FOURTH EDITION

GYNECOLOGIC HEALTH CARE

WITH AN INTRODUCTION TO PRENATAL AND POSTPARTUM CARE

KERRI DURNELL SCHUILING FRANCES E. LIKIS

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Dedication

To:
The innumerable individuals and communities who are marginalized, we hope this book will give readers a deeper understanding of the importance of inclusivity and health equity;
The indomitable Kitty Ernst, thank you for encouraging us to always look for ways to improve health care; and
Our colleagues, friends, and family members who have been encouraging and patient throughout the labor of this edition. There are too many to mention each of you by name, but you know that we know who you are. We truly appreciate the support you provided.
—Kerri and Francie

To:
The many outstanding staff, students, faculty, and administrators at Northern Michigan University and members of NMU's Board of Trustees who provided support for this edition in myriad ways;
Joani, Sue, Lisa, Julia, Judith, Mona, and Jane, whose friendship supports me in ways too many to mention;
Bill, keeper of my heart;
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My parents, Marie and Don Hall, whose belief that I can do anything makes me believe that I can;
My children, sons-in-law, and grandchildren, Mary, Mike, Spencer, Quinn, Sean, Sarah, Galen, Gryffin, and another grandson soon to arrive, who bring me life's greatest joys; and
Francie, my student who became a highly respected colleague and treasured friend, your expertise in editing is unparalleled. Your significant contributions to our book make each edition better than the last. I sincerely thank you for leading the way with inclusive language that embraces the core philosophy of our book. You are an amazing book partner and I will forever be grateful to have taken this book journey with you.
—Kerri

To:
Zan, your love and support for me are unequaled, and I am the luckiest you are mine;
My nephew Knox, my niece Elizabeth, my sister Mary, and my mother Katey, you inspire me in my work to make health care better, and I am very thankful for all of the time and travels we have together;
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Simon, you and your generous astute advice have helped me become a better writer, editor, and accomplice;
Tekoa, Patty, and Brittany, we are a great team, and working with the three of you has honed the skills I contribute to this book. Tekoa, I am forever appreciative to you for telling me many years ago that I write well and should keep doing that. Your encouragement started me down my path to becoming an author and editor; and
Kerri, the amount and quality of effort you devote to all of your work, including our book, is exceptional. I am grateful we have a collaborative relationship in which valuing our shared attributes, including a relentless attention to detail that anyone else might not find so endearing, and our differing talents and perspectives has strengthened the creation and development of our book. Thank you for being a wonderful book partner and friend.
—Francie

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PREFACE

Historically, gynecologic health was framed within a biomedical model by clinicians. A biomedical model is disease oriented and focuses on curing illness—an approach that risks pathologizing normal aspects of physiology. When a biomedical lens is used to assess people's health, there is a risk of essentializing individuals and reducing them to their biologic parts. This reductionism transfers to practice when an individual's body parts become the focus of diagnosis and treatment. The meaning of the diagnosis to the individual, and the impact that the diagnosis has on them, their significant others, and their life, is not addressed in this approach.

In contrast to the biomedical model, a holistic model assesses health within the context of each individual's life. A holistic approach is grounded in caring for the whole person within their lived experience. Each person is recognized as an expert knower whose agency should be supported. As experienced clinicians, we use this holistic practice philosophy as an overarching framework for this text. A related core principle of the text is our use of the health-oriented perspective that is vital to the philosophy of care espoused by nursing and midwifery, in which we both strongly believe.

We initially embarked on creating a book that presented gynecologic health from a woman-centered, holistic, and feminist viewpoint. Our goal was to produce a book that emphasized the importance of respecting normal physiology; provided evidence-based clinical content appropriate for assessment, diagnosis, and treatment; and promoted the value of collaboration among clinicians. Some aspects of this holistic, feminist approach will be obvious to readers, whereas others may be more subtle. For example, we use illustrations of whole individuals, rather than pictures of only breasts or genitalia, when possible. We refer to a person who has a specific condition rather than referring to the person by their condition. For example, we speak of the individual who has HIV, as opposed to the HIV-positive individual. We use the term "birth" as opposed to "delivery" because it situates the power within the person giving birth versus transferring it to the clinician. And for the first three editions of this text, we purposefully used "women's" rather than "gynecologic" as the first word of the book's title. Our intention in making these deliberate choices was to encourage readers to keep first in their mind that they are treating a whole person, not just body parts or a condition. We hope that this approach emphasizes the importance of treating all individuals holistically within their lived experiences.

As we began work on the fourth edition of this text, we recognized the need for our book to better support gender-inclusive health care. Transgender and nonbinary people deserve compassionate clinicians who understand their unique healthcare needs. One of our goals for this edition is to maintain the core philosophical beliefs from the previous editions while broadening them to incorporate gender inclusiveness. A gender-inclusive approach is consistent with the book's person-centered, holistic, feminist foundation. Although this edition does not remove all gendered language, we address the need for gender-inclusive care throughout the text and changed the title to the gender-inclusive *Gynecologic Health Care*. Our decision to keep some gendered language, which is discussed later, is not meant to exclude people who do not identify as women and seek gynecologic care or become pregnant.

The shift in gender language in this new edition has been challenging. It can be difficult to balance the desire to be gender inclusive and holistic with the need to provide clear information and accurate presentation of original sources. The language of health care and previous editions of this book is gendered. Historically, health care and health-related research have been based on a gender binary in which there are only two genders, female and male, and gender is determined by sex assigned at birth. While it is now recognized that gender is not binary and does not always align with sex assigned at birth, one cannot ignore the long-standing use of a gender binary. For example, most studies to date report the gender of participants based on their sex assigned at birth. Changing the original language of a source, such as using only gender-neutral language for a study reported to have "women" as its participants, does not accurately portray the information that was published. In addition, it is impossible to simply change every gendered word to gender-neutral alternatives, such as "individual" or "they," because everyone does not have the same anatomy. The sex individuals are assigned at birth affects their health. For example, the assessment and management of sexually transmitted infections differs depending on whether one has a vagina or a penis, so it can become confusing to use only gender-neutral language when discussing this topic. As an alternative to gendered language, some have proposed language such as "people with vaginas." However, identifying people by their genitals is counter to our strongly held principle of avoiding reductionism. Last, but certainly not least, the prominent use of the word "women" in the first three editions of this text was very intentional, and we struggled with where to retain and remove it. We do not want to reverse the great progress that has been made in positioning women, not just their body parts or conditions, as the focus of their health care. We also do not want to lose sight of how sexism profoundly affects women's lives, including their health.

This edition was written at a time when gender language was rapidly evolving and still the source of controversy. Being at the forefront of this evolution with a textbook is risky. Some readers will like the gender inclusivity in this edition, and others will not. Some will think we have moved too far toward inclusivity, and others will think we have not moved far enough. In a few years, it is likely that the language used in this edition will be dated. All of this uncertainty has weighed heavily on our minds. Yet there are two things we are certain about: gender-inclusive health care is important, and we would rather address that imperfectly than avoid it. Overall, our guiding principles regarding gender language have been to do our best within current language use and limitations; to consider accuracy, clarity, and brevity when making word choices; and to stay true to the core tenets of the book. We believe the gender language changes we have made are a step in the right direction, and we are also well aware they are only a step. We have the best of intentions and hope readers will give us grace for the inevitable imperfection of the changes we have made.

This book encompasses both health promotion and management of health conditions that individuals experience. All of the content is evidence based. The first section introduces the feminist framework that permeates the book and provides readers with a context for evaluating evidence and determining best practice. The second section provides a foundation for assessment and promotion of gynecologic health. The third section addresses the evaluation and management of clinical conditions frequently encountered in gynecologic health care. The fourth section provides an introduction to prenatal and postpartum care.

In this fourth edition of *Gynecologic Health Care*, we have updated, and in many cases extensively revised, all of the chapters from the third edition to ensure comprehensive content that reflects current standards of care. We have also added three new chapters. The content of Chapter 2 provides a foundation to help clinicians address racism and race-associated health disparities. Chapter 8 provides an overview of essential content for providing sexual and reproductive health care for males. Chapter 31 focuses on preconception care.

We are fortunate to have many excellent contributors and reviewers for this book. Some are nationally known; others might be new to many readers. The common thread among all of our contributors and reviewers is their expertise in their respective areas and their recognition of the importance of evidence-based practice. Our contributors and reviewers are expert clinicians, educators, and scientists. Frequently, coauthored chapters represent a clinician and researcher team, whose collaboration provides readers with a real-world view that is grounded in evidence.

We are gratified by how well the first three editions of this book were received by clinicians, students, and faculty. This edition builds on the precedents set in the previous editions. We hope it contributes to individuals receiving evidence-based, person-centered, holistic health care within their lived experiences. As before, we welcome feedback from readers that can improve future editions.

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SECTION

1

Introduction to Gynecologic Health Care

CHAPTER 1

A Feminist Perspective of Women's Health

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HEALTH CARE AND GYNECOLOGIC HEALTH

The state of health care today reflects the intersections of the varied identities we hold combined with our position in society. Many healthcare advances have been made, yet comprehensive, compassionate healthcare services that address the complexity and diversity of how we live our lives and experience health and disease are still lagging.

This text is based on a feminist framework in an effort to advance the quality of health care generally; it was initially aimed at addressing disparities in women's health care in today's society. The complexity of women's health is considered by paying attention to women's status in society and their unequal access to opportunity and power, while focusing on women's gynecologic health and well-being. When we say "women," do we really mean all women? Transgender women, transgender men, and nonbinary-identifying individuals may find that the terms "woman" and "women's health" are exclusionary, creating a silence or invisibility to their lived experience of health and health care. Language remains imperfect as we continue to search for inclusive ways to describe varied experiences regarding health, particularly gynecologic health. Throughout this chapter we have retained the terms "woman" and "women's health" and acknowledge that this does present complexities and challenges in addressing health disparities and being inclusionary. We address this challenge by using nongendered language when possible and by retaining the word "woman" when it is essential to the context and example being presented.

The purpose of this chapter is to provide an overview of the experience of health using a feminist perspective and gender considerations as a lens for exploring women's health in general and gynecologic health in particular. The glossary in **Box 1-1** offers definitions of key terms that are used throughout this text and are linked to feminist critical analysis of gender and health.

WHAT IS FEMINISM?

The author bell hooks (2000) offers a definition of feminism that is well suited for addressing the context in which people experience health and wellness: feminism is a perspective that acknowledges the oppression of women within a patriarchal society and struggles toward the elimination of sexist oppression and domination for all human beings. Acknowledging the oppression of women is increasingly difficult because affluence and increased opportunities within some sectors of employment and education are construed as equal access or equity in opportunity. However, hooks defines oppression as "not having a choice." With this definition, many more individuals can recognize constraints in their personal experiences. Examples of such practices include unjust labor practices, lower wages for equal work, lack of maternity leave policies, limited access to a range of contraceptive options, and inability to access desired healthcare providers. These examples indicate the breadth of experiences within the context of a patriarchal society that denies women equal access to power, resources, and opportunities.

Characteristics of a feminist perspective include the use of critical analysis to question assumptions about societal expectations and the value of various roles on both sociopolitical and individual levels. The process of critical analysis is accomplished by rejecting conceptualizations of women as homogeneous and acknowledging the range of experiences and expressions of sex/gender. It acknowledges power imbalances and uses the influence of gender as the foremost consideration in the analysis. Using a gender lens that is informed by feminism permits areas of disparity to be identified both among groups, based on gender, and within groups, based on the recognition of heterogeneity.

Feminist health perspective explores the context of how individuals generally, and women specifically, live their lives both collectively and individually within a patriarchal society. The various social, environmental, and economic aspects become integral to understanding the context in which people are able to achieve health and well-being. Furthermore, feminism requires consideration of health, as influenced by the intersection of sexism, racism, class, nation, and gender, within a framework that acknowledges the role of oppression as it affects women and their health as individuals and as a group. **Box 1-2** summarizes the components of a feminist perspective when considering health issues or models of care, which can help reframe one's view of the experience of health from a feminist perspective.

GENDER

What does gender have to do with the experience of health? Although women's health is focused on the female sex (as determined by chromosomes, genitalia, and sexual organs), its priorities are shaped by what are considered socially important

BOX 1-1 Glossary of Key Terms

cisgender: An individual whose gender identity coincides with that individual's birth-assigned sex (e.g., a cisgender man is often referred to as simply "man," and a cisgender woman is often referred to as simply "woman").

classism: Discrimination or prejudice on the basis of social class.

discrimination: The prejudicial treatment of an individual based on that person's actual or perceived membership in a certain group or category (e.g., race, ethnicity, sexual orientation, national origin).

feminism: A movement to end sexism, sexist exploitation, and oppression (hooks, 2000).

gender: A socially constructed category addressing how people identify and act based on sex (e.g., men and women).

homophobia: Prejudice against individuals with same-sex attraction.

intersectionality: The unique combination of multiple identities based on race, class, gender, and other characteristics, and the compounded experience of oppression based on these identities.

medicalization: Defining or treating a physiologic process or behavior as a medical condition or disease.

oppression: Exercise of authority or power in an unjust manner; according to hooks (2000), "not having a choice."

patriarchy: A social system of institutions that privileges men, resulting in male domination over access to power, roles, and positions within society.

power: The ability to do something, act in a particular way, or direct/influence others' behavior or a course of events.

race/ethnicity: Socially constructed categorization of individuals and communities based on a combination of physical attributes and cultural heritage.

racism: Individual and structural practices that create and reinforce oppressive systems of race relations.

sex: Biological classification as female or male based on chromosomes, genitalia, and reproductive organs.

sex/gender: Combined term of sex and gender acknowledging that the discreet meanings of these terms are not easily separated in research and practice.

sexism: Individual and institutional practices that privilege men over women.

social construction: The process by which societal expectations of behavior become interpreted as innate, biologically determined characteristics.

socioeconomic status: An indicator that encompasses income, education, and occupation.

structural racism: Macro-level systems, social forces, institutions, and processes that reinforce oppressive race relations.

trans*: A term, pronounced "trans star," that represents multiple identities in transgender communities (Erickson-Schroth, 2014).

transgender or trans: An individual whose gender identity does not coincide with that individual's assigned sex at birth.

BOX 1-2 Components of a Feminist Perspective in Health

- Works *with* individuals as opposed to *for* individuals
- Uses heterogeneity as an assumption, not homogeneity
- Minimizes or exposes power imbalances
- Rejects androcentric models as normative
- Challenges the medicalization and pathologizing of normal physiologic processes
- Seeks social and political change to address health issues

attributes of being a woman (such as reproductive capacity and feminine appearance). Gender is defined as a person's self-representation as man, woman, or nonbinary and the way in which social institutions respond to that person based on the individual's gender presentation. Gender is often congruent with sex (e.g., a person with female genitalia identifies as being a woman, or cisgender), but it can also be incongruent (e.g., a person with female chromosomes may identify as being a man, or transgender man). Sex and gender are irreducibly entangled from both the research and practice perspectives, however, and are better referred to by the combined term sex/gender, which acknowledges the combined contribution of both the biologic and socially constructed aspects (Springer et al., 2012).

Sex/gender is a socially constructed attribute that is shaped by biology, environment, and experience and is expressed through appearance and behavior (Fausto-Sterling, 2012). Social construction is the process by which societal expectations of behavior become interpreted as innate characteristics that are biologically determined. Thus, behaviors associated with femininity become confused with innately determined behaviors rather than being recognized as socially constructed behaviors. As a result, health risks, treatments, and approaches to care are not necessarily biologically based aspects of health, but rather they are determined by social expectations rooted in assumptions about sex/gender differences. In addition, diagnoses can be influenced by sex/gender assumptions regarding behavior or what is socially constructed as feminine behavior. A significant body of literature has documented such influences on the manner of diagnosis and treatment in mental health (Neitzke, 2016) and obesity (Wray, 2008), as well as in the misdiagnosis of women's cardiovascular risks (Worrall-Carter et al., 2011) and inadequate education to prevent cardiovascular disease in women (Hilleary et al., 2019).

Three primary aspects must be considered when examining the impact of sex/gender on women's health. The first is the priorities assigned to research, treatment, and outcomes in women's health as compared to men's health. The second is the context of sex/gender, including how it affects the process of providing healthcare services, which encompasses an acknowledgment of power differentials. The third aspect is the social construction of sex/gender, including how it affects health. Each aspect has implications for the manner in which people access, receive, and respond to health care. Collectively, these three aspects provide opportunities for us to better understand healthcare experiences and assist in the identification of underlying factors that influence the healthcare disparities experienced by women.

