Available online at www.sciencedirect.com
ScienceDirect
Nurs Outlook 61 (2013) 5–15
Nursing Outlook
www.nursingoutlook.org

Where we are today: Prioritizing women's health services and health policy. A report by the Women's Health Expert Panel of the American Academy of Nursing

Judith A. Berg, PhD, RN, WHNP-BC, FAAN, FAANP[a,*], *Diana Taylor, PhD, RNP, FAAN*[b], *Nancy Fugate Woods, PhD, RN, FAAN*[c], *The Women's Health Expert Panel of the American Academy of Nursing*

[a] *Clinical Professor, University of Arizona College of Nursing, Tucson, AZ*

[b] *Professor Emerita, School of Nursing, University of California, San Francisco and Research & Evaluation Director, UCSF Primary Care Initiative, Advancing New Standards in Reproductive Health Program (ANSIRH), UCSF Bixby Center for Global Reproductive Health, San Francisco, CA*

[c] *Dean Emerita and Professor, University of Washington School of Nursing, Seattle, WA*

ARTICLE INFO

Article history:
Received 14 December 2011
Revised 5 June 2012
Accepted 11 June 2012

Keywords:
Women's health
Affordable Care Act
National Prevention Council and Strategy
World Health Organization
Institute of Medicine
Unintended pregnancy

ABSTRACT

There has been a recent resurgence of interest in women's health as evidenced by several federal and international policy-shaping reports that will impact women's health services. These reports include the 2010 Affordable Care Act, the formation of the National Prevention Council and Strategy, the 2011 IOM report on clinical preventives services for women, and the World Health Organization strategic plan for 2010-2015. In this paper, we summarize and discuss these reports and discuss implications of enacting the suggested health policies. We highlight policy strategies and recommendations that will extend national and global recommendations to improve women's health and wellness across the lifespan and emphasize the urgent need for preventive services. We conclude this paper by detailing our broad recommendations for putting prevention into practice illustrated by specific recommendations related to unintended pregnancy prevention and management.

Cite this article: Berg, J. A., Taylor, D., & Woods, N. F. (2013, FEBRUARY). Where we are today: Prioritizing women's health services and health policy. A report by the Women's Health Expert Panel of the American Academy of Nursing. Nursing Outlook, 61(1), 5-15. http://dx.doi.org/10.1016/j.outlook.2012.06.004.

In the wake of the Affordable Care Act, there has been a resurgence of interest in issues and priorities related to women's health. In a previous paper, we summarized and discussed the recent NIH Office of Women's Health vision for the women's health research agenda for 2020 and the Institute of Medicine (IOM) report on women's health research. In this article, we summarize federal and international actions as well as policy-shaping reports that will affect women's health services: the 2010 Affordable Care Act (U.S. Department of Health and Human Services, 2010a), the formation of the National Prevention Council and Strategy (National Prevention Council, 2011), the 2011 IOM report on clinical preventive services for women (Institute of

The authors wish to acknowledge the following individuals for their contributions to this paper: Joan Shaver, PhD, RN, FAAN, Ellen Olshansky, PhD, RN, FAAN

* *Corresponding author:* Dr. Judith A. Berg, Clinical Professor, 800 The Mark Lane #2901, San Diego, CA 92101.
E-mail address: jberg@nursing.arizona.edu (J.A. Berg).

http://dx.doi.org/10.1016/j.outlook.2012.06.004

Medicine, 2011), with comments regarding the World Health Organization (WHO) strategic plan for 2010–2015 (World Health Organization, 2009). We end by highlighting policy strategies and recommendations that will extend these national and global recommendations to improve women's health and wellness and, using unintended pregnancy as a starting point, we propose an integrated, comprehensive model of care for women that provides a strong framework for the prevention services outlined in the early sections of this article.

The Affordable Care Act

Signed into law by President Obama on March 23, 2010, the Patient Protection and Affordable Care Act (ACA) reforms the nation's health care system and, when fully implemented, holds the promise of dramatically improving the health of women throughout their lives. The aim is to provide all Americans with quality, affordable, comprehensive health insurance. The impact on priority healthcare issues for women includes access to health insurance coverage, healthcare affordability, scope of benefits, reproductive health, and long-term care.

By increasing the number of women with health insurance, this federal legislation should improve women's health. For example, because currently young women (ages 18–44) are most likely to be without health insurance and postpone preventive health care and treatment, providing health insurance becomes a preventive health service. The new law specifies a minimum package of services that must be offered by qualified health plans (e.g., individual, group, and state exchanges); these services referred to as "essential health benefits" broadly include ambulatory and emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services (including behavioral treatments), prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, chronic-disease management, and pediatric services (including oral and vision care). Table 1 outlines benefits (and gaps in benefits) under the ACA and Figure 1 highlights relevance to women and other major improvements.

