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## Structural Competency and Reproductive Health


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**Abstract**

Reproductive health disparities—particularly those experienced by racial and ethnic minority groups—are considered a persistent public health issue in the United States. Frameworks that focus on social determinants of health seek to identify the forces producing these disparities, particularly social conditions that create vulnerability to premature death and disease. Such frameworks pose challenges to health care provision, as structural factors can seem immutable to health care professionals trained to treat individual patients. Here, we discuss the links between reproductive health disparities and social determinants of health. We then apply to reproductive health care the *structural competency* framework, developed by physician-scholars to encourage health care professionals to address health disparities by analyzing and intervening upon sociopolitical forces.


### Introduction

The World Health Organization (WHO) defines reproductive health as an integral component of complete well-being, noting that reproductive health indicates that people "have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" as well as access to "safe, effective, affordable and acceptable methods of fertility regulation" [1]. Reproductive health care's success in advancing this vision is mixed [2, 3], suggested by persistent reproductive health disparities in the US, particularly with respect to race, gender, and socioeconomic status. Women of color and low-income women fare worse than their white and higher-income counterparts in nearly every aspect of reproductive health, including access to prenatal care [4], maternal mortality [5], cervical cancer mortality [6], sexually transmitted infections [7, 8], access to services (including assisted reproductive technologies) [2], and education [4].

For clinicians trained to treat individual patients, the structural underpinnings of these reproductive health disparities pose practical and conceptual challenges. *Structural competency* is a framework developed by physician-scholars that seeks to address these challenges and to encourage health care professionals to recognize, analyze, and intervene upon the structural factors that impact health disparities. Here, we define "structural" factors as those that codify, in systems like medicine, law, or welfare, differential access to social, political, and economic opportunities [9]. Structural factors produce group-differentiated vulnerabilities to harm, including health disparities, as well as group-differentiated access to goods, services, and resources [10]. In response to persistent reproductive health inequities and to challenges reproductive health professionals face in adequately engaging the social determinants of health, this paper applies structural competency to reproductive health care.

**The Social Determinants of Reproductive Health**

No single factor accounts for the persistent reproductive health disparities in the US. Major health organizations, such as the Centers for Disease Control and Prevention (CDC) and the WHO, have embraced social determinants of health as an explanatory framework to highlight the role of unequal social conditions in creating and perpetuating avoidable differences in health [11, 12]. These social conditions include those created by laws, policies, and practices overseeing "where persons work, live, learn, and play" [13], such as those regulating health care professionals and wider spheres (e.g., zoning, educational systems, food access, courts, and labor markets) [14]. The CDC states that familiarity with social determinants of health data can help practitioners better recognize "root causes" [15], which health care professionals can miss if they only rely upon individual-level assessment and interventions [16]. Amidst calls for health care institutions to play a role in eliminating reproductive health disparities and in incorporating social determinants of health into practice [17], scholars argue that reproductive health care operates within paradigms that directly and indirectly create or exacerbate reproductive health disparities [2, 3, 18, 19].

These paradigms impede access to care and reify disparities for many women by limiting patient autonomy, perpetuating stereotypes about marginalized groups, and undergirding negative health care experiences that might curtail future health care seeking [2, 20]. Consider *Madrigal v Quilligan*, a 1978 federal class action lawsuit brought forward by Latina women coercively sterilized in a Los Angeles public hospital. A former medical student testified that Dr. Quilligan, the named defendant under whom she trained, connected poverty, overpopulation, and social benefits of racialized sterilization. Quoting Dr. Quilligan, Gutiérrez writes "poor minority women in Los Angeles County 'were having too many babies,' that this was placing a 'strain on society,' and that it was 'socially desirable' that the women be sterilized" [21]. Here, public health policies underlay the connections between individual patient characteristics (e.g., being Mexican, low income) and the perceived social danger of overpopulation. Beyond *Quilligan*,

examples of health care practices and policies that replicate reproductive oppression and impede care for many women include the twentieth century's forced sterilization of poor and working-class women, disabled women, and women of color [22] and the coercive sterilization of at least 148 women in California prisons between 2006 and 2010 [23]; long-acting reversible contraception (LARC) promotion targeting racial or ethnic minority and poor women without regard for the ways that this might invoke population control [3]; and state family cap policies that deny cash benefits to children born in families already receiving benefits [24].

