent of individual choice. These decisions, or structural determinants, determine whether resources necessary for health are distributed equitably or unjustly in a society. Structural competency is defined by five specific competencies: recognizing the structures that shape clinical interactions; developing an extra-clinical language of structure; rearticulating "cultural" formulations in structural terms; observing and imagining structural interventions; and developing structural humility.¹¹ This was our curriculum's foundational pedagogy.

We also conducted a review of community-generated scholarship with recommendations for health care professionals to promote equity,^{4,15,16} which included: prioritization of patient and community expertise; incorporation of cultural humility, reproductive justice, and trauma-informed care models; and interdisciplinary training and education. We also prioritized these in our curricular development process and content.

Learner Needs

We conducted a targeted assessment of structural equity education, which included 25 obstetrics and gynecology residents from a single institution during a mandatory didactic session. Of note, these residents trained in a department with a strong commitment to equity and inclusion and their core curricula includes social determinants of health and care for marginalized populations. Two primary needs were identified from this assessment: 1) foundational content on structural determinants and historical context of present-day inequities and 2) increased learner self-efficacy in addressing structural determinants in clinical practice.

Goals, Objectives, and Educational Strategies (Steps 3–4)

The curricular goals encompassed the following: understand the historical context and implications for inequities; analyze how structures of power and oppression manifest within health care systems and affect outcomes; identify bias, privilege, and fragility within patient interactions and promote practices for self-reflection; and integrate a justice framework and

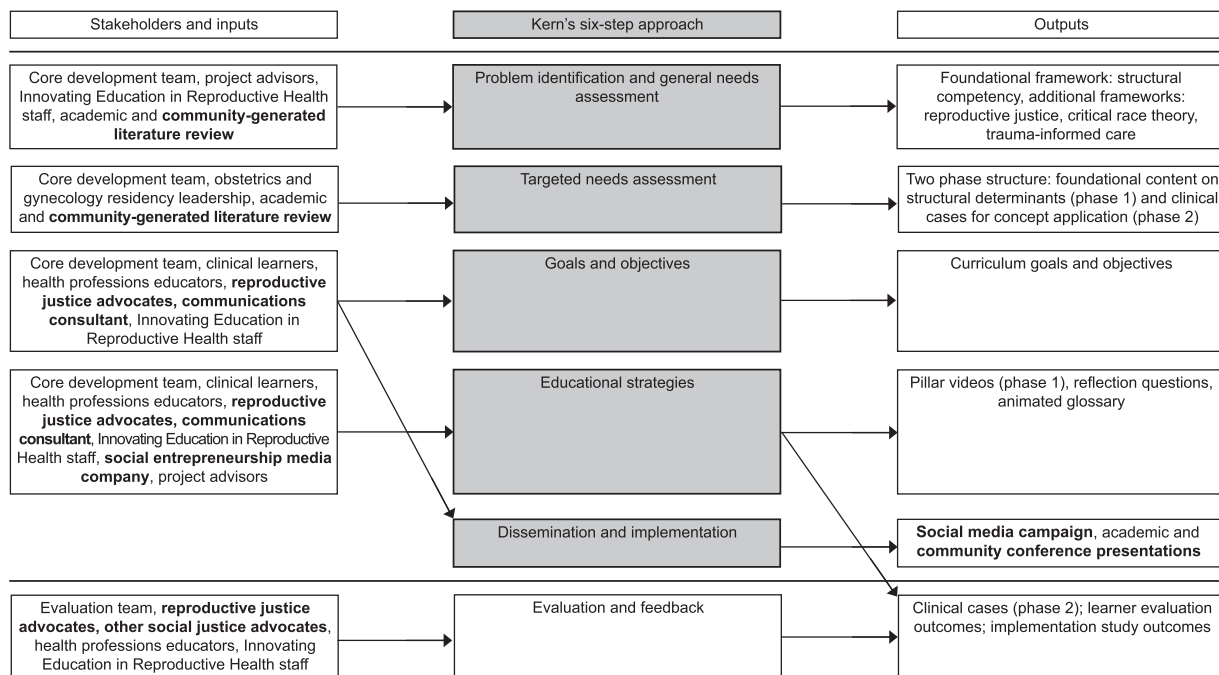


Fig. 1. Structures and Self curriculum development process using Kern's six-step approach. *Bold text* indicates community engagement.

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structural analysis as tools to promote equitable outcomes. We used these to develop subsequent learning objectives and define phase 1 of the curriculum: four pillar videos including graphics and recorded footage. We used videos because of the flexibility of integrating content in myriad educational settings, including self-directed learning.