Many of the important details that will shape how well the law improves insurance rates and access to care for women will depend on the regulations promulgated by the Department of Health and Human Services (DHHS) as well as the choices that state policymakers will make regarding their Medicaid programs and new insurance exchanges. According to a 2010 Women's Health Care Report Card, collaboratively created by the National Women's Law Center and the Oregon Health Sciences University, the majority of states consistently fail to protect the health of women. Overall, the U.S. has failed to meet most goals for women's health as proposed by Healthy People 2010 (National Women's Law Center Health Care Report Card, 2010). In the Report Card grading of women's health status, although progress was made for rates of smoking, colorectal cancer screenings, and coronary heart disease mortality, only three benchmarks were met (women receiving mammograms, colorectal screenings, and annual dental visits) and 23 benchmarks were missed. Women's health benchmarks missed by all states include those related to health insurance, poverty, obesity, wage gap, life expectancy, high blood pressure, diabetes, infant mortality, unintended pregnancy, pap smears, *Chlamydia* treatment, and nutrition (National Women's Law Center, 2010).

An important part of the ACA has been the prohibition on charging patients for preventive healthcare costs (See Table 1). Within qualified health plans (in 2010) and Medicare (by 2011) the new law eliminates cost-sharing for the "highly effective" services recommended by the U.S. Preventive Services Task Force (USPSTF) and immunizations recommended by the Advisory Committee on Immunization Practices. Although deductibles, copayments, or other cost-shifting practices might not be eliminated entirely, all new insurance plans are required to cover preventive health services without cost sharing.

Although the ACA addresses many of the women's health services receiving a failing or unsatisfactory grade on the National Women's Health Report Card (2010), many prevention services relevant to women were not recommended for coverage without co-pays. Reducing unintended pregnancies even with contraceptive coverage and counseling is not clearly addressed by the ACA. This omission exists, although preventing unintended pregnancy is an unmet national health goal and prevention of unintended pregnancy has been recommended for increased research funding by a 2010 Institute of medicine (IOM) Committee Report, titled, *Women's Health Research: Progress, Pitfalls, and Promise* (Institute of Medicine, 2010). Although unintended pregnancy prevention interventions might be included in annual well-woman examinations, they were not recommended for no-cost inclusion. The ACA treats abortion care, an essential component of reproductive healthcare services, differently from all other healthcare services. The ACA places onerous restrictions on some private insurance coverage of abortion services, forcing some individuals and healthcare plans to follow certain administrative requirements if they want to offer or purchase insurance coverage that includes abortion services.

In summary, although the Affordable Care Act provides for many preventive services for women (Table 1), several gaps related to reproductive healthcare will remain. In particular, lack of attention to family planning, contraceptives, well-woman visits, preconception counseling, and domestic-violence prevention, as well as abortion care, were omitted.

Table 1 – Affordable Care Act Benefits that Improve Access for Women and Girls

ACA Benefits	Benefits that Improve Access for Women and Girls	Benefit Gaps in ACA
Primary Care	Incentives to increase primary care providers (PCPs) CNMs and OB-Gyn MDs as PCPs Coordinated primary care for Medicaid-Medicare eligible patients	
Preventive Care	No cost-sharing for preventive services rated as highly effective by USPSTF (A–B rating) Immunizations including HPV vaccine for women and girls < 26 yrs. Early cancer detection and counseling: Breast, ovarian, cervical and colorectal cancers; Mammography for women at age 40 STI/STD screening, counseling and treatment: HIV, GC, Syphilis, Chlamydia Chronic condition prevention, screening: HTN screening, Diabetes screening if HTN, Osteoporosis screening, cholesterol screening, aspirin prescription Pregnancy-related: Tobacco use counseling/interventions; breastfeeding counseling; Hepatitis, anemia and bacteriurea screening. Lifestyle/Healthy Behaviors: alcohol screening/counseling; depression screening; tobacco use counseling/interventions; healthy diet counseling for high-risk people; obesity counseling/ interventions.	Family Planning, contraceptives, well woman visits, preconception counseling, domestic violence prevention NOT COVERED No requirements for Medicaid to cover highly effective preventive services, financial incentives for the states with increased federal payment match.
Maternity Care	Allow low-income new mothers and newborns to maintain Medicaid coverage beyond the postpartum period Requires tobacco cessation programs for pregnant women on Medicaid Increased support for reimbursement of CNMs, birth attendants, and free-standing birth centers. Post-partum depression education-support services Maternal, infant, early childhood home visiting programs Expanded workplace breastfeeding support services	
Reproductive Health	Allows states to extend eligibility for family planning services to those with incomes below 185% poverty without federal permit process. Provides funding to states to provide evidence based sex education to reduce teen pregnancy rates and STI incidence Restores funding for State Title V Abstinence Education Grant Program (non-evidence based). Plans that do cover abortion beyond Hyde limitations must segregate funds, but the separate premium must be charged of all enrollees.	Family Planning counseling and contraceptive devices not specifically named as an essential benefit. Abortion coverage specifically banned from being required as part of essential benefits.
Older Women's Health	Several changes to Medicare to decrease out-of-pocket costs for drugs and preventive services Annual personalized health plan and risk assessment No cost-sharing for mammograms, pap smears, bone density testing Some assistance with long-term care costs through voluntary insurance program (CLASS Act)	
Federal Offices on Women's Health	Codifies establishment of Offices of Women's Health in major federal agencies—DHHS, CDC, FDA, HRSA, and AHRQ Offers protections to agencies without direct approval of Congress	