**Structural Competency as a Response to the Challenges of Addressing Reproductive Health Disparities**

What should reproductive health care professionals take from these examples of reproductive oppression? First, reproductive health care professionals must realize that their field has played a role in exacerbating health disparities by serving as gatekeeper to services, resources, and technologies that facilitate or constrain reproductive choice [25]. These practices are not matters of individual bias or failure or of health care professionals acting as "bad apples" [14, 26]. Rather, the medicalization of wider social problems (e.g., poverty, racism, nationalism) vividly emerges in reproductive health care [27]. The (potentially) pregnant body is a site of systematized and heightened regulation and surveillance, particularly when those bodies are poor, disabled, immigrant, minority, and so on [27]. The medicalization of social problems has ethical implications for reproductive health care professionals, who must balance their pursuit of patient care and respect for patient autonomy, justice, beneficence, and nonmaleficence with the realities of institutional and structural discrimination experienced by patients. Indeed, research indicates that health care professionals do not feel equipped to understand or intervene upon structural factors, despite acknowledging the impact such factors have on their profession [28, 29]. Trained to treat individuals, reproductive health care professionals might contribute to the replication of problematic health care trends by ignoring structural barriers to care [30] because they and their institutions lack the skills and resources to identify, analyze, and imagine structural interventions.

*Structural competency*, an emerging paradigm in health care, seeks to address medicine's overemphasis on the individual (e.g., biology, behaviors, characteristics) while addressing the hierarchies that produce unjust health conditions. Structural competency responds to dominant paradigms in health care education that neglect the ways in which access to the resources needed to make health changes and choices are influenced by unjust social determinants such as the differential treatment patients receive from health care institutions and professionals with respect to race, class, or immigration status, for example [31]. Developed by physician-scholars, structural competency is a means not only to analyze structural factors that impact health disparities but also to operationalize health care interventions to reduce health disparities, including in reproductive health [13, 32, 33]. Structural competency moves beyond cultural competency, which can

reinforce racial, ethnic, linguistic, or other stereotypes by positioning these cultural groups as unsophisticated subjects and professionals as sophisticated or objective [34]. Structural competency offers a means to pursue ethical practice in a context of structurally produced health disparities without blaming the individual for health outcomes produced by upstream social conditions that are ultimately beyond his or her control.

Universities and clinics across the US have engaged with structural competency, offering conferences, trainings, and semester-long programs [28, 35]. A shift to structural competency is ultimately a hopeful one. To health care professionals, the social determinants of health can feel immutable; structural competency helps demystify health's causal pathways and identify systematic ways to help patients.

**Applying Structural Competency to Reproductive Health**

Structural competency has particular utility in politically charged settings such as reproductive health care, where the day-to-day activities of health care professionals are highly sensitive to changes in the social, political, and economic spheres. Successfully treating patients while navigating these rapidly changing conditions requires understanding of the structures shaping these conditions. Metzl and Hansen outline five core elements of structural competency generally: defining clinical interactions in structural terms, developing an extra-clinical language of structure, rearticulating "cultural" presentations in structural terms, observing and imagining structural intervention, and developing structural humility [14]. Here, we apply these elements to reproductive health care.

*Recognizing the structures that shape clinical interactions*. Structural competency holds that recognition of structures shaping clinical interactions—including laws, funding mechanisms, and markets—is important, as it allows health care professionals to understand the wider spheres governing their clinical work. With that understanding, health care professionals can identify and correct missed opportunities to support their patients in navigating structural barriers to care. Abortion counseling services provide an instructive example of the structures shaping clinical interactions and their implications for health care and outcomes [31]. Owing to targeted state legislation that drains clinic budgets by forcing compliance with regulations beyond what is needed for patient health and safety [32, 33], many abortion clinics must meet patient need in minimal time. In turn, clinics cut services such as in-depth counseling, which provides space for patients to process their values and preferences related to abortion [36]. Furthermore, in-depth counseling can enhance quality of and access to care when it identifies structural barriers to health outcomes (for example, difficulties travelling to follow-up appointments among undocumented persons due to police checkpoints) [36]. A structurally competent approach to abortion care, incorporated into education and training curricula, would provide health care professionals with a framework to understand and analyze the social

and political conditions that constrain the types of care available and influence clinical outcomes.