Social role expectations based on sex/gender can create undue burdens for women and may subsequently lead to increased health risks. For example, limited access to all contraceptive options may create reproductive health risks. Extensive cultural preoccupation with dieting and thinness may lead to unsafe dieting practices and precipitate eating disorders. Anorexia and bulimia are more prevalent among women despite the lack of a clear biologic explanation for this predominance.

Another example of a health risk based on sex/gender is the disproportionate amount of violence that women experience (Modi et al., 2014). Gender-based violence includes any act that results in physical, sexual, or psychological harm or suffering (United Nations General Assembly, 1993). The multiple health consequences of violence reveal the persistent layers of health consequences associated with a gender-based health risk. Refer to Chapters 15 and 16 for further discussion of this topic.

INTERSECTIONALITY

Sex/gender interacts with many other identities that affect healthcare delivery and outcomes. Intersectionality is the unique combination of multiple identities based on race/ethnicity, socioeconomic status (SES), sex/gender, nation status, ability, and other factors, as well as the experience of oppression based on these identities. Disparities in health outcomes are often better explained by considering the intersections of multiple forms of oppression based on identity (Etherington, 2015; Warner & Brown, 2011). For example, women of color who are poor often obtain fewer or receive different health services and have worse health outcomes compared to more affluent white women. Although low SES is the single most powerful contributor to illness and premature death (Mehta et al., 2015), numerous examples of poorer health based on race/ethnicity can be cited even after controlling for SES (Williams, 2008; Williams et al., 2016).

Race as a category has been critiqued as creating a false perception of biological difference despite gene-level similarities across defined races. Thus the term “race/ethnicity” is used to describe a socially constructed combination of physical attributes and cultural commonality (Williams, 2008; Williams et al., 2016). Although disparities in health outcomes across race/ethnicities are often assumed to be genetic or biologic, in reality they are significantly impacted by social forces of discrimination. Discrimination is unjust treatment that is based on appearance or identity and is often described primarily as an interpersonal construct (e.g., a person expressing racist opinions). Even more damaging than interpersonal discrimination is systemic or structural discrimination; such injustice perpetuates large-scale, often invisible processes, policies, systems, or structures (e.g., underfunded school systems in poor districts, locations of subsidized housing) that are much harder to dismantle than individual opinions. Structural discrimination impacts the social, political, geographic, and economic influences on health, yet it is very difficult to quantify and often is misidentified (Krieger, 2014).

The structural components of where we live, learn, work, and play impact health across the life span. Where we live encompasses factors such as access to living space with good air quality, access to safe drinking water, access to green space, a safe environment for spending time outdoors, local grocery stores with high-quality fresh food, neighborhood and community support, and even the distance to a place of employment, which dictates the ability to walk to work versus having a lengthy car commute. Where we learn incorporates factors such as access to well-equipped, safe schools with challenging and engaging curricula that teach skills to prepare students for high-quality employment and future life skills. Where we work reflects access to living wages, safe working conditions, healthcare benefits, and a sense of meaningful work. Where we play includes types of recreation that promote physical activity, community connection, and long-term healthy behaviors such as exercise. Feminist considerations in relation to health disparities in these areas include race/ethnicity and sex/gender bias in hiring, access to resources, availability of healthcare providers, and contraceptive options. Policies or practices that impose undue stress or limit access based on sex/gender contribute to health disparities and are a form of structural bias.

The social embeddedness of health generally, and women’s health specifically, must attend to multiple factors—such as types of medical care, geographic location, migration, acculturation, racism, exposure to stress, and access to resources—when exploring disparities in women’s health. Only by incorporating these factors into the discussion can we fully and accurately appreciate the health disparities women experience, including factors of sexism.

A MODEL OF CARE BASED ON A FEMINIST PERSPECTIVE

A model of care that is based on a feminist perspective contrasts sharply with a biomedical model, particularly in the areas of power and control and also in the definition of what is health compared to pathology. A feminist model supports egalitarian relationships and identifies the person as the expert on their own body. The person is at the center of this healthcare model. The following key points provide further insights into a feminist-based model of care:

- The model of care must focus on *being with*, not *doing for* the person. This frames the model of care as a partnership as opposed to a model of care in which treatment decisions are directed by others and then dictated to the person.
- Heterogeneity, rather than homogeneity, is assumed. Using broad generalizations like “all women,” with their inherent gender-based assumptions, essentializes women rather than acknowledging diversity among individuals and across experiences. An assumption of heterogeneity considers people on an individual basis, tailoring health care and services to each individual’s unique needs rather than treating all females as a group with the assumption of similarity across all considerations of health.
- The feminist model of care seeks to minimize or expose power imbalances that are inherent in most current healthcare models, especially those based on a biomedical model. Power should be distributed equally within the healthcare interaction, and the interaction should be based on a belief in an individual’s right to self-determination and their self-knowledge of their body. Therefore, the role of the clinician focuses on providing support, information, education, and skillful knowledge, as opposed to asserting authority over the decision-making ability of the individual.
- A feminist framework rejects androcentric models of health and disease as normative. The pervasiveness of male-based models being extrapolated and applied to women assumes

that women are merely a biologic variant of men. This misapplication of androcentric models to women's health also serves to medicalize or pathologize normal physiologic processes, such as menstruation, childbirth, and menopause (Lorber & Moore, 2011). In contrast, the feminist model acknowledges as normal those physiologic changes that occur over an individual's life span, such as menarche and menopause.

- A feminist perspective challenges the process of medicalizing and pathologizing by identifying and exploring women's unique health experiences and normalizing them. Medicalization is the process of labeling conditions as diseases or disorders as a basis for providing medical treatment. The medicalization of biologic functions, such as menstruation, pregnancy, and menopause, is frequently cited as an illustration of both the social construction of disease and the general expansion of medical control into everyday life (Conrad, 1992; Zola, 1972). In addition, characterizing behaviors that are not gender normative as potential pathology, instead of appreciating the social context in which they occur, serves as a form of pathologizing. Examples are defining sexual desire using androcentric models and then developing treatments for it without considering the potential for coercion or a prior history of sexual trauma.
- A feminist framework acknowledges the broader context in which individuals live their lives and the subsequent challenges to their health as a result of living within a patriarchal society. It argues for a process of social and political change that would eliminate gender bias and sexism. This includes consideration of how the personal health decisions and healthcare interactions a woman experiences are influenced by the larger structural and political context in which people live their lives, including access to services and resources.

SOCIAL MODELS VERSUS BIOMEDICAL MODELS OF HEALTH

As the discussion of the social construction of sex/gender and its relationship to health unfolds, it becomes evident that a broader model of health must be employed to address the health consequences of gender bias and sexism and their implications for overall health and well-being. The first step in broadening the model of health requires redefining health itself. Health is biomedically defined as the absence of disease—a narrow definition that does not address the context in which the absence of disease may occur. Considering only the absence of disease fails to address quality of life or the opportunity to reach the individual's potential. To gain a fuller appreciation of the scope of health, the dominance of the medical model as the rubric that defines health must be challenged in an effort to broaden the lens of what is health and to expand its definition. Without a broader definition, opportunities to understand the social realities and complexities within the healthcare system and the experiences of health for an individual and the collective community will remain limited. Without a broader perspective, which aspects of health are understood or studied will also be limited to individual characteristics or behaviors devoid of the context in which those behaviors and/or experiences are occurring. The biomedical model, as a conceptualization of health, generally does not address health beyond an individual perspective.

An alternative to the biomedical definition of health is offered by the World Health Organization (WHO, n.d.), which defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This broader definition is based on assumptions of what must be present to secure health for individuals and the community in which they live. It addresses the social context in which individuals live their lives, including the communities where they live, work, and play. According to WHO, the following prerequisites must be in place before health can occur:

- Freedom from the fear of war
- Equal opportunity for all
- Satisfaction of basic needs for food, water and sanitation, education, and decent housing
- Secure work
- Useful role in society
- Political will
- Public support

Germane to this definition is the commitment to address social injustice, equity, economic development and opportunity, and accessibility of healthcare services as a basic human right for all individuals in any society. WHO's definition of health requires that the community and environment in which women live must also be considered in the same context as a new medical procedure. The constraints of an individualistic biomedical model of health that focuses only on disease become readily apparent when WHO's broader context and definition of health are considered. Through the use of this definition of health, the social aspects of health and the contributors to health are acknowledged, broadening the lens to include factors that must be addressed to support individual and collective health.

A social model of health is more congruent with a feminist perspective, compared to the biomedical model. The social model of health expands the contributors to health beyond just the individual body, extending them to the family, community, and society. This broader perspective enhances the understanding of health disparities that are rooted in the social and cultural forces that affect how individuals live their lives.

The interconnectedness of working and living conditions, environmental conditions, and access to community-based healthcare services becomes a focus when health and well-being are framed within a social context. Questions about health and well-being for an individual home in on these factors as well as lifestyle decisions and health habits. The prevention of health problems becomes both a social burden and an individual responsibility. This wider emphasis, in turn, forces greater consideration of the various social factors that can either support or degrade an individual's health.

A social model of health also requires asking questions about the health effects of socially situated factors such as racism, sexism, and other forms of oppression. Consideration of women as central to the health model, rather than marginal to it, is a requirement of the feminist social model of health care. The broader social models do not ignore biologic or genetic components of health, nor is the significance of individual lifestyle health habits denied. However, the broader social model frames these issues as important to health, but no more so than experiences within everyday life, access to healthcare services, SES, racial/ethnic identity, and membership within a community (Schiebinger, 2003).

The health risks associated with the social construction of sex/gender and the inequities associated with gender-based assumptions are essential components of the feminist social model of health. As links are forged among human rights, social models of health, health disparities, and opportunities to address those disparities, a feminist perspective offers new strategies and ways of thinking or asking questions that can promote expanded approaches to health issues.

FEMINIST STRATEGIES FOR THE ANALYSIS OF HEALTH

Several aspects of analysis are important when considering health from a feminist perspective. The following strategies for analyzing health using a feminist framework are adapted from Franz and Stewart's (1994) strategies for conducting feminist research. Each of the strategies listed in **Table 1-1** can be used to form a question one can ask about health issues. Taken together, they constitute a feminist lens that allows for new considerations to arise as health issues are reframed. The following discussion highlights the manner in which some of the strategies can be applied.

Look for What Has Been Left Out or What We Do Not Know

This strategy is particularly applicable to investigations into the scientific basis of women's health. Much of what we know about women's health needs, outside of reproductive health, is historically based on androcentric models of men's health considerations. For many years, almost all medical research that was not related to gynecology was conducted using male participants (human and animal), with the findings then being generalized to women. Large-scale investigations focusing on health promotion have been based primarily on study populations composed of only men. This approach was consistently practiced until the 1990s, but it continues to be an issue (Pinnow et al., 2014; Schiebinger, 1999).

According to feminist scientist Londa Schiebinger's analysis, many common health promotion measures have been assumed to be true for both men and women despite the fact that the evidence supporting the measures came from research in which the study populations included only men. Examples of such studies include the Physicians' Heart Study, in which the findings led to recommendations on the use of aspirin to prevent heart disease, and the Multiple Risk Factor Intervention Trial, which evaluated correlations among blood pressure, smoking, cholesterol, and heart disease. In fact, one of the first studies to investigate the use of estrogen for heart disease was conducted on a study population consisting of only men (Schiebinger, 2003)!

The lack of women being represented in research trials reflected a prioritization of men's health issues and was also rooted in gendered assumptions about the potential impact of research on women's reproductive capacity. Additional considerations focused on women's hormonal variations throughout the menstrual cycle as potentially challenging issues in studies of medications. These and other biases related to women's participation as research participants extended through 1988, when clinical trials of new drugs were routinely conducted predominately on men, even though women consume approximately 80 percent of the pharmaceuticals in the United States (Schiebinger, 2003). In employing one of the feminist strategies, the question of what has been left out can be asked, and the answer is considerations of women's biologic variations in processing drugs. The significance of potential hormonal variations was not considered in exploring the impact of particular treatments on women or was not factored into study designs. For example, acetaminophen is eliminated in women at 60 percent of the rate at which it is eliminated in men. This finding obviously has sex/gender-related implications for prescribing dosage regimens. Alternatively, it should not be assumed that all medications will have variations or that variations in dosing regimens are the same for all women because women after menopause may be more similar to men than they are to women who are menstruating.

Examples abound of the problematic manner in which the scientific base for women's health, beyond reproductive health, was initially developed. Even when positive study examples are cited, limitations were often present in the design of the studies. Many key women's health studies, such as the Framingham Heart Study and the Nurses' Health Study I and II, were either observational or epidemiologic investigations instead of randomized clinical trials, even though the latter design has long been considered the gold standard for investigative research (Schiebinger, 2003). Examples such as these suggest that women were being left out of the scientific quest to understand many health issues that directly affected them.

Consumer health advocates, women's health activists, and members of the scientific community have been instrumental in coming together to address the many limitations concerning women's health care and scientific investigations of women's health issues. In 1993, the National Institutes of Health's (NIH) Revitalization Act was considered a milestone in this regard. The Revitalization Act required that women and minorities, and their subpopulations, be included in all NIH-supported biomedical and behavioral research, including phase 3 clinical trials, in numbers adequate to ensure valid analysis of differences in intervention effects; that the cost not be the basis for exclusion from clinical trials; and that outreach programs to recruit these individuals for clinical trials are adequately supported. As a result of this policy change, important progress has been documented in terms of significantly greater inclusion of women and minorities in research investigations. In this case, asking what had been left out or what was missing provided an opportunity to alter what had been left out of women's health research.

There is an ongoing need to employ this strategy to expose blind spots in what is being presented under the rubric of women's health. An example can be found in the current focus on heart disease in women. Heart disease is now the most common cause of mortality among US women. Every step in the healthcare process related to cardiovascular disease—from identification of symptoms to diagnosis, treatment, and referral—demonstrates sex/gender-related differences. The need to explore this disease process in women becomes even clearer when the question of what has been left out of prior studies is asked. The answer has helped frame new ways to address this heart or cardiovascular disease in women. Rather than accepting the inappropriate misapplication of findings to women when research was conducted only in men, researchers are being charged with exploring new avenues of research and new ways of asking the research question.

TABLE 1-1 Strategies for Analysis of Health from a Feminist Perspective

Strategies	Questions
Look for what has been left out or what we do not know.	• What do we know, how do we know it, and who knows it? • Why don't we know? What do we want to know and why? • Who determines what is left out or who has access to what we want to know?
Analyze your own role or relationship to the issue or topic.	• Is it personal? What is the meaning of this issue for you as an individual? • Is it political? What is the meaning of this issue for you as a woman or as a member of an identified group? • Depending on your relationship to the issue, can you be objective in its analysis or are you engaged personally and subjective? • Are you invested in the outcome or topic or not? • Why do you care about the issue?
Identify a person's agency in the midst of social constraints and the biomedical paradigm.	• Are people really just victims, or are they acting with agency? • Are individuals making choices despite positions of powerlessness? • Are the choices allowing individuals to remain in control, or do they allow individuals to have some form of power in the context of the situation? • By identifying a person's agency in a particular context, can we learn new ways of understanding or approach to the health implications?
Consider the social construction of sex/gender and how its assumptions may be used to define what health is, limit options, or presume which behaviors and/or choices can be made within the context of health.	• Explore gendered assumptions about the value of anatomy such as breasts or facial appearance. • Would this health issue be defined or explored in the same manner if it primarily affected one sex or another? • Do socially prescribed gender norms influence how this health condition is understood or defined (e.g., mental health)?
Explore the precise ways in which sex/gender defines or affects power relationships and the implications of those power dynamics in terms of health.	• Physician/nurse • Clinician/patient • Parent/adolescent • Husband/wife • Parent/child • Father/daughter • Partnered or not partnered woman • Heterosexual/transgender
Identify other significant aspects of an individual's or group's social position, and explore the implications of that position as it relates to health issues.	• Consider examples such as an adolescent who is seeking reproductive healthcare services or a same-sex couple seeking fertility services. • Ask who has access to various forms of healthcare services and resources and who does not. • Consider the intersections of race, class, gender, sexuality, and socioeconomic status. • Who has a choice, what constitutes a choice, and who is able to exercise the right to make choices within the context of health?
Consider the risks and benefits of generalizations and speaking in terms of groups versus individuals.	• Who are "all women"? Are "all women" the same? • Consider who benefits from generalizations or assumptions of homogeneity versus heterogeneity. • Is value placed on having a coherent understanding of a health issue compared to acknowledging diversity or complexity in how the issue is experienced? • Which reflects reality most accurately—a coherent story or an appreciation for diversity in the understanding of the health issue? • When "grouping" occurs, who is missing from the group or who might not be reflected in the group process?