Reforms of special relevance to women include the following:

- Ensure that insurance companies will not exclude coverage of individuals or the conditions for which they need care
- Financial assistance to help individuals with limited income obtain affordable coverage
- Requirements that a broad range of health care services are covered
  New mechanisms to make it easier for uninsured individuals and small employers to shop for, compare, and choose the best insurance to meet their needs in new "Exchanges"
- Significant expansion of Medicaid, the public health insurance program for low-income people.

Other major improvements in the ACA include:

- Addresses health disparities and discrimination, including by prohibiting most insurance companies, health care providers, and health programs from discriminating on the basis of sex.
- Promotes prevention and wellness, including by requiring new insurance plans to cover preventive health services at no cost and charging a new National Prevention, Health Promotion, and Public Health Council with developing a prevention and health promotion strategy for the country.
- Improve health care quality and access by increasing the number of health care providers and building incentives into the system for providing high quality care.

Figure 1 – The Affordable Care Act: Care Benefits to Women and Other Major Improvements.

The National Prevention Strategy: America's Plan for Better Health and Wellness

Along with the passage of the Affordable Care Act in July 2010, the National Prevention Council was formed and tasked with developing and implementing the first-ever national prevention strategy to promote evidence-based interventions to improve health and wellness. Created by the National Prevention Council (comprised of the heads of 17 Federal agencies and chaired by the Surgeon General along with an Advisory Group of outside experts), the *National Prevention Strategy: America's Plan for Better Health and Wellness* spotlights the importance of quality healthcare that stops disease before it begins (National Prevention Council, 2011).

Especially commendable is the recognition of interrelationship of health and the context in which people live their lives, with attention to factors such as clean air and water, safe outdoor spaces for physical activity, safe workplaces, healthy foods, violence-free environments and healthy homes. The unique viewpoint of moving healthcare from sickness and disease to wellness and prevention is a groundbreaking national policy advance focused on decreasing mortality and disease as well as ensuring that people's lives are healthy and productive.

Better health is seen as a way to reduce healthcare costs, and both public and private partners are needed to help all Americans stay healthy. Four concepts are emphasized: building healthy and safe community environments; expanding quality preventive services in both clinical and community settings; empowering people to make healthy choices; and eliminating health disparities. Evidence-based recommendations most likely to reduce preventable death and morbidity specify seven priority areas: tobacco-free living; preventing drug abuse and excessive alcohol use; healthy eating; active living; injury and violence-free living; reproductive and sexual health; and mental and emotional well-being.

The recommendations of the National Prevention Council are encouraging because most state laws and regulations, as well as the ACA do *not* fully serve to protect and promote the health of women, particularly those related to reproductive health. This circumstance is evident when comparing state policies on access to contraception through private insurance, immediate access to emergency contraception (especially as a component to post-sexual assault care), abortion access (including limitations on private insurance or state-funded payment, requiring parental notification/consent, requiring a waiting period/counseling), and patient protections in the case of provider refusal (ie, sterilization, abortion, emergency contraception) (National Women's Law Center, 2010).

In sum, despite a multicomponent priority statement of the National Prevention Council, including reproductive and sexual health, the ACA does not assure access to appropriate services. Although preexisting mental-health conditions cannot serve as a reason to deny health insurance under the ACA, in its present form it does not expand access to mental-health services significantly.

Institute of Medicine Report on Clinical Preventive Services for Women: Closing the Gaps

Commissioned by the DHHS Office of the Assistant Secretary for Planning and Evaluation, in 2011 the IOM

issued a report on *Clinical Preventive Services for Women* focused on closing the gaps in existing preventive services for women authorized by the ACA (Institute of Medicine, 2011). Figure 2 details the questions addressed. This report was to guide implementation of the ACA preventive services coverage with respect to: 1) determining which preventive services are necessary for women's health and well-being and should be considered in the development of comprehensive guidelines for preventive services for women, and 2) recommending a process for regularly updating the preventive screenings and services to be considered for coverage under the ACA (U.S. Department of Health and Human Services, 2010). The committee focused on females who are 10 to 65 years of age, looked for other evidence beyond systematic evidence-based reviews, were informed by the USPSTF mammography screening specified in 2002 (United States Preventive Services Task Force [USPSTF], 2009), did not duplicate processes used by USPSTF (Agency for Healthcare Quality [ARHQ], accessed 12/8/11), did not consider cost-effectiveness of screenings or services, and focused on preventive services for clinical settings, but not those that were community-based.