*Developing an extra-clinical language of structure*. An extra-clinical language of structure refers to incorporating terms and concepts from social, political, and economic theory into the health care encounter. Consider the case of promotion of LARC to prevent adolescent pregnancy. Although adolescent pregnancy is now recognized to be influenced by a complex set of factors—including education, housing, and employment—that pregnancy prevention alone cannot solve [37], Higgins argues that promoting LARC as if contraceptive efficacy were a panacea to structural barriers faced by young, poor women of color is unfair to patients and health professionals alike because it puts the onus on individual patients and professionals to solve a problem better addressed by more robust funding of education, housing, and employment programs [37]. In this context, language engaging social conditions (e.g., poverty) is ineffectual and does not reach the level of extra-clinical language suggested by structural competency, given that these arguments are not informed by the rich discussions of structural barriers in social, political, and economic theory. Drawing on structural competency, health care professionals might see how the absence of structural factors and social well-being in discussion of LARC locates the origin of social problems in the reproduction of poor adolescents. They could then be ready to discuss contraceptive decision making with their patients (and colleagues) in terms that go beyond clinical effectiveness, which is commonly promoted by physicians as the most important contraceptive consideration for women, although women often consider other aspects such as acceptability, values, and autonomy to be of equal or greater importance [30, 38]. A structurally competent perspective surfaces the ways that social inequities with respect to race, gender, class, and age are reproduced within clinical settings and in rhetoric about LARC, highlighting the need for alternative counseling approaches (such as shared decision-making models, which seek maximum patient input and use patient-directed language) [31].

*Rearticulating "cultural" presentations in structural terms*. Rearticulating "cultural" presentations in structural terms refers to understanding the structural factors producing differential clinical outcomes and presentations based on race or ethnicity and including these factors in any assessment and treatment plan. Health care professionals must consider the ways in which their knowledge base (e.g., research studies that refer to young, poor, or minority women as "at risk" for pregnancy and that replicate moralizing risk discourses [39]) and their professional norms explicitly and implicitly stratify women's fertility based on stereotypes that are often framed as inherent to group "culture" [40]. One example is the stereotype that young, poor women of color are at risk for unintended pregnancy due to the controversial notion of a "culture of poverty" [41, 42] or "cycle of poverty" [43] that devalues education and other means of social mobility and promotes promiscuity. In rearticulating "cultural" presentations, health care

professionals should analyze how patients' decisions, feelings, and resources related to reproductive health might be influenced by differential opportunities to parent and exercise autonomy over childbearing options. Rearticulating cultural presentations in structural terms enables health care professionals to recognize stereotypes when they emerge in practice and to treat patients' issues more accurately and acceptably [31].

*Observing and imagining structural intervention.* Observing and imagining structural interventions means health care professionals are both *aware* of key examples of thinking beyond the individual and *capable* of envisioning how they might apply them in practice. Reproductive health professionals can look to the past, present, and future to observe and imagine structural interventions. Women of color launched the reproductive justice movement in 1994, because they were dissatisfied with the reproductive rights movement's narrow focus on "choice." They openly challenged the exclusion of abortion access from health care reform and pushed for an intersectional understanding of reproductive oppression, particularly the forces that denied women of color the human right to have children and to parent with safety and dignity, as well as the right not to have children [44]. These activists paved the way for minority women's leadership in health advocacy and in organizing successful campaigns against unjust policies and practices [45]. One example of reproductive justice in action is Black Women Birthing Justice, a San Francisco Bay Area collective that seeks to ensure, for black women, the right to birth with safety and autonomy—where, how, and with whom they choose. This organization works closely with local health providers and grassroots community groups to expand access to the range of pregnancy and postpartum care options for black women (e.g., Medicaid coverage of home birth, access to doulas and midwives of color, and access to trauma-informed, strengths-based breastfeeding support) as well as to increase the accountability of medical institutions to black pregnant women through community accountability boards [46].