Information from Franz, C., & Stewart, A. (Eds.). (1994). *Women creating lives: Identities, resilience, and resistance*. Westview Press.

Analyze Your Own Role or Relationship to the Issue or Topic

Traditionally, the focus on women's health has been relegated to systems between the breasts and the knees. Pregnancy and childbirth were long the focus when it came to health care of women because the value of women was based on their role in procreation and continuation of the citizenry. Historically, this focus on reproductive health created opportunities to promote maternal and child health reforms in the public health arena. In such cases, women typically took advantage of the focus on reproductive health to advance an agenda that addressed both maternal and child health. At the same time, the practice of addressing only reproductive health carried risks because it enabled normal physiological reproductive processes to be medicalized within a biomedical context.

In response to the practice of medicalizing aspects of women's health and traditional models of women's health care, consumer activism by women has been directed at reframing women's health and calling for reforms at even the most basic levels. The strategy of analyzing your own role or relationship to the issue may help reveal the role women play in relation to the process of rejecting medicalization of many normal, healthy physiologic processes they experience.

Over the past 50 years, aspects of women's health have been topics of public debate and of organized social action. Two notable waves have occurred in the women's health movement. One wave coincided with social action movements, such as the civil rights and women's rights movements. A key feature of this wave was its grassroots orientation, with a key focus on access to information and expanded knowledge regarding health. One outgrowth of this movement was the creation of the Boston Women's Health Book Collective (BWHBC) and its publication of *Our Bodies, Ourselves* for consumers in 1974. During this period, primary access to health-related information was available only through medical textbooks. In contrast to this historical practice in which women's health information and knowledge was framed as reserved for the domain of medical professionals, particularly physicians, the BWHBC promoted open access to health information for women as consumers. Members of the BWHBC were consumers who sought out information prior to the advent of the internet and readily available online access. Arguably, they were the forerunners to the wealth of accessible online health information sources that are available today. The BWHBC's membership included women who were healthcare consumers; they developed a consumer-oriented women's health book through a process of conducting individual research related to women's health. The framework that the BWHBC used was one of reclaiming health for themselves, using the feminist perspective of reducing power differentials to access information. Knowledge about health empowered women to seek out services, redefine what health was, and consider a wider range of treatments or choices they might not have otherwise been exposed to or offered.

With this wave of health activism came a strong rejection of the medicalization of physiologic processes, with women reclaiming control of their health by offering new definitions. A key aspect of this ongoing process is the demystification of health conditions and processes to promote women's agency and autonomy and empower them to engage effectively with clinicians. This change supported women in taking control of their health away from medical professionals and assuming responsibility for their healthcare decision making, rather than simply adhering to the older biomedical model, which placed authority for decision making firmly under the control of the clinician. The BWHBC was an initial pioneer in this movement, as was the Women's Health Network.

Although this phase of the women's health consumer movement in the 1970s and 1980s was, in many ways, pivotal in defining a women's health agenda, it also lacked an appreciation of intersectionality and diversity. Essentially, this wave of the women's health movement could be critiqued as assuming homogeneity of women's health issues rather than heterogeneity. In response, the National Black Women's Health Project was launched in 1983 by Byllye Avery, with the goal of understanding Black women's health issues in the broader social context. This project, which was eventually renamed the Black Women's Health Imperative, remains the only national organization dedicated to improving the health and wellness of Black women (Black Women's Health Imperative, 2015). Importantly, this organization defines its goal as addressing health and wellness through a framework that includes physical, emotional, and financial aspects, thereby incorporating social considerations and the biological elements of health. According to some scholars, the launch of this project was not intended as a rejection of the importance of other women's health organizations, but rather it highlighted the need for independent organizations to frame questions or areas of emphasis that were unique to them while also opening opportunities for collaboration in collective areas of interest (Hart, 2012). From a practical standpoint, this meant that instead of everyone working within one organization on what presumably are issues for all women's health, individual organizations, representing and defined by various groups, could organize to address their specific health concerns. However, the various organizations could build alliances and coalitions with one another when issues of common interest were identified (Hart, 2012).

The ongoing efforts directed toward close examination of how the intersections of racism and sexism affect health disparities are essential to disentangling the social determinants of health and how they impact overall health outcomes for women of color in particular. Asking the question of how a health issue relates to you personally or politically is an important first step in considering that issue's significance, but it is also important to consider how individual factors can or cannot be extended in making assumptions for a larger population of women.

Consider the Risks and Benefits of Speaking in Terms of Groups versus Individuals

Reclaiming control of women's health care from clinicians and focusing on women's role and authority over their own health was initially promoted by well-educated white, straight, cisgender women from middle- and higher-income groups. This limited view within the women's health movement revealed the problematic underpinnings of presumed homogeneity across all women.

The strategy of considering the risks and benefits of speaking in terms of groups versus individuals acknowledges this problematic aspect of the women's health movement. Today, women's health activists demonstrate greater diversity and focus on a wider range of issues that affect the health of women and their families.

Consider the Social Construction of Sex/Gender and How Its Assumptions May Limit Options or Presume Choices That Are Made within the Context of Health

Earlier discussions regarding the social construction of sex/gender highlighted the implications of this strategy. An additional aspect to consider is the manner in which women's health issues are described; that is, the terminology used. The language used for many women's health concerns has been described by anthropologist Emily Martin (2001) as reflecting an androcentric bias; for example, the image of menstruation in medical texts is that of "failed reproduction" (p. 92).

Another example is the practice of referring to a woman who has experienced sexual assault as a victim rather than a survivor, implying inherent weakness rather than strength. Descriptions of childbirth usually invoke the term "delivery"; that is, a woman being *delivered* rather than *giving birth*. The "delivery" terms focus on the actions of the clinician and place the woman in a passive position, rather than appreciating her as the central figure: the one giving birth.

Explore the Precise Ways in Which Sex/Gender Defines Power Relationships and the Implications of Those Power Dynamics on Health

Creating health care from a feminist perspective requires the acknowledgment of power differentials between individuals who are consuming health care and those who provide it (clinicians). It also mandates attempts to minimize power differentials by developing a partnership model of care provision. In this model, rather than invoking a level of authority by virtue of being a clinician, the clinician acknowledges the life experiences and knowledge that the person brings to the interaction. What makes a practice feminist is not who provides the health care, but rather how that care is provided, how the clinician thinks about their work, and which populations the clinician works with.

Hierarchical relationships and structures are typically elements of the traditional healthcare delivery system, but feminist practice requires an active process of action to decrease asymmetrical relationships. Examples of simple actions include not having a person undress prior to meeting the clinician so the individual can greet the clinician as an equal rather than from a vulnerable position (naked and wrapped in an ill-fitting paper gown); and having a person check their own weight, as opposed to having someone else do it, to place some accountability for health on their shoulders. These actions send the message that the person can control aspects of their healthcare experiences. Although these simple changes can be readily made in the healthcare office setting, each demonstrates power sharing rather than placing the patient in a dependent position for aspects of her health care that she should rightly control.

Additional ways for clinicians to address gender dynamics and power relationships include supporting a feminist model of care that focuses on the ways in which the healthcare interaction is addressed. Key features of this model deal with how one listens and trusts what the person brings to the interaction. These steps include removing assumptions from consideration and not ascribing meaning without confirming it directly with the person. Checking power imbalances and addressing them, even simply by means of introduction and the manner in which the clinician sits in relation to the person, can give them greater power in the relationship. Careful use of language and terminology must occur in all discussions and information that is provided. Seeking consent before touching and assuring the person has control over what is or is not done during an examination is required. For additional considerations of promoting a feminist approach to healthcare interactions, see the blog *Feminist Midwife* (http://www.feministmidwife.com/).

Each of the strategies discussed in this chapter provide an opportunity to consider the details and the global aspects of health care and women's health issues. These strategies can be applied both individually and collectively. They are not meant to be an exhaustive checklist to determine whether something is being considered from a feminist perspective, but rather are meant to serve as guidelines and considerations that allow for the identification of blind spots in how we are able to think about health issues when we are potentially constrained by the limitations of the biomedical model. Through the use of these strategies, clinicians, policy makers, and women themselves are able to reframe expectations, approaches, and the focus of health research, healthcare delivery, and receipt of healthcare services.

WHY A TEXT ON GYNECOLOGY?

Taking the same feminist strategies we use for analyzing women's health and applying them to this text on gynecologic aspects of health creates opportunities. Why, when a feminist perspective is being presented, along with the limitations of considering women's health as being equivalent to reproductive health, would a text purportedly using a feminist framework focus primarily on the gynecologic aspects of health? The reason is that gynecologic health is still important. Focusing on gynecology for clinicians is important because reframing and expanding considerations of gynecologic health from a feminist perspective may more accurately reflect the experience of gynecologic health for people in their everyday lives. By offering a feminist perspective throughout the chapters in this text, we seek to dispel myths that pathologize normal gynecologic functioning, and we seek to support normality as opposed to medicalizing it. We also offer a framework for providing gynecologic health care that considers the social, emotional, and intimate and physical nature of this aspect of health care. Rather than ignoring gynecologic health and allowing it to remain within the biomedical domain, this text seeks to reframe aspects of gynecologic health issues within a feminist framework. This perspective expands the opportunities for understanding gynecologic health within a wellness-oriented, person-centered framework that considers both the social and the biologic elements and encourages clinicians providing health care to look beyond the medical model and to *support* normalcy instead of *manage* it.

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CHAPTER 2

Racism and Health Disparities

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INTRODUCTION

People of color, especially Black and Indigenous people, suffer from gross inequities in health. These health inequities are the embodiment of racism. The aim of this chapter is to help clinicians address disparities that are rooted in racism by understanding and being prepared to address racism. The chapter begins with key concepts and definitions to ensure all readers have a common language. This is followed by a brief history of the development of racism in the United States. The chapter describes a range of theories, frameworks, and concepts for understanding and addressing racism in health care, and it provides an overview of race-associated gynecologic health disparities data. The final section of the chapter presents key interventions for addressing racism and related disparities.

Author Reflexivity

All people in the United States are born into and grow up with the constructs of racism permeating our experience. The authors of this chapter are no different. Even as a multiracial group with a collective commitment to antiracism, each of us has our own bias and areas for growth. We recognize that dismantling this system requires collective effort. With that in mind, we give thanks to those who supported the development of this chapter, especially Juana Rosa Cavero, California Coalition for Reproductive Freedom; Lisa Fu, MPH, California Healthy Nail Salon Collaborative; Patricia O. Loftman, CNM, LM, MS, FACNM; Felina M. Ortiz, DNP, CNM; and Aisha Mays, MD, Director of Adolescent and School-Based Health Services, and Founding Director of the Dream Youth Clinic Roots Community Health Center.

Even with this collective effort, we recognize that there may be content within this chapter that may unintentionally reinforce the very structures we aim to dismantle. We humbly ask that readers of this chapter keep an open mind and a critical eye. If you recognize room for growth in this chapter, share this with your fellow students and the authors. It is only by working together and bringing each other along that society will dismantle the systems that privilege the few at the expense of the many.

KEY CONCEPTS AND DEFINITIONS

Health Equity and Health Disparities

Gross inequities in human society are responsible for preventable death and morbidity of millions of people (Commission on Social Determinants of Health, 2008). Achieving optimal health, reducing unconscionable premature loss of life, and averting preventable health conditions requires working toward equity not just in clinical care, but also in society. This work requires understanding health equity and health disparities.

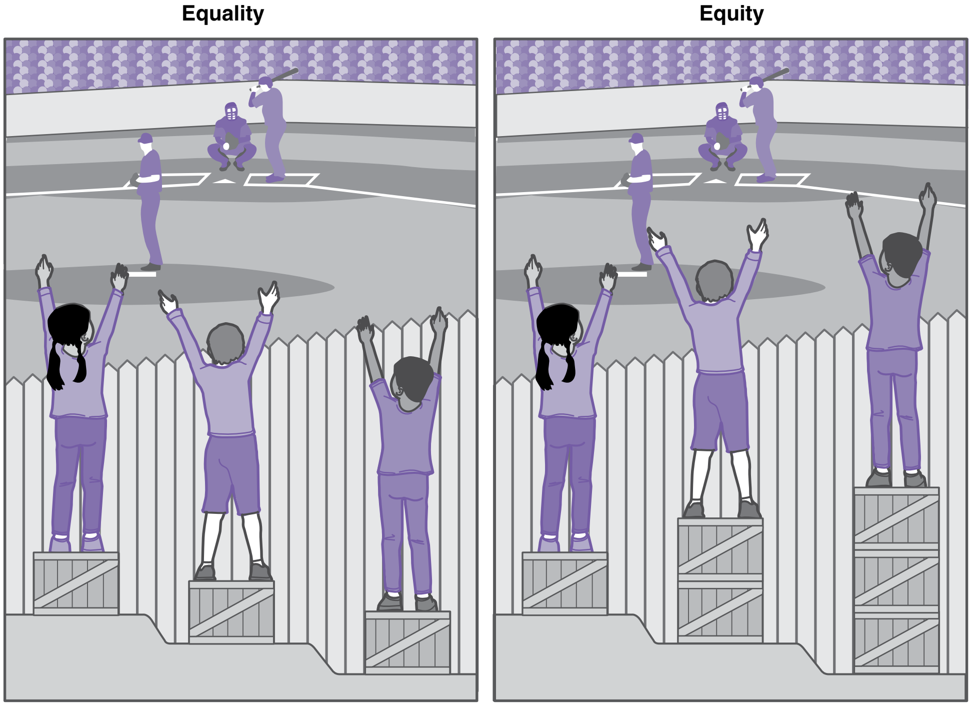
"Health equity is the ethical and human rights principle that motivates us to eliminate health disparities, which are differences in health or its key determinants (such as education, safe housing, and freedom from discrimination) that adversely affect marginalized or excluded groups. . . . Equity is not the same as equality; those with the greatest needs and least resources require more, not equal, effort and resources to equalize opportunities" (Braveman et al., 2018, p. 3). See **Figure 2-1** for a depiction of this concept. To achieve health equity, it is critical that healthcare providers understand the social, political, and institutional structures and the interpersonal relationships that impact individuals' and communities' health, values, and relationship to health care. Healthcare providers must also understand how these forces shape their personal life experiences and impact their approach to the provision of health care and how healthcare professions and institutions are shaped by these forces.

"Health disparities" is the term used to describe the differences in health that adversely affect communities that are socially and/or economically disadvantaged. It is important to note that a health disparity is not simply a health difference, but rather a difference that is plausibly avoidable and impacts individuals from communities that are socially, politically, and/or economically disadvantaged, such as people who are lesbian, gay, bisexual, or queer, transgender, immigrant, poor, disabled, and/or of color (Braveman et al., 2018).

Power, Privilege, Oppression, and Intersectionality

Individuals from socially, politically, and/or economically disadvantaged communities are not inherently disadvantaged. Instead, their inequality is the result of political and social structures that create and maintain hierarchical relationships among social groups. These hierarchical relationships ensure that individuals from certain social groups, such as people who are cisgender, male, heterosexual, and/or white, have greater access to power. Power is the ability to direct or influence the behavior of others, oneself, or a course of events (Givens et al., 2018). When power is unearned and unfairly advantages some people over others, it is called privilege. When certain groups

FIGURE 2-1 **Equality and equity.**



To achieve equity, some individuals and communities need more and/or different resources. Equality is depicted in the image on the left, which shows each person receiving the same resources in the form of a single box. This results in the person on the left easily viewing the game, while the two people on the right have an obstructed view. Note that the two people on the right side of these images are depicted as being on ground that slopes down and behind a fence that slopes up, both of which combine to restrict their access to watching the game. The ground and fence illustrate the structural nature of inequity. In the image on the right, equity is represented by the increasing number of boxes under the people so that all three individuals can easily view the game. Note that all of the people have similar heights to indicate comparable inherent abilities.

Reproduced from Kuttner, P. (2015). The problem with that equity vs. equality graphic you're using. http://culturalorganizing.org/the-problem-with-that-equity-vs-equality-graphic/. © Copyright 2015, Paul Kuttner.

are systematically denied access to power, it is called oppression. Privilege and oppression grant variable and inequitable access to social, political, and economic resources, such as wages, high-quality education, safe housing and communities, and comprehensive health care, which results in variable and inequitable access to power.