The IOM Committee defined preventive health services as measures—including medications, procedures, devices, tests, education, and counseling—shown to improve well-being, and/or decrease the likelihood or delay the onset of a targeted disease or condition. They looked beyond the traditional disease focus of the USPSTF, taking into account contextual issues related to gaps in existing services affecting women's health and well-being. Across groups such as the USPSTF (12/8/11), professional organizations or federal agencies, they clarified ambiguities occurring in USPSTF Grade A and B recommendations about gaps in services or periodicity of screenings. The committee also reviewed the USPSTF Grade C for which the balance of potential benefits and harms does not strongly favor recommending the service to all patients, as well as Grade I recommendations for which evidence is insufficient to suggest effectiveness. In addition the committee considered the Bright Futures recommendations, realizing that primary-care providers would need to identify priorities among multiple preventive services for visits based on the unique circumstances of each patient, such as for girls and adolescents (American Academy of Pediatrics, 2008; Institute of Medicine, 2011).

In addition to the 31 preventive services already recommended by the USPSTF as highly effective (Table 2), the IOM Committee recommended 8 additional services to be included for no-cost coverage in health plans, detailed in Table 3. The committee also recommended a process for updating preventive services for women that was: independent; free of conflict of interest; evidence-based; gender-specific; life-course oriented; transparent; informed by systematic surveillance and monitoring; cognizant of the need to integrate clinical preventives services with effective interventions in public health, the community, workplace, and environment; and appropriately resourced. Furthermore, the committee recommended that the Secretary of DHHS establish a commission to recommend ACA coverage of new preventive services for women and to identify existing bodies or appoint new ones as needed to review the evidence and develop clinical practice guidelines to be reviewed by a preventive services coverage commission (Institute of Medicine, 2011).

Progress in National Healthcare Policies and Services for Women

The IOM Committee on Clinical Preventive Services for Women has made significant contributions to guide inclusion of prevention services for women beyond those covered by the ACA. Not only do they recommend those "highly effective" services included in the USPSTF preventive services, their recommendations augment significant gaps in preventive healthcare for women and adolescent girls, especially those of reproductive age. Using a variety of approaches, the committee identified services that have been indicated for screening in women, whose risk for complications is elevated (e.g., screening pregnant women at high risk for diabetes at the first prenatal visit). For all sexually active women, they recommended HIV and sexually transmitted disease counseling and screening; for initiation at 30 years of age human papilloma virus (HPV) testing for women with normal cytology results;

1. What is the scope of preventive services for women not included in those recommended preventive services for USPTF Grade A and B (defined as highly effective)?
2. What additional screenings and preventive services have been shown to be effective for women? Consideration was given to those services shown to be effective but not well utilized among women disproportionately affected by preventable chronic illnesses.
3. What services and screenings are needed to fill gaps in recommended preventive services for women?
4. What models could HHS and its agencies use to coordinate regular updates of the comprehensive guidelines for preventive services and screenings for women and adolescent girls?

Figure 2 – Questions Addressed by the Institute of Medicine's Clinical Preventive Services for Women Committee in 2011.

Table 2 – IOM Committee on Clinical Preventive Services Recommendations: U.S. Preventive Services Task Force Grade A and B with specification of additional evidence-based services (in bold) for inclusion in well woman visits under the Affordable Care Act

Prevention/ Health Promotion	Screening	Counseling	Interventions
Pregnancy-related	Anemia Bacteriuria Chlamydia Hepatitis B Syphilis Rh incompatibility **PPD** **Suicide** **History of CVD-related conditions in pregnancy** **Prenatal Care**	Breast-feeding Tobacco Use **Prenatal Care**	
Cancer	BRCA Breast Cancer Cervical Cancer Colorectal Cancer	BRCA	BC Chemoprevention
Chronic Illness	BP Lipid Diabetes Osteoporosis **Metabolic Syndrome**	Osteoporosis	
Substance Use		Alcohol Misuse Tobacco Use	Tobacco Use
Healthy Behaviors	Obesity **Physical activity levels, Eating behaviors, Preconception Care**	Healthy Diet Obesity **Refer for interventions** **Preconception Care**	Folic Acid supplementation **Preconception Care**
STI	Chlamydia <25yo GC HIV Syphilis **CT/GC screen >25 in high risk communities**	All STI counseling for high risk teens, adults	
Mental Health	Depression-adolescents, adults		

for women of reproductive age, they recommended contraceptive methods counseling. They recommended breastfeeding support, including supplies and counseling; screening and counseling for interpersonal and domestic violence; and at least annual well-woman health care visits. Notably, the committee did choose to recommend a well-woman visit as well as "bundled" services based on expert testimony. Overall, recommendations specific to older women are limited, although Medicare will begin to cover mammograms and annual well-woman exams without charging the Part B coinsurance or deductibles (Allina, 2011; US Department of Health and Human Services, 2010b).