In the current political climate, health care professionals might consider structural interventions such as training in how to resist collaboration with US Immigration and Customs Enforcement (ICE) and other policing institutions within their own clinics and at community-led direct actions [47, 48]. For example, citing erosion of community safety and public trust in local institutions, Planned Parenthood Mar Monte in California was one of 18 signers of a letter demanding that the Fresno sheriff immediately end a partnership between ICE and the police department, which had facilitated detainment and deportation proceedings of over 100 people [47]. Detainment and deportation can worsen reproductive health outcomes (e.g., increased risk for unintended pregnancy and sexually transmitted infections) by depriving patients of necessary reproductive care as well as subjecting undocumented women and families to disproportionate state violence and surveillance, thereby constraining their reproductive choices and experiences [49, 50]. Reproductive health care professionals might also consider following the example of movements such as White Coats for Black Lives, which leverages clinicians' professional

privilege to galvanize political support for the Black Lives Matter movement [51]. The Black Lives Matter movement and reproductive health equity are inextricable, given that police brutality and surveillance can be understood in the words of one physician as "particularly extreme forms of maternal stress" and might influence black women's health outcomes or childbearing decisions [48]. As the political climate surrounding reproductive health intensifies, professionals are in a privileged position to advocate for structural interventions addressing not only the immediate reproductive health care needs of their patients but also the conditions that produce differential vulnerabilities in the first place. Structural competency allows for more appropriate interventions by aiding clinicians in recognizing and responding to the most salient structural contexts in the clinical encounter itself while also motivating clinicians and their health care systems to intervene in the extra-clinical determinants of health.

*Developing structural humility*. Structural humility is the capacity of health care professionals to appreciate that their role is not to surmount oppressive structures but rather to understand knowledge and practice gaps vis-à-vis structures, partner with other stakeholders to fill these gaps, and engage in self-reflection throughout these processes. Self-reflection allows health care professionals to better discern how structures are impacting them and their patients and identify systematic ways to help patients. By definition, structural issues cannot be addressed by an individual. Health care knowledge and interventions will always be partial. Engaging with this reality rather than clinging to professional status and expertise means that professionals will be better able to capture the complexity of their own experience as well as that of patients and other allies.

Although necessary, increased awareness of structural influences on health through more robust education and training will only take reproductive health professionals so far. Collective, coalition-based action to create lasting structural changes must follow reflection and awareness raising [14]. One example is taking a collaborative, movement-based approach to reform, such as the movement for single-payer health care [52, 53]. Reproductive health care professionals are well poised to argue for full access to reproductive health care (including abortion) in legislation that expands health care delivery [54], which would address social determinants of reproductive health by lowering financial barriers to the full-range of health care options patients need to achieve reproductive autonomy. In order to be fully visible and influential, they must do so alongside other health care professionals and advocacy groups such as Physicians for a National Health Program or National Nurses United [53]. Embracing structural humility, reproductive health care professionals must be careful not to dominate discussions or strategy at the expense of other stakeholders but rather cooperate and compromise as they move into spaces where multiple knowledges, identities, and priorities converge.

## Conclusion

Structural competency represents a powerful framework for shifting the burden of eliminating health inequities from individual professionals and patients to institutions and systems, including health care, schools, and clinics. Structural competency training with a reproductive health focus might improve clinician sensitivity to social determinants of health, encourage generative self-reflection, and open opportunities for solidarity with patients. It might help health care professionals offer safer, more acceptable, and therefore more effective care. Given that reproductive health care professionals may work within "beleaguered" systems [55], structural competency is a means to empower these professionals to face occupational difficulties and organize for transformative change [56]. Because changes in structure cannot be achieved by individuals alone, structurally competent reproductive health care will take collective force, skill, and imagination but can ultimately play a key role in helping health care professionals to advance a vision of reproductive health as part of complete community well-being, to the benefit of patients and professionals alike.

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