It is important to note that this discussion refers to population-level effects. The fact that "some individuals in an excluded or marginalized group may have escaped from some of the disadvantages experienced by most members of that group . . . do[es] not negate the fact that the group as a whole is disadvantaged in ways that can be measured" (Braveman et al., 2018, p. 4). Similarly, the fact that some people from privileged social groups may experience disadvantage does not negate the privilege experienced by the group as a whole.

Further, each individual is a unique mix of social identities and the interactions among those identities (e.g., race, ethnicity, gender, class, sexual orientation, age, disability/ability, migration status, religion) (Bowleg, 2012; Hankivsky, 2014). In some individuals, a socially privileged identity may moderate the disadvantages of a socially oppressed identity. In other cases, individuals who have multiple socially oppressed identities may experience disparities that are different than those found at the population level of any single disadvantaged group. The compounding effect of having multiple socially oppressed identities is called intersectionality. The term was coined by Crenshaw (1994) in her work describing the unique challenges faced by Black women in sex and race discrimination legal cases because they were both Black and women. Black men did not face the same gendered experiences as Black women, and white women did not face the same racialized experiences as Black women. The Black women she was representing experienced unique racialized and gendered discrimination.

Race and Racism

Understanding the role racism plays in health inequities requires a shared understanding of the concepts of race and racism. In this chapter, race is defined as social classification of people based on a combination of phenotype, culture, and family and social history. This definition recognizes that race is a multifaceted social construct; there are no biological or genetic markers that map directly onto the socially constructed definitions of race (Williams & Sternthal, 2010). This chapter uses the definition of racism described by Jones (2002): "Racism is a system of structuring opportunity and assigning value based on phenotype ('race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole through the waste of human resources" (p. 10).

Racial Descriptors

It is important for readers to be aware of the language the authors of this chapter use to describe different racial groups. Because race is a social construct, the terms used to describe different groups and the boundaries of these groups change over time. For example, "Subcontinent Indians were counted as Hindu in three censuses (1920–1940), but as white in the next three censuses. In 1980 they were counted as Asian, a status they retain today" (Prewitt, 2005, p. 7). Even people who would commonly be recognized as white in the current era, such as Irish and southern and eastern Europeans, have been "defined as 'others' at one point or another and have been associated with inferior physical, mental, and moral attributes in relation to the dominant white population" (Sáenz & Morales, 2019, pp. 165–166). Much of the evolution of formal language used to describe race is a reflection of efforts to maintain the racial hierarchy for the benefit of those in power (Prewitt, 2005; Snipp, 2003). Thus, it is important to be clear about the terms used in this chapter and why the authors chose to use them.

Throughout this chapter the authors use the term "people of color" as an umbrella term to describe all people not currently racialized as white in the United States. The term encompasses people from a wide range of racial, ethnic, and cultural identities. Because US society operates within a racial hierarchy that privileges white people above others, it can be helpful to view the experiences of people who are not racialized as white together when describing the impacts of racism generally. However, the term "people of color" completely loses its power when it is used instead of a more precise term (e.g., using "people of color" instead of "Black" or "African American" to describe the people of the African diaspora).

As for words that describe specific communities, the authors intentionally use a variety of terms within this chapter to recognize that racial categorization is challenging and imperfect. Racial categories can be externally imposed, internally developed, or developed through a process that is a combination of social interactions, self-identification, and others perceptions (Lemelle, 2011). This chapter uses dual terms for individual racial categories, including African American and Black, Native American and Indigenous, and Hispanic and Latinx. The authors recognize that some individuals will identify with both terms, while others may self-identify with a single term. The hope is to be inclusive of the wide range of ways that individuals identify and to help demonstrate the challenge of language for describing socially constructed racial groups. In the interest of preserving any terms of self-identification, and in an attempt to offer the richest level of data and information to readers, when applicable this chapter uses terms cited in the primary references. Readers will also note throughout the chapter that "white" is the only racial term that is lowercased, while other ethno-racial terms are capitalized. The authors agree with Kapitan's position that "general editorial standards may call for equal treatment when it comes to the words *Black* and *white*, but until equal treatment exists in our larger society, calls for equal treatment in language only serve to whitewash cultural context, identity and history" (2016, para. 4).

The US census and much scientific research makes a distinction between race and ethnicity for Hispanic people. This distinction is not typically made of any other people when collecting or reporting population-level data. Census categories, also used in health science research, identify race as white, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. Respondents are asked to identify their ethnicity (Hispanic or non-Hispanic) and their race separately. Ethnicity is typically understood to refer to people who share common ancestry, language, and other cultural attributes (Sáenz & Morales, 2019; Temkin et al., 2018). When a distinction is made between race and ethnicity, race is described as being primarily related to physical attributes. However, attempts at distinguishing between these two concepts are fraught with difficulties; it is clear that many people who identify with a shared race also share ancestry, language, and other cultural attributes. Because this chapter is focused on the impact of racism on health, the authors have chosen to use the language of race throughout. Ethnicity is mentioned only when that language was used by the underlying study.

Lastly, the authors have chosen to use the term "race-associated disparities" instead of "race-based disparities." The latter term reinforces the false idea that race, not racism, is the cause of the disparities. The disparities seen in research are associated with individuals' race, but the basis of this disparity is the individuals' exposure to racism, not their race.

HISTORY

The Development of Racism in the United States

"The variable 'race' is not a biological construct that reflects innate differences, but a social construct that precisely captures the impacts of racism" (Jones, 2000, p. 1212).

This section presents an overview of the development and maintenance of pro-white/anti-Black racism in the United States. It is beyond the scope of this chapter to provide a complete and in-depth presentation of all people's history with respect to the construction of race and the development of the system of racism in the United States. This section focuses on the development and persistence of anti-Black racism because it is deeply embedded in how race is more generally constructed in the United States. By understanding the construction of anti-Black racism, readers can more deeply understand other forms of racism. However, a risk of sharing this story alone is that it plays into the perception that racism is something that occurs only to Black people and that it is perpetuated only by white people. Of course, this misses the experiences of wide swaths of people in the United States. It is the authors' hope, however, that sharing this brief introduction to the history of the construction of race for one people can deepen readers' understanding of the environment in which healthcare providers practice and that it will encourage readers to be aware of the need to further their understanding with respect to other communities.

Humans have long identified differences between those who share their own group identity and those who do not (i.e., in-group and out-group) based on cultural practices, geographic location, language, and other identifying factors. Within this framework, the concept of race was first developed by slave traders to justify and support the development of the African slave trade (Kendi, 2016). The slave traders created the notion of an inferior "Black race" that encompassed all people from the phenotypically, lingually, geographically, and culturally diverse communities of Africa. With this racial construct in place, they justified slaving expeditions by suggesting that slavery and exposure to Christianity was an improvement over freedom in Africa where people "lived like beasts [and] had no understanding of good, but only knew how to live in bestial sloth" (Kendi, 2016, p. 24). Thus, the concept of a superior white race was already 200 years in the making when it was brought to the Americas by early English, French, Spanish, and Dutch colonizers.

Within the US colonies and early states, these ideas were transformed into a system of legally and socially defined categories (Kendi, 2016). Racial categorizations that privileged a "white race" were used to justify and uphold the displacement and genocide of Indigenous peoples and the capture and enslavement of African peoples. These efforts directly benefited people of European descent, allowing for the acquisition of land, free labor, and corresponding resources (Bailey et al., 2017). Stereotypes developed to support the legal and civic codes that upheld slavery, and they persist to this day; Black people were represented as lazy, stupid, aggressive, more sexually promiscuous, and having a higher pain tolerance (Bailey et al., 2017; Kendi, 2016; Prather et al., 2018).

Belief in the inherent superiority of the white race persisted beyond the dissolution of the institution of slavery. For example, it underpinned the legalized anti-Black racial segregation of the Jim Crow era. It facilitated the state-sanctioned removal of Indigenous children from their homes and forced their assimilation into both the English language and European cultural norms in boarding schools (Bailey et al., 2017). It supported the internment of Japanese people during World War II while white Germans remained free (Dower, 2012; S. L. Smith, 2005).

The construction of race and the impacts of racism persist in structures that develop and maintain the racial inequities seen today. Take, for example, persistent housing segregation and its impacts on African American wealth accumulation. From the 1930s to the 1960s, the Federal Housing Administration (FHA) subsidized the development of suburban housing while requiring that these homes not be sold to Black people. Simultaneously, in a process known as redlining, the FHA systematically denied insurance on mortgages for homes owned by African Americans. Readers can find their community's historical redlining documents on the University of Richmond's Mapping Inequality website (https://dsl.richmond.edu/panorama/redlining/#loc=4/36.71/-96.93&opacity=0.8). The lack of access to government-insured mortgages meant that Black families were subject to predatory loans (Coates, 2014) that conferred a higher risk of losing their homes. These families also spent more money on homes that had less resale value, and they were less likely to be able to take out a second mortgage. Collectively these policies ensured ongoing racial segregation and supported the persistence of the wealth gap between African Americans and white Americans (Gross, 2017), such that as of 2011 "the median white household had $111,146 in wealth holdings, compared to just $7,113 for the median black household" (Sullivan et al., 2015, p. 1).

Redlining and the resulting housing segregation and lack of access to home equity as a means toward wealth accumulation is often cited as a primary example of the role of structural racism in the development and maintenance of pro-white/anti-Black racial inequities. However, it is important to note that the nature of structural racism is such that housing segregation does not act alone; it is the fulcrum from which a cascade of inequity operates. Residential segregation results in segregated education. Education funding is tied to property values; thus, communities with lower property values almost always have underresourced schools. Subpar education subsequently limits employment opportunities and access to increasing a community's financial resources. Further, residential segregation results in poor communities of color often living in substandard housing that is overburdened with environmental toxins, has inadequate access to healthy food, and has higher rates of exposure to the criminal justice system, all of which combine to cause poor health.

The criminal justice system's overpolicing of communities of color (Alexander, 2012) results in incarceration rates for African Americans that are five times those of white Americans (National Association for the Advancement of Colored People, n.d.). The overpolicing of Black communities was developed as an explicit economic response to the loss of free labor when slavery was outlawed; people in power needed continued access to cheap or free labor, so Black people were disproportionally incarcerated and forced to work while incarcerated (Alexander, 2012). Overpolicing persists today, in part due to the profits that can be made from the cheap labor of incarcerated people (Petrella & Begley, 2013).

African American communities also face discrimination and disparities in the education system. In grade school education, they are less likely to have access to college preparatory and honors courses and are more likely to have underprepared teachers (United Negro College Fund, n.d.). Educators are more likely to have lower expectations for Black students than their white peers, and African Americans experience much higher rates of school discipline. At the intersection of the criminal justice system and the education system, African American students are 2.3 times more likely than white students to be referred to law enforcement or subjected to a school-related arrest (United Negro College Fund, n.d.).

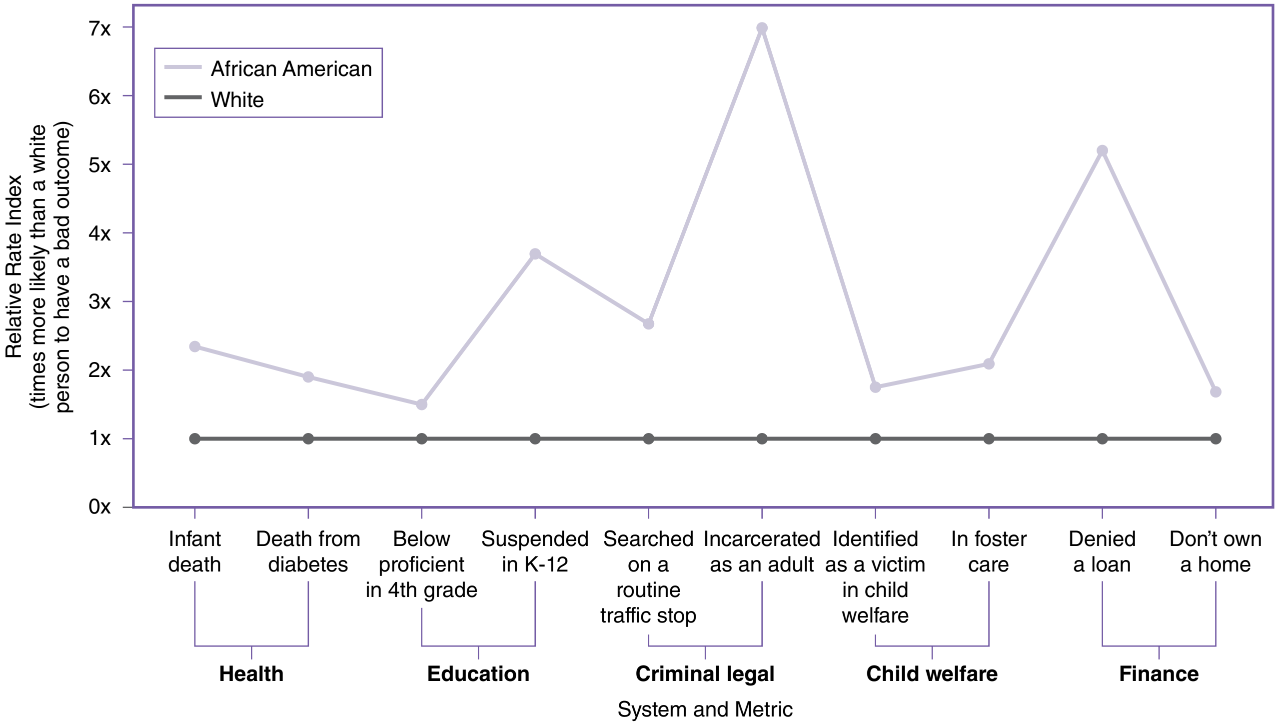
These disparities, and many more, act in concert to create persistent race-associated disparities across multiple axes. The Racial Equity Institute has produced a graphic (see **Figure 2-2**) that shows a broad range of disparities faced by African Americans. Understanding the pervasiveness, persistence, and structural nature of the disparities will help clinicians recognize that differences in health outcomes are not due principally to health behaviors, genetics, or cultural factors; rather, health disparities are the physical manifestation of racism. Additional resources about the history and effects of racism in the United States can be found in **Appendix 2-A**.

Reproductive Coercion and Abuses

"Every indignity that comes from the denial of reproductive autonomy can be found in slave women's lives—the harms of treating women's wombs as procreative vessels, of policies that pit a mother's welfare against her unborn child, and of government's attempts to manipulate women's childbearing through threats and bribes" (Roberts, 1997, p. 23).

Control over Black African slaves' reproduction, and the destruction of family units in both Black African slave and Native American communities, were key strategies employed to develop and maintain the power of white men in the early United States (Dunbar-Ortiz, 2014; Kendi, 2016; Roberts, 1997). One of the earliest laws codifying the racial categories of slavery was an 1862 Virginia law that ensured any child born of an enslaved woman would be a slave; this law clarified that slaves who were raped by their white owners, or who were forced into sexual relationships with other slaves, would bear children who would be owned by those slave owners (Kendi, 2016; Roberts, 1997).

FIGURE **2-2** **Likelihood of having a bad outcome among African American and white people in the United States.**



African Americans are 1.5 to 7 times more likely to have a bad outcome across systems. Disparities due to racism are pervasive, persistent, and structural in nature.

Reproduced from Hayes-Greene, D., & Love, B. P. (2018). The groundwater approach: Building a practical understanding of structural racism. The Racial Equity Institute. https://static1.squarespace.com/static/578fa7e3d482e9af82f8f507/t/5c1b08a50ebbe8eec9f38d21/1545275564106/REI+Groundwater+Approach.pdf.

Soon thereafter, laws followed to ensure that any white woman who had a relationship with a man of color would endure a stiff penalty (Kendi, 2016).

The white colonialists also employed tactics to control Native American reproduction. From 1869 into the 1960s, Native American children were stolen from their families and placed in boarding schools with the explicit intent to "Kill the Indian, Save the Man" (Dunbar-Ortiz, 2014; National Native American Boarding School Healing Coalition, n.d.). The children were forbidden to speak their native language, wear traditional clothes, or engage in traditional cultural practices (A. Smith, 2005). Sexual and physical abuse was rampant in the schools and persisted well into the 1980s. A 1987 FBI investigation found that one teacher had sexually assaulted more than 142 boys during his 9-year tenure at a Hopi school (Associated Press, 1987; A. Smith, 2005), and it was not until 1989 that the Bureau of Indian Affairs issued a policy to ensure stronger background checks on prospective teachers (A. Smith, 2005). The violence in boarding schools and the destruction of family and community connections are recognized as the root cause of the grave disparities in sexual and intimate partner violence seen in Native American communities (A. Smith, 2005).