President Obama supported the IOM committee recommendations, and on August 1, 2011, the DHHS adopted the additional Guidelines for Women's Preventive Services (US Department of Health and Human Services, 2011)—including well-woman visits, support for breastfeeding equipment, contraception, and domestic violence screening—that will be covered without cost sharing in new health plans starting in August. Since the Supreme Court ruling in July, 2012 upheld the ACA by classifying it as a tax measure, the hope is that almost all women covered by insurance will have preventive-services coverage within the next 5 to 10 years or even sooner if current plans adopt the recommendations.

As of October 2011, the proposed religious-employer exemption from the contraceptive coverage requirement of the ACA is at issue. An interim final rule was released to give religious organizations the choice of buying or sponsoring group health insurance that does not cover contraception if that is inconsistent with their tenets. The proposed exemption would allow churches, synagogues, mosques, seminaries, and religious orders (but not religious hospitals and social services agencies) to exclude contraceptive coverage from the insurance plan that they offer to their employees. The nation's Catholic bishops have launched an intensive campaign to broaden the religious-employer exemption so any religious employer—including Catholic hospitals and Catholic charities—could refuse to include contraception in its employee health insurance. Broadening the exemption would deny this preventive care to many thousands of women, including both Catholic and non-Catholic employees of these large institutions. There

Table 3 – New Services Recommended by the IOM Committee on Preventive Services for Women

Service	For Whom	When
Screening for gestational diabetes	Pregnant women	24-28 weeks; 1st prenatal visit for pregnant women at high risk for diabetes
Human papillomavirus testing—addition of high-risk human papillomavirus DNA testing in addition to cytology testing in those with normal cytology results	Women	30 years of age and no more frequently than every 3 years
Counseling for STIs	Sexually active women	Annually
Counseling and screening for human immunodeficiency virus	Sexually active women	Annually
Contraceptive methods (full range of FDA approved methods, sterilization) with patient education and counseling	Women with reproductive capacity	Not specified
Breastfeeding support, supplies and counseling; comprehensive lactation support and counseling and costs of renting breastfeeding equipment by a trained provider to ensure successful initiation and duration of breastfeeding	All pregnant women and those in postpartum period	During pregnancy and postpartum
Screening and counseling for interpersonal and domestic violence: involves elicitation of information about current and past violence and abuse in culturally sensitive and supportive manner to address current concerns of safety and other current or future health problems	Women and adolescents	Not specified
Well woman visits for recommended preventive services including preconception and prenatal care	Adult women	At least one well-woman preventive care visit annually; several visits may be needed to obtain all necessary recommended preventive services depending on health status, health needs and other risk factors

has been strong opposition to this exemption, most prominently from the American Public Health Association, which supports women's access to public health services based on what is best for the health of the patient and the decision left to patients and health professionals, not employers.

Putting Prevention into Practice for Women's Health: Beyond the National Prevention Strategy and the IOM Report

The ACA, the National Prevention Strategy and the expanded recommendations for women's preventive services are groundbreaking and if enacted would profoundly promote and improve women's health and close gaps in health inequities. The National Prevention Strategy document calls for elimination of health disparities and prioritizes reproductive and sexual health, injury and violence-free living, and health promotion strategies (National Prevention Council, 2011). The IOM report includes recommendations for preventive services targeting national health goals for women including prevention of chronic health conditions as well as several preventive services related to prenatal care, postpartum depression, suicide screening, care for cardiovascular disease-related conditions in pregnancy, and preconception care. In addition, the IOM Committee recommendations related to metabolic syndrome, physical activity levels, eating behaviors, and sexually transmitted infections (STI) screening were included in addition to those that had already received a USPTF evidence rating of A or B. The IOM Committee did not make specific health system recommendations, aside from identifying the need to bundle services to assure their inclusion in healthcare (Institute of Medicine, 2011).

We assert that beyond the prevention recommendations emphasized in the ACA, the National Prevention Strategy, and the IOM Report, the following would make for an improved system of services for women (and men) across the lifespan.

- Comprehensive healthcare delivery approach to preventive services for women
- Gender-sensitive and lifespan prevention services coordinated in a primary healthcare system of primary healthcare and public health
- Preconception healthcare as a model of integrative prevention practice
- Integration of primary, secondary and tertiary prevention guidelines in practice
- Development and maintenance of a competent workforce to implement preventions services and meet national health goals

Using reducing rates of unintended pregnancy as an organizing priority, we illustrate the utility of these recommendations for service delivery below, drawing on models from the US and the globe.

Need for a Comprehensive Healthcare Delivery Approach for Women

We see a need to link more seamlessly reproductive and conventional care for physical and mental health conditions with emphasis on prevention. This includes prevention of chronic diseases, pregnancy-related problems, unintended pregnancy, STI, and consequences of violence. In the U.S., women's health services, including reproductive healthcare and family planning services, have been provided in vertical and fragmented delivery systems and not in an organized system of public health and primary care. Furthermore, gender-sensitive prevention interventions, especially those related to sexual and reproductive health promotion, have not been standardized or integrated into primary care.