An interdisciplinary core development team, composed of nursing, midwifery, and physician members drafted the initial video scripts and worked collaboratively with a public health-trained, strategic communications consultant to synthesize them. We elicited initial content feedback from three stakeholder groups to provide learner and community accountability: certified nurse-midwifery students, physician trainees and medical educators, and reproductive justice advocates from Black Women Birthing Justice. We held focus groups with stakeholders, then integrated feedback into the final scripts for video production. Table 1 delineates phase 1 of the *Structures and Self* curriculum, the relationship between each pillar video, the goals and learning objectives, and corresponding constructs of the structural competency framework highlighted in each module. We created reflection questions, resources to accompany each video, and a visual glossary. All materials are freely available online through Innovating Education in Reproductive Health, a platform offering open-access, evidence-

based curricula (<https://www.innovating-education.org/course/structures-self-advancing-equity-and-justice-in-sexual-and-reproductive-healthcare/>). Materials are accessible for individuals or independent small groups, as a primary curriculum within a training program, or as a supplement to pre-existing syllabi. Phase 2 will consist of clinical cases that provide learners the opportunity to apply concepts presented in the pillar videos.

EXPERIENCE

Dissemination, Implementation, and Evaluation (Steps 5–6)

We provided clinical learners, educators, professional organizations, and community members with direct access to video content, minimizing barriers and ensuring community transparency and accountability. We did this through social media, direct communication, and curricular promotional materials at national conferences. We presented phase 1 at a national convening of the reproductive justice community hosted by SisterSong Women of Color Reproductive Justice Collective through an interactive workshop, directly engaging with advocates to elicit their expertise on further implementation strategies. We collected preliminary evaluation data of phase 1 with medical and nursing learners who either interacted

Table 1. Phase 1 Modules, Goals, Objectives, and Constructs of *Structures and Self*

Pillar Video Module	Goal	Objective	Structural Competency Constructs
Own our legacy	Understand historical context for inequities in sexual and reproductive health.	Identify 3 examples of legacies of oppression in sexual and reproductive health.	Recognizing the structures that shape clinical interactions; developing an extra-clinical language of structure.
Recognizing the structures of oppression	Analyze how the structures of power and oppression manifest within health care systems and affect sexual and reproductive health outcomes.	Define and distinguish structural and social determinants of health.	Recognizing the structures that shape clinical interactions; developing an extra-clinical language of structure; rearticulating “cultural” formulations in structural terms.
Check yourself	Identify bias, privilege, and fragility regarding patient interactions, relationship to structures of oppression, and practices for self-reflection and self-care.	Identify 1 example of their own implicit bias.	Rearticulating “cultural” formulations in structural terms; developing structural humility.
Taking action	Integrate justice framework and structural analysis as health equity–promotion tools.	Demonstrate increased self-efficacy in equitable care provision	Observing and imagining structural interventions; developing structural humility.

with the curriculum as part of a workshop, as required coursework via a learning management system, or accessed the content independently. The University of California, San Francisco Institutional Review Board provided exempt status. Of the 61 learners who completed the course evaluation, 82% felt the phase 1 videos definitely met the learning objectives, and 97% felt that the course was extremely useful or somewhat useful.

DISCUSSION

In an effort to fill a gap within structural health equity training in the health professions, we developed this curriculum using a rigorous development process and novel education frameworks. The emphasis on community engagement in our process follows in the legacy of community-based participatory research, as well as social accountability in health professions education. As defined by the World Health Organization,¹⁷ social accountability requires health professions schools and health systems alike to equally emphasize the values of relevance, quality, cost-effectiveness, and equity in all institutional activities, including clinician education. There is an increasing prevalence of social medicine, social determinants of health, and health equity topics incorporated into physician and nursing training.¹⁸ However, as this emphasis grows, there must also be continued innovation in curriculum development and implementation that centers equitable community participation to ensure clinician education meets societal needs. We created an academically and culturally rigorous¹⁹

curriculum through community partnership in content creation, authentic incorporation of their feedback, and transparency in dissemination practices.

Our ongoing work includes more rigorous evaluation assessing efficacy of community-participatory clinician education in structural equity training with various learner groups in multiple settings. We will consider strategies to strengthen community partnership including a community advisory board, and co-development of principles of partnership to ensure transparency and accountability. Additionally, we plan to include queer and transgender liberation organizations and disability justice organizations as community partners, centering perspectives from other justice movements affected by reproductive health inequities. Through these efforts, we offer structural equity training in obstetrics and gynecology as a single, but critical component of the institutional transformation required to equitably meet the needs of our learners, communities, and ultimately the public.

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