State efforts to control the reproduction and family formation of those deemed unfit found new life in the Eugenics movement from the 1920s to1940s (Roberts,1997; Stern, 2016). This movement was fueled by fears of white "race suicide" due to lower birth rates among white US-born women, as compared to foreign-born women, and racist ideas that described the moral and intellectual superiority of the white race (Roberts, 1997). During this period, 32 states enacted compulsory sterilization laws (Stern, 2016). These laws initially focused on incarcerated and institutionalized men, but they were subsequently applied more aggressively to women (Roberts,1997). Female sterilization laws focused on women who were mentally disabled, poor, and of color (Roberts,1997; Stern, 2016). Even as the Eugenics movement was debunked and fell out of favor, forced sterilization of people of color, especially women, persisted into the 1970s. Women of color, especially Black, Latinx, and Native American women, were sterilized without their consent after giving birth, during treatment for other unrelated concerns, or for the purpose of physician resident education (Roberts, 1997; Tajima-Peña, 2015). Meanwhile, white women encountered barriers to accessing sterilization (Roberts, 1997). Activist efforts in the 1970s resulted in sterilization reform that persists today; federally funded programs require informed consent and a 30-day waiting period, hysterectomies may not be performed for sterilization, and sterilization may not be performed on those who are minors, mentally incompetent, or institutionalized. Even with these protections in place, some people are still subject to coercion. As recently as 2010, 146 inmates in California prisons underwent sterilization without required state approval, and many of these individuals were coerced (Johnson, 2013).

Reproductive coercion is not limited to sterilization efforts. In the 1990s many states enacted laws that required women who relied on government aid to use Norplant, a long-acting, highly effective, provider-controlled method of contraception (Roberts, 1997). Efforts to control poor women's reproduction persist; as recently as 2017, South Dakota Medicaid would not reimburse for the removal of a contraceptive implant if the intent was for the recipient to become pregnant (McKee, 2016; National Women's Health Network, 2019).

Beyond government policies, there is strong evidence that providers themselves continue to pressure women of color to limit reproduction. Providers are more likely to recommend intrauterine devices to Black and Latinx women with low socioeconomic status than to white women with similar socioeconomic status (Dehlendorf et al., 2010). Women of color and women with low incomes are more likely to report being pressured to use a contraceptive method and limit their family size (Dehlendorf et al., 2016). In a qualitative study of 38 young Black and Latinx women, 71 percent recounted experiences of pressure in contraceptive care. The authors note that "experiences of implicit pressure influenced participants' uptake and discontinuation of contraception, interactions with providers writ large, and willingness to seek future care" (Gomez & Wapman, 2017, p. 223). Similarly, in a study of 1,783 women from across the United States, women of color were more likely than white women to rate the following features of contraception as extremely important: user control over starting and stopping the method, methods that would not change the user's menstrual cycle, and methods that would not affect return to fertility. The authors note it is probable that the history of reproductive abuse of poor people and people of color underpins some of these preferences (Jackson et al., 2016). Additional resources about reproductive coercion and abuses can be found in Appendix 2-A.

Research and Racism

No history of gynecology would be complete without mention of the racist history of medical experimentation on Black and brown bodies. The most well-known example is the Tuskegee Study of Untreated Syphilis, in which the US Public Health Service studied the life course of syphilis in approximately 400 Black men. The men were denied the effective standard treatment of penicillin and advised not to seek treatment elsewhere. The researchers endeavored to ensure that local physicians and clinics would not treat these men if they sought care elsewhere. Additionally, the men were made to undergo unnecessary phlebotomy, lumbar punctures, and autopsies (Alsan & Wanamaker, 2018; Howell, 2017). The consequences of untreated syphilis were borne not only by the men, but also by entire communities because the men's partners and children were allowed to contract the disease (Washington, 2011). This experimentation was made possible due to racist beliefs about biological differences between the races; the researchers were interested to learn if neurosyphilis would manifest differently in "primitive" and "underdeveloped" Black brains (Howell, 2017). This study continued for 40 years and was stopped only after a journalist broke the story in 1972 (Alsan & Wanamaker, 2018; Howell, 2017). Awareness of the Tuskegee Study of Untreated Syphilis has been demonstrated to reduce Black men's utilization of both inpatient and outpatient medical care (Alsan & Wanamaker, 2018).

Lesser known is the 1946 to 1948 study by the US Public Health Service in which vulnerable people (children, orphans, prostitutes, Indigenous people, people with leprosy, people with mental illness, prisoners, and soldiers) in Guatemala were intentionally infected with syphilis, gonorrhea, and chancroid without their consent (Rodriguez & García, 2013). **Box 2-1** contains an explicit and graphic description of the experience of one woman who was subjected to this study. This description is included to humanize the individuals upon whom this research was perpetrated and to encourage readers to fully face the complex history upon which current scientific knowledge and practices are based.

Well before the Tuskegee study, J. Marion Sims, often called the father of modern gynecology, performed much of his groundbreaking research on the repair of vesicovaginal fistulas and the development of the Sims speculum on enslaved Black women who were forced to undergo repeated unanesthetized surgeries. As slaves owned by Sims, these women lacked the freedom to consent to participation in the experimental studies (Owens, 2017). Similarly, the first large-scale study on oral hormonal contraceptives was performed on women in Puerto Rico who were poor and were not informed that the pill was experimental (PBS, n.d.).

Criminalization of Pregnancy

Finally, it is important to review the role racism has played in the criminalization of pregnant people. In Paltrow and Flavin's review of 413 cases where being pregnant was "a necessary factor leading to attempted and actual deprivations of a woman's physical liberty" (2013, p. 299), over half of the cases involved a pregnant woman who was Black. Of these Black women, almost half (48 percent) were reported to the authorities by their

BOX 2-1 Experience of Berta, a Woman in the Guatemala Sexually Transmitted Disease Experiments

Berta was a female patient in the psychiatric hospital. Her age and the illness that brought her to the hospital are unknown. In February 1948, Berta was injected in her left arm with syphilis. A month later, she developed scabies (an itchy skin infection caused by a mite). Several weeks later, [lead investigator Dr. John] Cutler noted that she had also developed red bumps where he had injected her arm, lesions on her arms and legs, and her skin was beginning to waste away from her body. Berta was not treated for syphilis until three months after her injection. Soon after, on August 23, Dr. Cutler wrote that Berta appeared as if she was going to die, but he did not specify why. That same day he put gonorrheal pus from another male subject into both of Berta's eyes, as well as in her urethra and rectum. He also re-infected her with syphilis. Several days later, Berta's eyes were filled with gonorrheal pus, and she was bleeding from her urethra. On August 27, Berta died.

Reproduced from Rodriguez, M. A., & García, R. (2013). First, do no harm: The US sexually transmitted disease experiments in Guatemala. *American Journal of Public Health*, *103*(12), 2122–2126. https://doi.org/10.2105/AJPH.2013.301520 healthcare provider, while less than one third (27 percent) of the white women were reported by their healthcare providers. Paltrow and Flavin defined deprivation of physical liberty as "arrests; incarceration in jails and prisons; increases in prison or jail sentences; detentions in hospitals, mental institutions, and treatment programs; and forced medical interventions, including surgery" (p. 301).

The majority (84 percent) of these cases, irrespective of the race of the person, involved illicit drug use. The criminalization of pregnant people who use drugs is directly tied to racism (Roberts, 1997). Prior to the war on drugs in the 1980s and the anti-Black racialized fear of "crack babies," few women were charged with such prenatal crimes (Campbell, 2018; Roberts, 1997). Additionally, the impact of criminalizing drug use by pregnant people is also racialized. Pregnant people of color, especially Black, Indigenous, and Latinx, are more likely to interface with government agencies and are therefore more likely to undergo drug screening and be reported (Campbell, 2018; Roberts, 1997). Additional resources about the criminalization of pregnancy can be found in Appendix 2-A.

THEORIES AND RELATED CONCEPTS

A number of scholars and theorists have proposed a variety of mechanisms and models for understanding the causes of healthcare disparities as well as tools and techniques for effective interventions. This section presents a brief introduction to these theories, frameworks, and related concepts, which are summarized in **Table 2-1** and explicitly focus on structural and systemic understanding and solutions. Theories and concepts that

TABLE **2-1** **Definitions and Key Concepts for Theories and Related Concepts Used to Understand and Address Health Disparities**

Theory	**Definitions and Key Concepts**
Critical race theory	• Racism is a common and everyday experience for people of color. • Racism preferentially benefits white people over people of color. • Race is a social construct. • Taking action is required to make change. • Change efforts are oriented toward contemporary manifestations of racism. • Change efforts are focused on and guided by the perspective, experience, and voices of people from marginalized communities ("center from the margins").
Reproductive justice	Reproductive justice is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities. To achieve reproductive justice, we must analyze power systems, address intersecting oppressions, center the most marginalized, and join together across issues and identities" (SisterSong, n.d., para. 1).
Social determinants of health	The social determinants of health are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries" (World Health Organization [WHO], 2019, para. 1).
Lifecourse Health Development Model	The Lifecourse Health Development model "explain[s] how health trajectories develop over an individual's lifetime" (Halfon & Hochstein, 2002, p. 433).
Cultural competency	Despite decades of research, there is not a formal agreed-upon definition of cultural competence, which is the dominant approach to training healthcare providers to care for diverse populations and reduce healthcare disparities (Alizadeh & Chavan, 2016; Metzl et al., 2018; Shen, 2015).
Cultural humility	Cultural humility is a "lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician–patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998, p. 123).
Structural competency	Structural competency is the trained ability to understand how symptoms, attitudes, or diseases represent downstream implications of a wide variety of upstream structural systems.
Implicit bias	As a technical term, implicit bias can be applied to any subconscious thought; however, the term is now commonly used to describe negative subconscious associations that people have toward groups of people.

focus on individual choices, health behaviors, lifestyle, and culture are not included. This focus is intentional; the root cause of race-associated disparities is racism. Because racism is socially constructed and maintained by institutions, theories that describe the problem and define the interventions must also be structural and systemic (Harvey & McGladrey, 2019). The one exception is the Implicit Association Test (IAT), discussed at the end of this section, which gives providers an opportunity to investigate and intervene on a personal behavioral level in their provision of care.

Critical Race Theory

Critical race theory (CRT) emerged out of legal scholarship in the 1970s. Its development was informed by radical feminism, critical legal theory, the Black power and Chicano movements, philosophy, and works by American antiracism leaders such as W. E. B. Du Bois, Martin Luther King Jr., and Cesar Chavez (Flores, 2017). Since the 1970s, CRT has become "a collection of activists and scholars engaged in studying and transforming the relationship among race, racism and power" (Delgado & Stefancic, 2017, p. 3) in fields as varied and diverse as education, psychology, communications, political science, and public health.

The core tenets of CRT hold that (1) racism is a common and everyday experience for people of color, (2) racism preferentially benefits white people over people of color, and (3) race is a social construct. CRT is grounded in a commitment to taking action to make changes to dismantle racism. The theory recognizes that the manifestation of racism changes over time, as does the racialization of different groups, and orients change efforts toward contemporary manifestations of racism. CRT holds that the key to dismantling racism is to center at the margins and uplift and share counter-stories. Centering from the margins means that perspective, experience, and voices from marginalized communities guide the work. Counter-stories describes the important role that storytelling, especially personal narratives and allegory, holds for shifting the dominant culture toward antiracism.

Ford and Airhihenbuwa (2010, 2018) have made important contributions to the public health literature demonstrating the importance of CRT to public health discourse and research, and they have demonstrated how to apply CRT to public health research. They note that CRT provides "tools [that] help researchers illuminate racial biases embedded in a field or in a study's aims, methods, conclusions, etc., and develop strategies to address them" (2018, p. 224).

Reproductive Justice

Reproductive justice is a human rights framework, a theory, and a sociopolitical movement that identifies the fundamental human right of reproductive autonomy (Ross, 2007; Ross & Solinger, 2017). The core principles recognize the fundamental human rights of reproductive autonomy, including (1) the right to not have a child, (2) the right to have a child, and (3) the right to parent children in safe and healthy environments (Ross, 2007; Ross & Solinger, 2017). The term "reproductive justice" was coined in 1994 by a group of African American women soon after attending the International Conference for Population and Development in Cairo, Egypt (Ross & Solinger, 2017). The analysis and movement were developed, in part, in reaction to the limited framework of choice presented by the pro-choice movement (Luna & Luker, 2013). The pro-choice movement, led by middle- and upper-class white, cisgender women, frequently ignored the reproductive health concerns of women of color, women who were poor, transgender people, and others. For example, the pro-choice movement has continued to focus on personal and individual choice in abortion care despite the fact that the Hyde Amendment, passed in 1976 just 3 years after *Roe v. Wade*, bans Medicaid coverage for abortion, disproportionately reducing access to abortion for people who are poor and people of color.

In 1997, the SisterSong Women of Color Reproductive Justice Collective was formed by members of the original group, in coalition with 16 organizations representing women from Native American, African American, Latinx, and Asian American communities. Since that time, the movement has grown, and a large number of organizations and individuals work collectively to realize reproductive justice. In the 20-plus years since its inception, Reproductive Justice has "expand[ed] the analysis of reproductive issues in ways that are more inclusive of the lived experience of all marginalized communities that contribute significantly to major organizing and political victories" (Simpson, 2014, para. 4).

Social Determinants of Health

Healthcare disciplines, especially nursing, midwifery, and public health, have long recognized the role of social, political, and economic factors on individual and population health (Irwin & Scali, 2007). In recent years the term "social determinants of health" has gained popularity for describing the impact of these forces on health. These forces include "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries" (WHO, 2019, para. 1). Both the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) websites contain numerous resources on the evidence behind social determinants of health and opportunities for taking action to address these factors. Healthy People 2020 highlights the importance of social determinants of health by making them one of the four umbrella goals for the century (Healthy People, 2019).

Readers are cautioned to critically review the ways that social determinants of health are conceptualized and the interventions that are favored. As Krieger states, "the social determinants of health literature is concerned with the health consequences of poverty, not with explaining why poverty exists" (2011, p. 184). Mitigating the health effects of poverty is not likely to be as effective a long-term solution as addressing the root causes of poverty. Similarly, Irwin and Scali (2007) found in their historical perspective on international efforts to address social determinants of health that while national policies can improve social determinants of health, "history shows the vulnerability of social determinants policies to resistance mounted by national and global actors concerned with maintaining existing distributions of economic and political power" (p. 252). Irwin and Scali found a number of cases where maintenance of the status quo was prioritized over effective interventions to address the root causes of social determinants of health.

Lifecourse Health Development Model

The Lifecourse Health Development (LCHD) model was first proposed by Halfon and Hochstein (2002). The model drew from cross-disciplinary research to explain how an individual's health over their lifetime is impacted by a range of biological and social events and that the impacts are cumulative and mutable (see **Figure 2-3**). Since that time, research from a variety of disciplines, including genetics, epidemiology, psychology, sociology, economics, and health sciences, has continued to support the overall concept that a diverse range of risk and protective factors interact to impact a person's health trajectory over time (Halfon et al., 2014). A key tenet of the LCHD model holds that these factors have both period-specific and cumulative impacts (Fine & Kotelchuck, 2010; Halfon & Hochstein, 2002; Halfon et al., 2014; Lu & Halfon, 2003). Period-specific impacts refer to developmental periods of high sensitivity, for example the importance of adequate folic acid intake prior to conception for reducing the risk of neural tube defects. Periods of high sensitivity may also refer to times of increased likelihood for health behavior change; these periods may be biological, such as puberty, pregnancy, or menopause, or social, such as school transitions, marriage, and retirement (Fine & Kotelchuck, 2010; Halfon et al., 2014). This model suggests that the foundation of healthy individuals is rooted in a healthy community (Brady & Johnson, 2014; Cheng & Solomon, 2014; Fine & Kotelchuck, 2010; Halfon et al., 2014). The development of healthy communities requires a reduction of economic inequity, racial discrimination, and other forms of injustice. Thus, the achievement of wellness and health requires a focus not only on the complete individual, but also on their family, their community, and the larger social structures in which they are embedded (Fine & Kotelchuck, 2010; Halfon et al., 2014).