Although heart disease, cancer and diabetes are leading causes of mortality and morbidity in American women, sexual and reproductive health problems are extremely common occurrences in women's lives, with half of all pregnancies reported as mistimed or unplanned. Worldwide, according to the WHO Medium Term Strategic Plan for 2010–2015 (World Health Organization, 2009), 12% of the global burden of ill health was attributed to conditions related to sexual and reproductive health (SRH). In the U.S., higher rates of unintended pregnancy among African-American and Hispanic women indicate a major health disparity (Taylor, Levi, & Simmonds, 2010). The crucial role of SRH to both the general health of the population and the social and economic development of a nation, and the lessons learned from past experiences, indicate that maternal child health, family planning, abortion, violence prevention, sexual health promotion, and other reproductive health services should not be structured as a single-issue vertical program, but delivered as a collection of integrated services.

Gender-sensitive and Lifespan Prevention Services Coodinated within a Primary Healthcare System of Primary Care and Public Health

Although current fragmentation and politicization of reproductive and gender-based healthcare may be ubiquitous in the U.S., established evidence shows that an organized effort, combining federal resources, public health advocacy, and established prevention guidelines can lead to health and behavior improvements. In the U.K., reproductive healthcare is provided to men, women, and adolescents in a coordinated system of primary care and public health services that are outcomes-focused and evidence-based. Lessons learned from the national health system in the U.K., where SRH care is well integrated into an organized system of primary care and public health, holds promise for extending the WHO SRH Strategic Plan in the U.S. as well as having the potential to improve women's health services under the ACA. In addition, SRH education, training, and certification have been established for RNs, nurses with advanced training, midwives, and nonspecialist physicians (GPs) working in the U.K. National Health Service. Competency-based education, training, and certification in the specialty of SRH care includes competencies in 10 areas: basic SRH services/skills; contraception; unplanned pregnancy care; women's health/common gynecology; assessment of specialty gynecology problems; pregnancy care; genitourinary conditions of men; sexual health promotion; public health, ethical, and legal competencies; and leadership, management, IT, and audit competencies (Royal College of Obstetricians and Gynaecologists, 2005).

Similar models for care of older women and men could provide gender-sensitive and comprehensive services across the latter part of life. For example, gender-sensitive services for women, including breast cancer screening, osteoporosis screening, screening for unique cardiovascular risk factors in women, fall-prevention interventions, screening for depression and cognitive impairment, as well as services to caregivers to prevent illness onset could be bundled in the wellness visit associated with welcoming older women to Medicare services.

Preconception Health Care: A U.S. Model of Integrative Services

Twenty years of accumulating research and analyses provide a strong scientific foundation for encouraging preconception wellness as a routine component of healthcare for all women of reproductive potential (Centers for Disease Control and Prevention, 2006; Jack et al., 2008; Moos, 2003; Moos et al., 2008). The purpose of preconception care is primary prevention of many poor pregnancy outcomes: to deliver risk screening, health promotion, and effective interventions as a part of routine healthcare. In the U.S., this approach is the standard used to achieve reductions in incidence of vaccine-preventable disease, heart disease, diabetes, and other chronic conditions and is similar to well-child care, prenatal care, and adult wellness care. The specific recommendations articulated by the Center for Disease Control and Prevention (CDC) and the Select Panel on Preconception Health (Centers for Disease Control and Prevention, 2006) went beyond clinical care (preventive visits, interventions for identified risks, interconception care, and pre-pregnancy evaluation), and they targeted consumers (self-management across the lifespan), public health strategies (integrated into existing primary prevention programs), financial systems and payers (insurance coverage for low-income women), and research (surveillance of impact and increasing the evidence base). Private-public partnerships (March of Dimes,

2008) have attempted to rise above the healthcare silos of federal programs as well as fragmented clinical services of obstetrical services, well-woman care, specialty services, and chronic disease care. For most women, what is needed is a conscious determination to provide preventive services to "every woman, every time," a concept first proposed by the California Preconception Initiative to take advantage of all healthcare encounters to stress prevention opportunities throughout the life span and to address conception and contraception needs and choices at every healthcare encounter (Massey, Rising, & Ickovics, 2006; Interconception Care Project for California). This involves all health professionals and medical specialties, not only those directly involved in reproductive health.

The CDC recommendations for preconception and interconception care are primary prevention strategies integrated into every primary-care visit (Royal College of Obstetricians and Gynaecologists, 2005). Different guidelines recommend eight–10 specific areas for preconception risk assessment, including 1) reproductive history; 2) environmental hazards and toxins; 3) medications that are known teratogens; 4) nutrition, folic acid intake, and weight management; 5) genetic conditions and family history; 6) substance use, including tobacco and alcohol; 7) chronic diseases (eg, diabetes, hypertension, and oral health); 8) infectious diseases and vaccinations; 9) family planning; and 10) social and mental health concerns (e.g., depression, social support, domestic violence, and housing). A number of educational strategies for improving primary prevention in the clinical visit (reproductive life plans), and helping clinicians with evidence-based prevention guidelines show promise for putting preconception/interconception health promotion into practice.

