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Reproductive Justice Teaching in Undergraduate Medical Education: An Opportunity to Partner with Communities beyond Traditional Medicine to Influence Health

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Reproductive health: The intersection of misogyny and white supremacy

As the U.S. confronts an obliteration of equitable abortion access, the medical field must reckon with how it was built for some and not others, contributing to white supremacist and patriarchal hierarchies. Unsurprisingly, these forces coalesce most acutely in reproductive care. Reproductive coercion is stippled throughout healthcare's history (Dillingham, 1977; Khabele et al., 2021; Lawrence, 2000; Manian, 2020). These traumas culminate in unjust disparities as Black women face 2.9 times greater risk of obstetric death when compared to white women (Center for Disease Control, 2022).

As healthcare providers, our inclination is to gaze inward for medical solutions. However, this approach discounts healthcare's infractions and underestimates non-healthcare organizations' expertise. In this paper, we offer reproductive justice (RJ), developed by Black women, as an exemplary framework of a more expansive educational pedagogy that can potentially improve Black and Brown people's reproductive health outcomes.

RJ: An expansive understanding of patient health

In 1994, twelve Black women leaders formed the historic Women of African Descent for Reproductive Justice (*Reproductive Justice*, n.d.; Silliman et al., 2016). These revolutionaries developed RJ, an approach that advocates for every person to have bodily autonomy, have children, not have children, and parent in safe environments (*Reproductive Justice*, n.d.; Ross, 2006).

Reproductive health's medical lens focuses on healthcare service delivery (Parker, 2020; Ross, 2006). Conversely, RJ expands upon healthcare services to include education, nutritional and environmental factors, and community safety, which all contribute to personal and family health (Ross, 2006). Centered on access, not choice, it views reproductive health delivery within the context of justice, discrimination, and opportunity (*Reproductive Justice*, n.d.; Ross, 2006).

Due to our proximity to health systems, medical professionals tend to focus solely on reproductive health delivery. We ignore harms done to patients within the wider medical setting, harms that many patients carry with them into exam rooms. Therefore, we propose that reproductive health professionals, educators, and trainees adopt an RJ lens, considering community approaches that will ultimately make RJ work sustainable and impactful.

Incorporating RJ into the UME classroom

For healthcare professionals to consider an RJ framework, change can begin within the Undergraduate Medical Education (UME) classroom. We developed an RJ "clinical" curriculum for medical students who have finished their core clerkship rotations. Learning objectives were drawn and adapted from previous RJ literature working to bridge the medical advocate and RJ activist (Loder et al., 2020). Upon

deliberation with multiple stakeholders, we identified the learning objectives to include: 1) improving the understanding of reproductive historical injustices; 2) building knowledge about RJ, access (the ability to obtain healthcare resources in a timely manner), and disparities (differences in this access across population groups); and 3) increasing appreciation of alternative approaches to reproductive care and advocacy (Agency for Healthcare Research and Quality, n.d.-b, n.d.-a).

The month-long advanced elective course uses a constructivist and experiential-based pedagogical model to innovatively offer both traditional clinical experiences, such as family planning, community health, and centering pregnancy prenatal groups, and nontraditional, nonclinical experiences, in which medical students work with various organizations, professionals, and activists across different medical-adjacent, legal, and community settings to instill an intersectional understanding of the RJ tenets. By creating an experience-based curriculum, we aim for students to not only develop skills and knowledge in advocacy and RJ, but we also expect them to contribute to the partnered organizations.

Early in curriculum development, we solicited feedback from collaborators. Important concerns were raised about pedagogy rooted in medicine. For example, how can medical providers and trainees better understand all RJ tenets, not only the ones that most readily intersect with medicine? Whose perspectives are essential in facilitating an RJ curriculum? How can students and curriculum facilitators engage community partners in meaningful ways? As one clinician asked, "How does this course do justice to RJ?" In response, we considered three driving principles, which can be widely applied to feminist curriculum development:

1.) *Anchor the curriculum in patients' exposures and experiences beyond the medical system*

The medical system has historically perpetrated racism, misogyny, homophobia, and transphobia. Alternatively, RJ is rooted in community advocacy. Therefore, instead of centering the curriculum within the health system, we aim to center our curriculum within the communities we serve as RJ does. We committed to only partnering with experts who are based locally and have specific knowledge of the communities in our area. Furthermore, traditional medical school reproductive health electives usually only focus on one or two of the dimensions of RJ such as family planning or obstetric care. However, we carefully chose a group of experts who have experience across the aforementioned RJ tenets.