Cultural Competency

The concept of cultural competency was first described in the health science literature by Cross et al. (1989). Since then, cultural competency has become the dominant approach to training healthcare providers to care for diverse populations and reduce healthcare disparities (Alizadeh & Chavan, 2016; Metzl et al., 2018; Shen, 2015). Despite decades of research, there is not a formal agreed-upon definition of cultural competence. There is also a paucity of data on effective tools to assess cultural competence and the impact of cultural competency trainings on improving care and outcomes (Alizadeh & Chavan, 2016; Shen, 2015). The theory underlying cultural competency is that improving healthcare provider familiarity with the values, customs, and belief models of various racial and ethnic groups will improve provider–client communication and thus mitigate health disparities. Most models describe the need for practitioners to continuously develop their cultural knowledge, awareness, and skills to develop their cultural competency (Alizadeh & Chavan, 2016; Danso, 2016).

In practice, however, cultural competency methods often present patients as static embodiments of the dominant culture's perceptions of their race and ethnicity, which perpetuates stereotypes and creates a false sense that clinicians can achieve mastery or a complete knowing of other cultures (Danso, 2016; Kleinman & Benson, 2006; Kumagai & Lypson, 2009). Another significant shortcoming of cultural competency is its one-way view focused exclusively on the culture of the patient, family, or community while largely ignoring the culture of the clinicians, care sites, and healthcare institutions (Danso, 2016; Kleinman & Benson, 2006; Kumagai & Lypson, 2009). Further, cultural competency trainings, which typically focus on improved intercultural communications, are ill-equipped to support learners to recognize and address power dynamics and oppression (Danso, 2016). For example, racism is rarely mentioned in cultural competency trainings (Kumagai & Lypson, 2009). Lastly, the term "cultural competence" suffers from the suggestion that, like other nursing and medical competencies, there is an end point the provider can achieve and thereafter be culturally competent. This is a recurrent critique despite the fact that the literature is relatively consistent in recognizing that the development of cultural competence is an ongoing process (Alizadeh & Chavan, 2016).

Cultural Humility

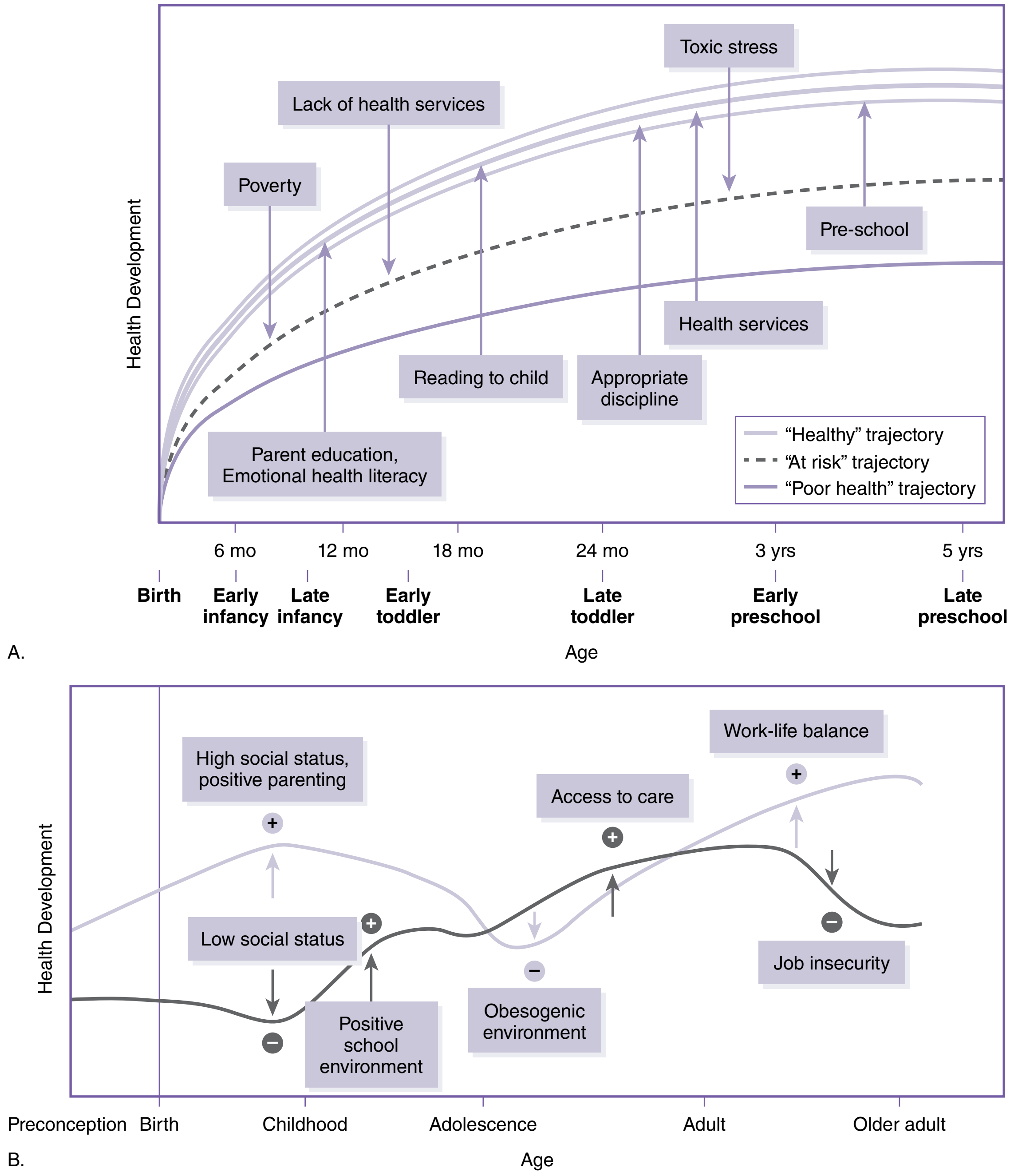
In 1998, Tervalon and Murray-García described cultural humility as a counterpoint to cultural competence. They define cultural humility as "incorporat[ing] a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician–patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998, p. 123). In their call for cultural humility, they make explicit the need to recognize and redress interpersonal, institutional, and systemic power imbalances. However, a 2016 concept analysis of the term by Foronda et al. found the key attributes of cultural humility were "openness, self-awareness, egoless, supportive interactions, and self-reflection and critique" (Foronda et al., 2016, p. 211). Taking action to redress power imbalances was not present in the literature such that it was identified as a core attribute.

Addressing health disparities requires the healthcare provider to be aware of power differentials and take action to redress power imbalances. The Fisher-Borne et al. (2015) conceptual model for cultural humility, grounded in Tervalon and Murray-García's earlier work, provides a useful model for conceptualizing and effecting cultural humility. According to Fisher-Borne et al., at the center of cultural humility are individual and institutional accountability; both are of equal importance and are interdependent. Individual and institutional accountability must work in concert to facilitate change and shift power balances. The model proposes that ongoing learning and critical self-reflection are skills and techniques that are required to develop and maintain this accountability. The model explicitly recognizes that the work of cultural humility happens within the context of individual and structural power imbalances, and it expects practitioners to be accountable for recognizing and shifting these power imbalances. Additionally, Fisher-Borne et al. provide individual and organizational questions to assess cultural humility (see **Table 2-2**).

Structural Competency

Structural competency, originally presented as a framework to expand and replace cultural competency in medical schools (Metzl & Hansen, 2014), quickly found utility in a wide range of disciplines for students and current practitioners alike. Structural

FIGURE 2-3 **Variable health trajectories.**



These figures demonstrate the concept of the Lifecourse Health Development Model (LCHD). Protective and risk-promoting exposures impact the individual's health development over a lifetime. In panel A the poor health trajectory pathway has more exposure to risk-promoting experiences and less exposure to protective factors, while the healthy trajectory has more exposure to protective factors and less exposure to risk-promoting experiences. Panel B illustrates the concept that health development trajectories are not fixed and that protective and risk-promoting exposures can have impacts across the life span.

Reproduced from Halfon, N., Larson, K., Lu, M., Tullis, E., & Russ, S. (2014). Lifecourse health development: Past, present and future. *Maternal and Child Health Journal, 18*(2), 344–365. https://doi.org/10.1007/s10995-013-1346-2

TABLE 2-2 Individual and Organizational Questions to Assess Cultural Humility

	Essential Questions for Critical Self-Reflection	Essential Questions to Address Power Imbalances
Individual level	• What are my cultural identities? • How do my cultural identities shape my worldview? • How does my own background help or hinder my connection to clients/communities? • What are my initial reactions to clients, specifically those who are culturally different from me? • How much do I value input from my clients? • How do I make space in my practice for clients to name their own identities? • What do I learn about myself through listening to clients who are different than me?	• What social and economic barriers impact a client's ability to receive effective care? • What specific experiences are my clients having that are related to oppression and/or larger systemic issues? • How do my practice behaviors actively challenge power imbalances and involve marginalized communities? • How do I extend my responsibility beyond individual clients and advocate for changes in local, state, and national policies and practices?
Institutional level	• How do we organizationally define culture? Diversity? • Does our organization's culture encourage respectful, substantive discussions about difference, oppression, and inclusion? • How does our hiring process reflect a commitment to a diverse staff and leadership? • Do we monitor hiring practices to ensure active recruitment, hiring, and retention of diverse staff? • Does our staff reflect the communities we serve? • Is our leadership reflective of the populations/communities we serve?	• How do we actively address inequalities both internally (i.e., policies and procedures) and externally (i.e., legislative advocacy)? • How do we define and live out the core social work value of social justice? • What are the organizational structures we have that encourage action to address inequalities? • What training and professional development opportunities do we offer that address inequalities and encourage active self-reflection about power and privilege? • How do we engage with the larger community to ensure community voice in our work? What organizations are already doing this well?

Reproduced from Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165–181. Reprinted by permission of the publisher (Taylor & Francis Ltd, http://www.tandfonline.com).

competency is the trained ability to understand how symptoms, attitudes, or diseases represent downstream implications of a wide variety of upstream structural systems. It is defined by the development of five core skills: (1) recognize the structures that shape clinical interactions; (2) develop an extra-clinical language of structure; (3) rearticulate cultural presentations in structural terms; (4) imagine structural interventions; and (5) develop structural humility (see **Table 2-3**). The structural competency framework has been used to improve clinicians' knowledge and skills in addressing racism and race-associated disparities in health care (Metzl & Hansen, 2014; Metzl et al., 2018).

Implicit Bias

The concept of implicit bias developed in the field of psychology. Psychologists have long recognized that humans' interactions with the world, themselves, and other human beings are informed by conscious thoughts and subconscious information. Implicit associations form a significant portion of the subconscious information, while explicit thoughts are formed from conscious knowledge and beliefs. Both implicit and explicit mental constructions can be negative, positive, or neutral. Explicit thoughts do not always mirror implicit associations. Thus, a healthcare provider who expresses deeply held values of equity and justice may also hold strongly negative implicit bias against a stigmatized social group. As a technical term, implicit bias can be applied to any subconscious thought; however, the term is now commonly used to describe negative subconscious associations that people have toward groups of people.

People from all social groups typically express greater implicit bias toward stigmatized groups. While people from stigmatized groups can have implicit bias toward people from their own group, people from stigmatized groups often show less implicit bias toward their own group than people who are not members of that group (Project Implicit, 2011). Abundant research links

TABLE 2-3 Five Skill Sets of Structural Competency

Skill	Description
Recognize the structures that shape clinical interactions	Consider how economic, social, and political forces impact the patient's presentation and health history and the interaction between the patient and clinician.
Develop an extraclinical language of structure	Utilize an interdisciplinary approach to study and understand how social structures impact the health of communities. Relevant disciplines include critical race theory, medical anthropology, sociology, economics, political science, and urban planning.
Rearticulate cultural presentations in structural terms	Develop the capacity to recognize and describe a clinical presentation in structural terms, especially when faced with a presentation that would typically be framed as cultural.
Imagine structural intervention	Conceive of structural interventions to address structural barriers to optimal health.
Develop structural humility	Recognize that one can never fully understand how economic, social, and political forces impact another 's life and thus approach all efforts to address structural inequality with an open mind and humility.

Reproduced from Serbin, J. W., & Donnelly, E. (2016). The impact of racism and midwifery's lack of racial diversity: A literature review. *Journal of Midwifery & Women's Health, 61*(6), 694–706. https://doi.org/10.1111/jmwh.12572

negative subconscious beliefs or associations to explicit negative treatment and poor communication toward people from stigmatized groups (Staats et al., 2017).

The IAT is the tool most commonly used to assess implicit associations. It was introduced in 1998 (Greenwald et al., 1998) and has proven to be a well-validated tool with good reliability (Maina et al., 2018). Readers can take a variety of IATs online to learn more about personal implicit biases (https://implicit.harvard.edu/implicit/). The IAT was first applied to healthcare providers in a vignette-based study; it found that physicians with higher implicit bias against African Americans were less likely to provide thrombolysis treatment to African American patients as compared to white patients (Green et al., 2007). Since that time, implicit bias has been proposed as an important cause of race-associated disparities (Maina et al., 2018; Sabin et al., 2009; Weinstock, 2012).

Numerous studies show that healthcare providers, like the general public, exhibit implicit bias against Black, Hispanic, American Indian, and dark-skinned people (Maina et al., 2018; Sabin et al., 2009; Weinstock, 2012). Like the general public, Black physicians and medical students have been shown to have less implicit bias against Black people (Maina et al., 2018, Sabin et al., 2009; Weinstock, 2012). Currently, data are lacking on the rates of in-group implicit bias for other racial groups and for other kinds of healthcare providers (Maina et al., 2018).

A systematic review by Maina et al. (2018) identified more than 20 studies that looked at the impact of race-associated implicit bias on healthcare outcomes. More than half of these studies were vignette-based studies, many of which found no correlation between disparities in care and implicit bias. However, this study design, which effectively removes patient–provider communication from the study, may not capture the mechanisms by which implicit bias operates. Studies that have investigated the impact of implicit bias on real patients demonstrate strong and compelling evidence that implicit bias negatively impacts patient–provider communication. These studies, all of which used the pro-white/anti-Black race IAT, show that providers with higher pro-white/anti-Black implicit bias communicate with more verbal dominance and use more anxiety-related words during visits with Black patients. The Black patients in these dyads perceive that the providers have low-quality interpersonal skills, unsupportive communication, and poor patient centeredness. These patients also experience lower satisfaction and confidence in recommended treatments and greater anticipated difficulty with completing recommended treatments (Maina et al., 2018).

HOW RACISM IMPACTS PHYSIOLOGY

Exposure to racism, whether it is structural or interpersonal, causes chronic, cumulative, biological stress. This stress negatively impacts both the individual and their offspring. It is critical to understand that the physiologic effects of racism are not due to underlying race-linked genetic differences, nor are they due to behavioral differences. This section reviews what is currently understood about the physiologic mechanisms whereby racism manifests in the body.

"Weathering" is the umbrella term used to describe earlier onset of negative health conditions and normal aging that results from chronic exposure to social and economic disadvantage (Forde et al., 2019). The concept was first proposed by Geronimus (1992, 1996) to explain why infants born to Black mothers tend to fare better when their mother is in her teens and infant outcomes worsen as maternal age increases into the 20s and early 30s. This contrasts with infants born to white mothers, whose outcomes are best when their mothers are in their 20s and early 30s. Subsequent research has demonstrated the weathering effect on a wide range of outcomes including body mass index, diabetes, hypertension, stroke, and longevity (Forde et al., 2019). A number of underlying mechanisms, described in this section, have been proposed as contributors to the pattern of weathering.

Allostatic load is an objective measurement of chronic stress (McEwen & Seeman, 2009; Rodriquez et al., 2019). Under health-promoting conditions, the body is responsive to external stressors and is able to maintain homeostasis. This ability to "maintain stability [or homeostasis] through change" (Sterling & Eyer, 1988, p. 636) is termed allostasis. In the face of cumulative or chronic stressors, this normal healthful mechanism can be disrupted. The effects of this dysregulation are termed allostatic load. Dysregulation involves multiple interconnected systems and affects cellular, metabolic, and cardiovascular function (Juster et al., 2010).

The concept of allostatic load is studied through a number of specific biomarkers. The original 10 biomarkers used in the research of allostatic load include four primary mediators and six secondary outcomes (Rodriquez et al., 2019). The primary mediators are the chemicals involved in sympathetic and parasympathetic regulation of homeostasis. The markers of the primary mediators include serum dehydroepiandrosterone sulfate, urinary cortisol, urinary epinephrine, and urinary norepinephrine. The secondary outcomes are indicators of the cumulative impact of regulation or dysregulation by the primary mediators. The secondary outcomes include systolic and diastolic blood pressure, waist–hip ratio, high-density lipoprotein cholesterol, total cholesterol, and glycated hemoglobin. Newer research includes additional markers of allostatic load, such as C-reactive protein, interleukin-6, and fibrinogen (Rodriquez et al., 2019). Collectively, the markers of allostatic load provide information regarding the health of the cardiovascular, metabolic, inflammatory, and neuroendocrine systems. Allostatic load "often reflects subclinical dysregulation, and as such, can potentially be used as an early warning indicator of disease risk. Allostatic load is associated with increased risk for mortality, cardiovascular disease, diabetes, higher pain scores, and decreased physical and cognitive function and is a better predictor of subsequent cardiovascular disease than the single biomarkers that comprise it" (Chyu & Upchurch, 2018, p. 259).