Integrating Parimary, Secondary, and Tertiary Prevention Guidelines in Practice: A Blueprint for Preventing Unintended Pregnancy in Clinical Practice

The 2006 CDC Preconception Health Care recommendations (Centers for Disease Control and Prevention, 2006) were conspicuously silent on strategies to reduce unintended pregnancy and focused primarily on reducing low birth weight, congenital anomalies, and improving women's health status. In spite of its frequency and significant costs, evidence-based clinical guideline development for prevention of unintended pregnancy has lagged behind other important health threats, resulting in a systemic failure to successfully provide care to individuals of reproductive potential who are at risk of unintended pregnancy. Prevention, if focused and coordinated, is a viable way to reduce unintended pregnancy in the U.S. Primary prevention strategies have the best empirical evidence, as described by the CDC related to preconception care (Massey, Rising, & Ickovics, 2006), yet there has been very little attention to linking secondary and tertiary prevention interventions within a coordinated system of best practices that assures the quick return of patients back to primary prevention. The incorporation of unintended pregnancy prevention strategies into primary care as discussed in the model is necessary to move towards health promotion for all individuals of reproductive potential.

A combination of ready access to coordinated reproductive health services, and new information about root contributors to unintended pregnancy that will be translated into improved education for both women and their providers can move us toward achieving relevant national health goals for reproductive health. Taylor and colleagues propose a comprehensive, evidence-based public health framework to reduce unintended pregnancy in which primary, secondary, and tertiary care prevention measures are implemented and evaluated for effectiveness in culturally diverse populations, compiled into nationally supported clinical guidelines, incorporated into standard primary care competencies for all health professionals, and supported by state and federal policies (Taylor, Levi, & Simmonds, 2010; Taylor & James, 2011).

Such an approach can be effective for influencing other national health goals. For example, promoting bone health in young women could begin with counseling for adequate calcium intake in the diet during adolescence, include screening during the middle years, and intensify preventive approaches to bone loss as women age.

Development and maintenance of a competent workforce to implement prevention services

The WHO has proposed that national healthcare systems improve provision of prevention services within primary healthcare systems by a competent workforce. Capacity-strengthening approaches include planning for and funding the training and education of health workers (United Nations, 2010). Toward this oal, the WHO has prioritized core SRH competencies to be included in the curriculum of primary care providers to address sexual health inequalities and increase the well-being of both men and women. These competencies and service standards are published in a 2011 report titled *Sexual and Reproductive Health Core Competencies in Primary Care* (World Health Organization, 2011). A supplemental document provides the technical and research evidence to support those standards and competencies. The U.S. is in a choice position to embrace integrating SRH practices into primary care, along with competency-based education for primary care and public health professionals (World Health Organization, 2011).

A similar approach to developing and maintaining a competent workforce to implement services for older adults has been given high priority by the Hartford Foundation and the American Academy of Nursing. Similar commitment would enhance the capacity of the nursing workforce to integrate

preventive services throughout the earlier portions of women's lifespan.

Recommendations for Putting Prevention into Practice

Our general recommendations for the profession of nursing and other health groups include:

1. Endorse the recommendations for additional clinical preventive services for women as put forth in the 2011 IOM Clinical Preventive Services committee report and the strategies for prevention in the National Prevention Strategies report.
2. Advocate for the adoption of ongoing prevention guidelines that are evidence-based, gender-sensitive, culturally appropriate, and inclusive of gay, lesbian, and intergender groups.
3. Mobilize health professionals within practice, education and research to address national health goals included in these reports.
4. Integrate the essential competencies for primary and secondary prevention and clinical management of SRH with overall health into professional practice curricula.
5. Focus service improvements on structural and social determinants of prevention services.

In addition to the broad recommendations for prevention and health promotion for women, we also advocate for greater attention to unintended pregnancy and its prevention and management. Our recommendations related to SRH illustrate a model for putting prevention into practice that could serve for all preventive health services.

These particular recommendations are:

- Critical review of the state of the science on a) sexual and reproductive health care and specifically prevention of unintended pregnancy and b) preconception healthcare as model of primary prevention for both men and women across the lifespan
- Provision of sexual and reproductive health care within a broad framework of population-based (men, women, lifespan) public health, prevention and primary care (as recommended by the WHO Sexual and Reproductive Health Medium-term Strategic Plan for 2010–2015)
- Evaluation of alternative models of service delivery, including better integration of SRH care into primary care
- Study of existing community-based models of services related to unintended pregnancy prevention to identify those with particular promise for vulnerable populations of women
- Promotion of clinical practice guideline development to prevent unintended pregnancy
- Evaluation of optimal training models for health professionals to integrate SRH services into primary care
- Requirement of prevention of unintended pregnancy as a standard component of health professional education in all accredited institutions
- Development of training mechanisms for community-based resources on unintended pregnancy prevention models.