2.) *Establish non-medical community partners and rely on their expertise to enrich medical students' learning*

To better capture the tenets' intersectional nature, we depend on the knowledge of activists, healthcare providers, and legal professionals as curriculum collaborators, didactic speakers, and practicum facilitators (Table 1). Specifically,

the curriculum relies on expertise from attorneys, doulas, fertility specialists, social workers, researchers, patient navigators, and community activists, among others. These experts can best capture and teach students about the expanse of RJ and its roots in community advocacy.

We identified community partners through multiple mechanisms. First, our team depended on previously established relationships that existed through other courses, professional networks, and extracurricular activities. Next, we expanded on this primary list by relying on word-of-mouth, asking collaborators if they knew others who could speak to our learning objectives. Finally, we returned to the core RJ tenets and reflected on missing voices. We then researched which community organizations and people might be able to fill these gaps.

3.) *Create an iterative, respectful, and mutually beneficial approach to foster open communication and longitudinal relationships with these community partners*

Finally, in working with community partners, we had to consider that our partnerships are not voyeuristic, exploitative, or brief. In creating this curriculum, we strive to be intentional and reflect a true partnership. We acknowledge our own and the students' positionality as medical professionals and recognize the harm that our profession has inflicted. Therefore, we come from a position of learners ourselves and attempt to create channels for open communication, responding to feedback and ideas from our community partners from curriculum development to course implementation. In this course, students will continue to carefully reflect upon these relationship dynamics through a self-directed capstone project that uses an inquiry-based pedagogical approach and encourages students to research a historic or recent aspect of RJ and critically consider the clinical, legal, and community-based contributors.

Table 1: Experts Recruited for Course.

Expert Position/Description	Area of Focus
To have bodily autonomy	
Social worker	Incarcerated populations
Researcher	Disability justice
Patient navigators	Community-level assets and approaches
Physician	Disability justice
Community organizations centering people who are incarcerated	Incarcerated populations
Clinician at gender-affirming care community health center	Care for transgender, binary, and gender-nonconforming people, assisted reproductive technology/reproductive endocrinology and infertility (ART/REI)
Community organization centering those who have faced sexual violence	Intimate partner violence (IPV), sexual violence, trauma
Law group	Legal reproductive rights and policy
Clinician who works within hospital-based IPV and mental health programs	IPV, sexual assault, and trauma-informed care
To have children	
Doulas	Community doulas
Centering pregnancy groups	Racial disparities in obstetric outcomes, focus on maternal mortality and morbidity

Federally qualified health center artificial insemination program	LGBTQ+ care, ART/REI
OB/GYNs	Obstetric violence, high-risk labor, hospital-based doula program
Attorney	ART/REI and LGBTQ+ care
To not have children	
Abortion clinics	Contraceptive equity and access to abortion care
Hospital-based family planning center	Contraceptive equity and access to abortion care
Community clinics	Contraception and community health, racial disparities in sexual health/ gynecological care
To raise children in safe and healthy environments	
Community organizations centering Black people	Community advocacy, disparities in OB/GYN care
Community organizations centering people who have immigrated	Immigrant populations
Local shelter	Populations facing housing insecurity, intimate partner violence

Conclusion

The medical institution has built barriers and contributed to reproductive disparities. Healthcare providers have been narrowly focused on siloed medical service delivery for too long. We must recognize that RJ is a wider-lensed approach that considers our patients' social contexts and is necessary in dismantling reproductive disparities. Our curriculum demonstrates that intentional, mutually beneficial partnerships between community and medicine can foster appreciation of RJ's intersectional approach. This paper's scope focuses on this curriculum's development; however, future directions of this work include assessing classroom

implementation. Furthermore, there are other aspects of medicine that have and can utilize the community approach, such as addiction medicine and mobile medicine. To create sustainable change, healthcare professionals and trainees must become allies in movement building towards RJ.

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