There are four mechanisms by which allostatic load is proposed to operate: (1) repeated activation, where the body does not have the time to return to homeostasis between exposures; (2) lack of adaptation, where the body does not adapt to a recurrent stress and learn to manage it more effectively; (3) prolonged exposure, where the body mounts an appropriate stress response but does not return to homeostasis in a timely manner; and (4) inadequate response, where the body mounts an insufficient response to the stressor (McEwen & Seeman, 2009). For example, the catecholamines, which include epinephrine (adrenaline), norepinephrine (noradrenaline), and dopamine, are involved in regulating heart rate and blood pressure, allowing an individual to transition among sleep, restful waking, and physical exertion while maintaining homeostasis. These chemicals can be beneficial in managing short-term stressors as well, providing oxygenation to the brain during stressful events. However, chronic exposure to stress-induced surges of blood pressure (repeated activation) or a body that is no longer able to downregulate blood pressure (prolonged exposure) is at higher risk for atherosclerosis and resulting coronary artery disease, stroke, peripheral artery disease, kidney problems, and type 2 diabetes (McEwen & Seeman, 2009).

Numerous studies have found increased allostatic load in Black people as compared to white people (Chyu & Upchurch, 2011; Geronimus et al., 2006; Rodriquez et al., 2018; Seeman et al., 2008). This difference persists when socioeconomic status is taken into account (Chyu & Upchurch, 2011). While being poor increases allostatic load for Black people and white people, Black people who are not poor, especially Black women who are not poor, have higher allostatic loads when compared to white people who are not poor. Geronimus et al. note that "the finding of larger racial disparities among the nonpoor than the poor, and among women than men, suggests that persistent racial differences in health may be influenced by the stress of living in a race-conscious society. These effects may be felt particularly by Black women because of 'double jeopardy' (gender and racial discrimination)" (2006, p. 830).

Research examining the effect of allostatic load on other racial groups is less developed. The authors of this chapter could not find research that looked at allostatic load in Indigenous communities living in the United States. There is scant research about the allostatic load of Asian Americans; the chapter authors could find only two studies that both focused on Japanese and Chinese-identified people (Chyu & Upchurch, 2018; Upchurch et al., 2015).

However, there is evidence that Latinx people experience higher allostatic load compared to white people and lower allostatic load compared to Black people (Crimmins et al., 2007; Rodriquez et al., 2018). Research on allostatic load in Latinx and Asian communities is complicated by the heterogeneity of the population. The Latinx population in the United States represents a wide range of racial identities and diverse countries of origin and migration experiences. Similarly, the Asian population also includes a wide range of countries of origin and migration experiences. A significant body of research suggests that recent migration to the United States is protective against high allostatic load (Chyu & Upchurch, 2018). In fact, a study examining the protective nature of recent immigration status found that it took 20 years of living in the United States for foreign-born Hispanic people to have similar allostatic load compared to US-born Hispanic people (Yellow Horse & Santos-Lozada, 2019).

The shortening of telomeres is another mechanism by which chronic stress may contribute to weathering. Telomeres are noncoding nucleotide sequences found on the ends of chromosomes. Telomeres help protect the genetic code of the chromosome during transcription. During each transcription event, a chromosome loses some of the nucleotides at the end of the chromosome. While telomerase helps to rebuild the telomeres, they shorten over time. Shorter telomeres are correlated with a number of age-related and chronic-stress-related diseases (Mathur et. al, 2016).

Epigenetics describes the mechanisms by which gene expression is turned on or off, or whether it is upregulated or downregulated, in response to environmental factors. For example, when chronic stress occurs, the genes responsible for inflammatory response are upregulated, while those responsible for antiviral and antibody production are downregulated. Chronic inflammation is implicated in a number of chronic diseases, such as hypertension, diabetes, obesity, and depression. Epigenetic changes have been proposed as a mechanism for increased weathering both in the individual and in their children (Conching & Thayer, 2019; Ohm, 2019). That is, offspring can be exposed to signals that change their gene expression in utero.

INEQUITY IN GYNECOLOGIC HEALTH

One of the most profound consequences of racism is its effect on individual and population health. Across a variety of health conditions and indicators, people of color, especially Black and

Indigenous people, have a greater incidence of disease and more frequent unfavorable outcomes than white people (National Academies of Sciences, Engineering, and Medicine, 2017). These adverse outcomes include higher rates of complications and mortality. There are also racial disparities in the quality of health care that individuals receive. These include lower rates of cancer screening, worse control of chronic diseases (e.g., hypertension, diabetes), and more frequent hospitalizations and rehospitalizations among Black people compared to their white counterparts (Fiscella & Sanders, 2016).

While increasing attention is being paid to the significant racial and ethnic disparities in maternal morbidity and mortality (Jain et al., 2018), there are also pervasive and persistent race-associated disparities across gynecologic health and health care. Examples of these disparities are presented in **Table 2-4**. When surveying the table to look for trends in various populations, it is important to remember that these numbers are not merely statistics. They represent individuals who experience undue suffering because of health disparities.

While statistics demonstrate the scope of the problem of race-associated disparities, knowing this information is only a small step toward health equity. The more important work is understanding why these disparities exist and designing effective interventions to remedy them. Unfortunately, research to date has often fallen short. This is illustrated in a recent race-conscious critique of the endometrial cancer disparities literature (Doll et al., 2018). Endometrial cancer is the most common gynecologic cancer in the United States; the 5-year survival rate is 62 percent for Black women and 83 percent for white women (Siegel et al., 2019). Doll et al. found seven major factors in the literature about contributions to racial disparities in endometrial cancer survival: high-risk histology, stage at diagnosis, chemotherapy response, molecular and genetic factors, treatment factors, comorbidity, and socioeconomic factors. A closer evaluation of the studies for each of these factors revealed that the literature is not always as clear as it seems. For example, while Black women are more likely to have high-risk subtypes of endometrial cancer than white women, the disparity in endometrial cancer mortality persists between Black and white women with these high-risk subtypes. Further, the size of the mortality gap within high-risk subtypes is not consistent across healthcare settings and is, in fact, absent in some studies from institutions that provide care for a large proportion of Black women (Matthews et al., 1997; Smotkin et al., 2012). Overall, Doll et al. found that race was usually defined as a biological, rather than a social, construct in the endometrial cancer disparities literature; therefore, inadequate attention was given to other racial disparity contributors. For example, eight studies reported treatment rates for Black women that were similar to or lower than rates for their white counterparts, despite the fact that the Black women's cancers had more high-risk features; however, no studies examined the reasons for differences in treatment or evaluated interventions to reduce treatment disparities. Doll et al. propose using the public health critical race praxis approach to generate new research questions that examine the effects of a racialized society on disease outcomes. They provide examples of such questions for endometrial cancer research and a framework for developing research questions that could be used for studying the effects of racism within and beyond gynecologic health and health care.

The work of the Metropolitan Chicago Breast Cancer Taskforce (MCBCTF) provides an example of how health disparities can be decreased when time is taken to understand the underlying structural causes and develop targeted interventions. The breast cancer mortality rate for Black and white women in Chicago was similar until the early 1990s when the rate for white women began to decrease while the rate for Black women remained the same. By 2003, the breast cancer mortality rate was 68 percent higher for Black women despite similar self-reported screening mammogram rates for Black and white women, and an increasing rate of early cancer detection in Black women. These findings indicated that diagnostic and treatment factors, rather than biology, were responsible for the disparity (Hirschman et al., 2007). In addition, while a higher breast cancer mortality rate ratio for Black women was not unique to Chicago, by 2005 the mortality rate ratio was much greater there (2.16) than nationally (1.47) or in New York City (1.21) (Ansell et al., 2009). Concern about these findings led to the formation of the MCBCTF in 2008, which began its work by investigating plausible explanations for the disparity in mortality rates. They found that compared to white women, Black women were more likely to have their mammograms at public institutions, less likely to have a digital mammogram, less likely to have a trained specialist read their mammogram, and more likely to have a cancer missed on a screening mammogram (Ansell et al., 2009; Rauscher et al., 2013). In addition, 24 of the 25 community areas with the highest breast cancer mortality rates were primarily populated by Black people and located on the south side of Chicago, yet there was only one hospital in those 24 communities with a cancer program approved by the American College of Surgeons Commission on Cancer, and there were only two such hospitals on the south side (Ansell et al., 2009). Collectively, these findings demonstrated the presence of structural racism. The MCBCTF developed multifaceted strategies to address the issue, including mammography technician training, workshops for physicians, quality improvement measures, and navigators to guide Black women with breast cancer to higher-quality care (Pallok et al., 2019). A comparison of Chicago breast cancer mortality rates between the time periods 1999–2005 and 2006–2013 revealed that the disparity in mortality for Black versus white women decreased by 20 percent. No decrease in disparity was seen nationally or in nine other cities with large Black populations (Sighoko et al., 2017). These findings indicate that the MCBCTF's "interventions disrupted the invisible, structural roots of inadequate breast cancer care provided by community hospitals serving segregated neighborhoods" (Pallok et al., 2019, p. 1490).

These examples from the endometrial and breast cancer literature underscore the importance of defining race as a social construct when designing examinations of and interventions for race-associated disparities in gynecologic health and health care. Researchers and clinicians must stop concentrating on biological conceptualizations of race and instead focus on the effects of racism on health and health outcomes. As Dr. Joia Crear-Perry states, "Black isn't the risk factor, racism is" (Muse, 2018, p. 24).

ADDRESSING RACISM AND RACE-ASSOCIATED DISPARITIES

The preceding sections have provided an overview of the history and current manifestations of racism. This background is needed for healthcare providers and scientists to have a clear understanding about what racism is and how it operates to shift thinking, research, and interventions away from race and

TABLE 2-4 Race-Associated Disparities in Gynecologic Health in the United States

	Total	White	Black	American Indian/Alaska Native	Asian/Pacific Islander	Hispanic	Data Source
Gynecologic Cancers[a]							
Breast cancer incidence	126.4	128.1	127.0	108.7	96.2	95.3	Ward et al., 2019
Breast cancer mortality	20.6	20.1	28.1	14.5	11.3	14.3	Ward et al., 2019
Cervical cancer incidence	7.7	7.5	9.2	9.9	6.2	10.0	Ward et al., 2019
Cervical cancer mortality	2.3	2.2	3.5	2.8	1.7	2.6	Ward et al., 2019
Uterine cancer incidence	26.6	27.0	26.2	23.7	19.1	23.5	Ward et al., 2019
Uterine cancer mortality	4.7	4.4	8.5	3.6	3.1	3.9	Ward et al., 2019
Ovarian cancer incidence	11.6	12.0	9.4	11.3	9.6	10.2	Ward et al., 2019
Ovarian cancer mortality	7.0	7.3	6.1	6.4	4.4	5.3	Ward et al., 2019
Gynecologic Conditions and Procedures							
Uterine fibroid prevalence	9.6%[b]	10.3%	18.5%	11.9%	11.5%	11.1%	Yu et al., 2018
Hysterectomy prevalence	Black women have increased odds of hysterectomy compared to white women		Odds ratio = 3.52 (95% CI, 2.52–4.90) Adjusted odds ratio = 3.70 (95% CI, 2.44–5.61)				Bower et al., 2009
Hysterectomy route	Women of color eligible for minimally invasive hysterectomy are more likely to receive abdominal hysterectomy than white women	Vaginal aPR = 1.0 (reference) Laparoscopic aPR = 1.0 (reference)	Vaginal aPR = 0.93 (95% CI, 0.90–0.96) Laparoscopic aPR = 0.90 (95% CI, 0.87–0.94)	Not included	Vaginal aPR = 0.88 (95% CI, 0.81–0.96) Laparoscopic aPR = 0.94 (95% CI, 0.88–1.03)	Vaginal aPR = 0.95 (95% CI, 0.93–0.97) Laparoscopic aPR = 0.95 (95% CI, 0.92–0.98)	Pollack et al., in press
Infertility	Black women are more likely than white women to experience infertility		Adjusted odds ratio = 2.04 (95% CI, 1.39–3.01)				Wellons et al., 2008

(*continues*)

TABLE 2-4 Race-Associated Disparities in Gynecologic Health in the United States (*continued*)

	Total	**White**	**Black**	**American Indian/Alaska Native**	**Asian/Pacific Islander**	**Hispanic**	**Data Source**
Abortion, Contraception, and Reproductive Coercion							
Abortions	14.6[c]	10.0	27.1	Not reported separately[c]	Not reported separately[c]	18.1	Jones & Jerman, 2017
Women in need of contraceptive services and supplies (change from 2010 to 2014)	Increased by 2%	Decreased by 1%	Increased by 4%	Not included	Not included	Increased by 8%	Frost et al., 2016
Reproductive coercion lifetime prevalence, including pregnancy coercion and/or contraceptive sabotage	25.9%[d]	18.0%	37.1%	Not reported separately[d]	Not reported separately[d]	24.0%	Holliday et al., 2017
Sexually Transmitted Infections							
HIV infection diagnoses[a]	7,312[e]	1,474	4,395	45	Asian: 120 NHOPI: 12	1,117	CDC, 2018
Chlamydia[a]	692.7[e]	281.7	1,411.1	1,146.3	Asian: 158.4 NHOPI: 1,033.5	541.3	CDC, 2019
Gonorrhea[a]	145.8[e]	62.7	433.3	397.1	Asian: 17.0 NHOPI: 163.2	87.4	CDC, 2019
Primary and secondary syphilis[a]	3.0[e]	1.8	8.4	9.8	Asian: 0.5 NHOPI: 3.5	3.1	CDC, 2019
Pelvic inflammatory disease lifetime prevalence	4.4% (95% CI, 3.1–5.7)[f]	4.4% (95% CI, 2.8–6.0)	6.8% (95% CI, 4.0–9.5)	Not included	Asian: 0.0	Not included[f]	Kreisel et al., 2017

Information from Bower, J. K., Schreiner, P. J., Sternfeld, B., & Lewis, C. E. (2009). Black–white differences in hysterectomy prevalence: the CARDIA study. *American Journal of Public Health, 99*(2), 300–307.
Centers for Disease Control and Prevention. (2018). *Diagnoses of HIV infection in the United States and dependent areas, 2017*.
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Abbreviations: aPR, adjusted standardized prevalence ratio; CDC, Centers for Disease Control and Prevention; CI, confidence interval; NHOPI, Native Hawaiians/Other Pacific Islanders.

[a] Rate per 100,000 women.
[b] Total includes women whose race is unknown.
[c] Total includes a fourth race category: non-Hispanic other.
[d] Total includes women who identified as multiracial and women in an "other" category, which includes Asian, Native Hawaiian, other Pacific Islander, American Indian, Alaskan Native, and other race or ethnicity.
[e] Total includes women who identified as multiple races.
[f] Total includes women who identified as Mexican American.

toward racism. This section highlights how individuals, healthcare teams, and communities are taking steps to improve race-associated disparities by confronting racism.

A number of health science scholars (Eichelberger et al., 2016; Hardeman et al., 2016; Jones, 2002, 2018; Metzl & Roberts, 2014; Nakaima et al., 2013) have considered what healthcare providers can do to address racism and mitigate race-associated disparities in health (see **Box 2-2**). Key themes that emerge are the importance of understanding the history and current manifestations of racism, the ability to identify and describe racism, and taking concrete action to address racism.

Reducing Implicit Bias

Maina et al.'s 2018 systematic review into research on implicit racial and ethnic bias in healthcare providers found only two studies that looked at interventions to reduce implicit bias in healthcare providers (Maina et al., 2018). One study found that participation in a multicultural training course reduced pro-white/anti-Black implicit bias (Castillo et al., 2007). The other study found no impact for providers who did a virtual cultural competency immersion training (Steed, 2009).