Conclusion

These recommendations are intended to guide health policy development that aims to improve the health of girls and women through improved clinical services and implementation of comprehensive prevention strategies. We believe that WHO recommendations and the experience from the U.K. National Health Services of integrating SRH services into primary healthcare holds potential as models of care for improving health outcomes that should be embraced in the U.S. Our recommendations serve as a call to action for nurses and other health professionals to advocate for clinical services, including expanded prevention strategies, which have the potential to improve women's health outcomes throughout the lifespan.

REFERENCES

Agency for Healthcare Research and Quality (AHRQ): United States Preventive Services Task Force (USPSTF) (Accessed, 12/8/11). Retrieved from http://222.ahrq.gov/clinic/uspstfix.htm.

Allina, A. (2011). Older women and health care reform: Get the facts. Women's Health Activist Newsletter. Retrieved from http://nwhn.org/older-women-and-health-care-reform-get-facts.

American Academy of Pediatrics (2008). Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition. Retrieved from http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html.

Centers for Disease Control and Prevention (2006). Recommendations to improve preconception health and health care. United States: A report of the CDC (No. RR-6). Retrieved from http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.

Institute of Medicine. (2010). *Women's Health Research: Progress, pitfalls, and promise*. Washington, DC: The National Academies Press.

Institute of Medicine. (2011). *Clinical Preventive Services for Women: Closing the Gaps (2011)*. Washington, DC: National Academies Press.

Interconception Care Project for California. Before, Between & Beyond Pregnancy: The National preconception curriculum and resources guide for clinicians. Retrieved 7 December, 2011 from http://www.beforeandbeyond.org/.

Jack, B., Atrash, H., Coonrod, D., Moos, Merry-K., O'Donnell, J., & Johnson, K. (2008). The clinical content of preconception care: An overview and preparation of this supplement. *American Journal of Obstetrics and Gynecology, 199*(6), S266–S279.

March of Dimes (2008). Get ready for pregnancy: Preconception health care. Retrieved from http://marchofdimes.com/pregnancy/getready_indepth.html.

Massey, Z., Rising, S., & Ickovics, J. (2006). Centering Pregnancy Group Prenatal Care: Promoting relationship-centered care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 35*. http://dx.doi.org/10.1111/j.1552-6909.2006.0040.x, 2860294.

Moos, M. K. (2003). Preconceptional wellness as a routine objective for women's health care: An integrative strategy. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 32*, 550–556.

Moos, M. K., Dunlop, A., Jack, B., Nelson, L., Coonrod, D., Long, R., Boggess, K., & Gardiner, P. (2008). Healthier women, healthier reproductive outcomes: Recommendations for the routine care of all women of reproductive age. *American Journal of Obstetrics and Gynecology, 199*(6, Supplement B), S280–S289.

National Prevention Council. (2011). *National prevention strategy: America's plan for better health and wellness*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

National Women's Law Center. Health Care Report Card (2010). Retrieved from http://hrc.nwlc.org/policy-indicators.

National Women's Law Center (2010). Making the grade on women's health: A national and state by state report card. Retrieved from http://hrc.nwlc.org/states/national-report-card.

Royal College of Obstetricians and Gynaecologists (2005). Sexual & Reproductive Health Competencies. Retrieved from http://www.rcog.org.uk/curriculum-module/sexual-reproductive-health-srh-0.

Taylor, D., Levi, A., & Simmonds, K. (2010). Reframing unintended pregnancy prevention: a public health model. *Contraception, 81*, 363–366.

Taylor, D., & James, E. A. (2011). An evidence-based guideline for unintended pregnancy prevention. Journal of Obstetric. *Gynecologic & Neonatal Nursing, 40*, 782–793.

U.S. Department of Health and Human Services (2010a). The Affordable Care Act's New Rules on Preventive Care and You. Retrieved from http://www.health care.gov/law/provisions/preventive/moreinfo.html.

U.S. Department of Health and Human Services. (2010b). *Strengthening the health insurance system: How health insurance reform will help America's older and senior women*. Washington, D.C.: U.S. Department of Health and Human Services. Retrieved from http://healthreform.gov/reports/seniorwomen/index.html.

U.S. Department of Health and Human Services (2011). Affordable care act ensures women receive preventive services at no additional cost. HHS Press Office: U.S. Department of Health and Human Services: Washington, D.C. Retrieved from http://www.hhs.gov/news/press/2011pres/08/20110801b.html.

United Nations. (2010). *Millennium Development Goals. The 2010 MDG Summit outcome*. New York: United Nations Development Programme.

USPSTF. (2009). Screening for breast cancer: U.S. Preventive Services Task Force recommendation statement. *Annals of Internal Medicine, 151*(10), 716–726.

World Health Organization. (2009). *Sexual and reproductive health strategic plan 2010–2015 and proposed programme budget for 2010–2011*. Geneva: World Health Organization.

World Health Organization (WHO) (2011). Sexual and reproductive health core competencies in primary care. Retrieved from http://www.who.int/reproductivehealth/publications/health_systems/9789241501002/en/index/html.