However, data from other fields offer evidence-based strategies for reducing implicit bias (Staats et al., 2017). Techniques for reducing the experience of in-group and out-group, or us versus them, mental constructs hold promise for reducing implicit bias. These include decategorization, recategorization, and intergroup contact. Decategorization is accomplished via individuation, which is seeking out information specific to an individual and can help to deactivate out-group implicit biases during interpersonal interactions. Recategorization is finding shared identity with a member of the out-group. Intergroup contact is personal interactions with people from the out-group. Personal contact

BOX 2-2 Interventions for Addressing Racism and Race-Associated Disparities

"Toward the Science and Practice of Anti-Racism: Launching a National Campaign Against Racism" (Jones, 2018) and "Confronting Institutionalized Racism" (Information from Jones, 2002):

- Name racism.
- Ask how racism is operating here.
- Organize and strategize to act.

"Structural Racism and Supporting Black Lives—The Role of Health Professionals" (Information from Hardeman et al., 2016):

- Learn about, understand, and accept the racist roots of the United States.
- Understand how racism has shaped our narrative about disparities.
- Define and name racism.
- Shift our clinical and research focus from race to racism. We can spur collective action rather than emphasize only individual responsibility.
- "Center at the margins"; specifically, diversify the workforce, develop community-driven programs and research, and help to ensure that oppressed and underresourced people and communities gain positions of power.

"Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge" (Information from Metzl & Roberts, 2014):

- Be skeptical of race-based differences in diagnosis.
- Create alliances between physicians and other professionals who serve the same vulnerable patients.
- Be creative in addressing extra-clinical structural problems.
- Learn from social science and humanities disciplines, such as sociology, anthropology, history, and CRT, to be more aware of the ways racism is embedded in institutions and operates apart from blatant acts of individual bias.
- Draw lessons from other professions that have taken active steps toward addressing structural racism.
- Be more politically vocal about structural issues that impact patients.

"Structural Racism and Health Inequities in the USA: Evidence and Interventions" (Information from Bailey et al., 2017):

- Institute place-based, multisector, equity-oriented initiatives.
- Advocate for policy reform.
- Train the next generation of health professionals.

"Black Lives Matter: Claiming a Space for Evidence-Based Outrage in Obstetrics and Gynecology" (Information from Eichelberger et al., 2016):

- Make racial disparities a key focus for quality improvement projects.
- Consider how study designs would change if they were centered on helping Black women.
- Modify interventions with the goal that they are successful only when they show racially equitable improvements.

has been shown to reduce both implicit and explicit bias, and there is promising new evidence that imagined intergroup contact can reduce implicit bias (Staats et al., 2017).

Other techniques that show efficacy in reducing implicit bias are negation and mindfulness (Staats et al., 2017). Negation is verbally rejecting biased thoughts or actions by stating "No!" or "That is wrong!" when confronted with stereotype. Mindfulness is a skill developed through the practice of meditation, which includes "attentional control (including paying attention to one's experience in the present moment), emotional regulation, self-awareness and a nonjudgmental and curious orientation toward one's experiences" (Burgess et al., 2017, p. 373). Evidence suggests that even brief, 10-minute mindfulness-based practices can reduce implicit bias.

Mindfulness may have particular utility for healthcare providers because mindfulness-based practices have been shown to reduce stress and decrease cognitive load (Burgess et al., 2017). Studies have shown that high levels of cognitive stressors increase implicit bias, and the impact of cognitive load on worsening implicit bias has been demonstrated to impact healthcare providers (Maina et al., 2018). Other techniques for reducing cognitive load include decreasing patient–provider ratios, improving insurance access for patients, integrating care so that referrals are more seamless, and other structural changes that would reduce the stress of providing modern health care.

Most importantly, research into techniques for reducing implicit bias shows that motivation is a key to successful reduction in implicit bias. By understanding the moral and ethical case for reduction in implicit bias and committing yourself to reducing your own implicit bias, you are setting yourself up for successful reduction in implicit bias (Staats et al., 2017).

Workforce Diversification

The most important intervention to address race-associated health disparities is to increase the racial diversity of those providing care (Boyd, 2019; Saha & Shipman, 2008; Serbin & Donnelly, 2016; Smedley et al., 2004; Sullivan Commission on Diversity in the Healthcare Workforce, 2004; US Department of Health and Human Services, 2011). By increasing the racial diversity of the professions that provide health care, the problem is tackled along multiple axes. As Boyd notes, "The lack of non-white professionals across the industry and persistence of racial health inequities for non-white patients reveal processes that empower, normalise, favour, and reward white people, as a population. The solution requires reordering the industry to dissolve the dominant racial hierarchy and its manifestations in decision-making structures, access points, and resource flows that result in the violence of racial exclusion and the devastation of inequitable disease" (2019, p. 2485).

Individuals with the Lived Experience of Racism Are Able to Provide Care That Recognizes and Addresses the Experience of Racism in Their Patients' Lives

Given the choice, people of color are more likely to choose healthcare providers who share their racial and ethnic identity (Jang et al., 2018; Smedley et al., 2004; Serbin & Donnelly, 2016). Clients with racially and linguistically concordant healthcare providers are more likely to receive better interpersonal care and be more satisfied with their care (Cooper et al., 2003; Saha & Shipman, 2008; Shen et al., 2018; Smedley et al., 2004; Traylor et al., 2010; Wusu et al., 2019). It is important to note that the setting in which racial concordant care is provided is equally important: "health care professionals cannot succeed in bridging the clinic and coethnic patients' lifeworlds without larger institutional transformations in place—for example, greater access to resources, more flexible institutional regulations, and an organizational culture committed to diversifying biomedical norms" (Lo & Nguyen, 2018, p. 165).

Increasing the Number of Healthcare Providers of Color Will Improve Access for Medically Underserved Populations

Providers of color are more likely to provide care for medically underserved populations, including people who have low incomes, those who live in rural areas, and people of color (Association of American Medical Colleges, 2006; Saha & Shipman, 2008; Smedley et al., 2004; US Department of Health and Human Services, 2011). Physicians who are people of color from the highest socioeconomic backgrounds are more likely to provide care to medically underserved populations than their white counterparts from the lowest socioeconomic backgrounds (Saha & Shipman, 2008). Saha (2014) argues that this may be because race "confers more durable disadvantage [than socioeconomic status]. Underrepresented minority students and physicians, regardless of socioeconomic status, do not escape the experience of discrimination, negative stereotyping, and exclusion. They must continuously deal with the unfairness of a racial hierarchy that, although officially abolished, remains deeply embedded in our social fabric and unconscious attitudes" (p. 292).

Healthcare Providers of Color Are Directly Impacted by the Forces That Develop and Perpetuate Racism, Thus Diversification of the Healthcare Professions Is an Intervention to Address Racism in Its Own Right

Providers of color are also healthcare recipients of color and members of communities of color. Addressing the social and structural barriers that people of color face in accessing higher education, secure and well-paying jobs, positions of leadership, and roles that promote personal and community power are powerful antiracism interventions (Cuellar & Cheshire, 2018; Saha, 2014; Serbin & Donnelly, 2016).

Increasing the Racial and Ethnic Diversity of Educational Institutions and the Workforce Has the Potential to Improve the Care of All Healthcare Providers

Research in both educational and clinical care environments suggest that greater racial diversity improves learning opportunities and care provision by white students and providers (American Association of Colleges of Nursing, 2015; Saha et al., 2008; Smedley et al., 2004). Saha et al. (2008) found that white students in medical schools that have higher rates of people of color were more likely to feel prepared to provide care to people from racial and ethnic backgrounds different than their own, and they had stronger attitudes about equity and access to care. Importantly, there appeared to be a threshold effect; these associations were more apparent when the student body was composed of 10 percent or more of students from groups that are underrepresented in medicine (Black, Latino, and Native American) and/or 36 percent or more for all nonwhite students. Further, the associations were seen only when "students perceived a more positive climate for interracial interaction and exchange of diverse perspectives" (Saha et al., 2008, p. 1141).

These data suggest that for racial diversification to impact the care provided by white healthcare providers, there must be significant numbers of providers of color, and all providers must have the training and skills to support and create an open and inclusive climate.

The rationale for workforce diversification is clear and compelling. Interestingly, however, the authors of this chapter were unable to find published work on successful models for diversification of the healthcare workforce. There is quite a bit published about increasing the pipeline and improving the numbers of people of color in health worker educational pathways. Little is written, however, about effective methods for recruitment, retention, and empowerment of people of color within the healthcare workforce. There is much work to be done to change the culture of the healthcare delivery systems so that all providers are fully respected and able to bring the full force of their talents to bear on addressing race-associated disparities.

Community Expertise

In addition to the significant structural changes needed to diversify the healthcare workforce, addressing the root causes of health disparities requires empowerment of the communities most impacted. Members of these communities are best qualified to identify the solutions to their health needs. Healthcare providers can partner with, learn from, and uplift community experts. Two examples of successful initiatives that harness community expertise are described in this section.

The California Healthy Nail Salon Collaborative

The California Healthy Nail Salon Collaborative (https://cahealthynailsalons.org/) was formed in 2005 in response to concerns raised by community health workers (Fu, 2019; L. Fu, personal communication, April 19, 2019). Asian Health Services community health workers were providing diabetes education in their communities when they noted concerns about asthma, chronic rashes, and miscarriages presented by nail salon workers. California nail salon workers are primarily low-income Vietnamese immigrant and refugee women of reproductive age. They typically experience chronic long-term exposure to a host of chemicals. Many of these chemicals are known cancer-causing agents and endocrine disruptors, while others have limited data and research on their health impacts. Beyond the chemical exposures, nail salon workers also experience labor violations, such as being paid less than minimum wage, lack of overtime pay, misclassification, and other violations.

Members of the collaborative include nail salon workers and owners, reproductive and environmental justice organizations, and labor advocacy organizations. The collaborative takes a multidisciplinary approach to addressing the health, safety, and rights of the nail salon workforce through outreach and leadership development, policy advocacy, research, and movement building. Outreach workers visit nail salons to develop trust and relationships with workers, even booking appointments to secure one-on-one time with those that work in busy salons. They conduct outreach and provide labor and health trainings in Vietnamese, the preferred language of the salon workers. The collaborative also works with California counties and cities to support nail salon owners to adopt specific guidelines to become recognized as a Healthy Nail Salon. These guidelines include using fewer toxic products, increasing ventilation, and training their staff.

Dream Youth Clinic

Established in 2017, Dream Youth Clinic (https://rootsclinic.org/dream-youth-clinic-2/) serves youth aged 12–24 in Oakland, California. Although their doors are open to all young people, the Dream Youth Clinic primarily serves youth experiencing homelessness; immigrant youth, including those who have come from detention centers; youth impacted by the juvenile justice and foster care systems; and young people involved in or affected by sex trafficking. The Dream Youth Clinic is colocated in two homeless youth shelters: DreamCatcher Youth Services, the only shelter in Alameda County that serves youth aged 13–18, and Covenant House, which serves youth aged 18–24. Within the wellness centers of the shelters, the clinics provide integrated holistic healthcare services utilizing the collaborative effort and expertise of both the medical and shelter staffs. Under the integrated Dream Youth Clinic model, youth can drop in for primary medical care, reproductive health care, or mental health care; to see the shelter case managers or staff members for support; to access showers, meals, or the internet; or simply to have a safe place to hang out (A. Mays, personal communication, August 2, 2019).

The motto of the Dream Youth Clinic is Health Is Everything, and they approach every aspect of their work with this principle at the forefront. The clinics provide daily drop-in services, and youth are informally engaged to provide feedback and suggestions to improve and optimize medical care delivery. The clinics also host formal youth focus groups approximately twice per month to ensure that the services they offer are truly responsive to the current needs of the youth they serve. Additionally, Dream Youth Clinic provides on-site workforce opportunities for youth by inviting interested youth to join the clinical team as peer-outreach workers, where they can invite their peers into the clinic and share their knowledge about the organization's healthcare and health navigation services (A. Mays, personal communication, August 2, 2019).

According to the Dream Youth Clinic founding medical director, Dr. Aisha Mays, the clinic "recognize[s] the brilliance of the youth [they serve] but doesn't rest on the laurels of their young people's resilience" (personal communication, August 2, 2019). To provide consistent support for the youth they serve, the clinic goes beyond traditional one-on-one healthcare visits and also offers group care. For example, the young moms group is open to pregnant and parenting youth as well as youth who are considering pregnancy. The group creates a space for the young people to get support from caring clinical staff, to support one another, and to access resources, education, and empathy around the joys and challenges of pregnancy and parenthood. The group provides wraparound support for the participants, cofacilitation by a health navigator, a group facilitator, and additional clinic support staff that ensures the youth at every gathering have access to the emotional support, social services, and supportive health care they need. It is revolutionary that the clinic recognizes and supports young people who are not yet pregnant but are considering parenthood by inviting them to join this group. By providing early support, Dream Youth Clinic can engage in vital preconception care and planning. If a youth becomes pregnant, the organization provides early and regular prenatal care, ensuring that youth who are seeking pregnancy are doing so with optimal support, from a place of good health, and in true partnership with their care provider (A. Mays, personal communication, August 2, 2019).

Law and Policy

Law and policy have significant impacts on the structures that impact the lives of patients who healthcare providers serve and on how, by whom, and in what settings health care is provided. Healthcare providers can support long-term improvements in health outcomes by participating in advocacy to change unjust laws and policies and to develop and implement equity-based laws and policies (Brown et al., 2019).

The California Coalition for Reproductive Freedom

The California Coalition for Reproductive Freedom (CCRF) was founded in the 1990s (https://reproductivefreedomca.org/). It is a coalition of more than 45 reproductive health, rights, and justice organizations in California (J. R. Cavero, personal communication, April 30, 2019). The coalition works to protect and advance reproductive freedoms for California women, youth, low-income individuals, people of color, and rural communities.

Member organizations represent a wide range of constituencies and approaches, including nursing, medical, legal, grassroots, faith-based, consumer advocacy, and community-based organizations from all parts of California. The coalition includes national organizations (American Civil Liberties Union, NARAL Pro-Choice America, Planned Parenthood, and the National Health Law Program), state leaders (California Women's Law Center and Essential Access Health), reproductive justice experts (ACT for Women and Girls, California Latinas for Reproductive Justice, and Black Women for Wellness), healthcare provider professional organizations (American Nurses Association, California Nurse-Midwives Association, and California Academy of Family Physicians), and organizations working at the intersection of reproductive justice and other justice issues, such as civil rights, environmental health and exposure, health care access, law, and criminal justice (J. R. Cavero, personal communication, April 30, 2019).

The coalition is instrumental in ensuring significant policy and budget efforts to improve reproductive freedom in California. For example, relationships built through CCRF led to six sponsoring organizations and more than 30 supporting organizations working together to pass a bill that made it legal for advanced-practice clinicians (certified nurse-midwives and nurse practitioners) to provide aspiration abortion in California. In fact, CCRF has played a role in all the reproductive health, rights, and justice policy accomplishments during the past 30 years in California. These accomplishments include the Reproductive Privacy Act in 2002, which codified *Roe v. Wade* in California law, the requirement that sex education be comprehensive and medically accurate, the expansion of contraception access, three successful campaigns to defeat parental notification for minors' abortions in California, and many others—victories that have made California a national leader and model for other states (J. R. Cavero, personal communication, April 30, 2019).

These successes are made possible through the support of the CCRF coalition, which helps to coordinate policy and advocacy efforts, provides technical support to organizations with modest resources, and supports member organizations to deepen relationships with advocates and policy makers across the state. Relationships developed through CCRF enable strategic coordination that is essential for member organizations to respond quickly to changes in the policy arena and to dismantle unhealthy power dynamics stemming from systemic oppression (racism, sexism, classism, homophobia, xenophobia, transphobia, etc.). Central to CCRF's success is the coalition's commitment to facilitating the inclusion and leadership of individuals and organizations that represent communities of color and geographic areas of the state that are too often left out of critical policy-level, decision-making discussions (J. R. Cavero, personal communication, April 30, 2019).

CONCLUSION

Racism in the United States privileges people identified as white at the expense of those identified as people of color, especially Black and Indigenous people of color. Racism, not race, is the cause of the pervasive and persistent race-associated disparities across gynecologic health and health in general. Racism also underpins the lack of racial diversity found in healthcare providers. Racism is socioculturally pervasive and persistent; it is woven throughout the social, political, and economic fabric of the United States.

Race-associated health disparities are the physical manifestation of racism, which is responsible for the unconscionable preventable death and morbidity of millions of people. Healthcare providers in specific, and people who live in the United States in general, bear the moral imperative to address racism by shifting power balances toward equity. Dismantling racist systems and structures requires collective effort. Each individual must determine where and how they will best contribute to the collective effort. This effort is a lifelong commitment, and the role an individual plays will necessarily change based on context and personal growth. The reader is invited to consider this question: What steps can I personally commit to take toward dismantling racism?

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