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The impact of systemic racism on health outcomes among Black women: Recommendations for change

Abstract: Black women suffer disproportionately from healthcare inequities in comparison to their White counterparts. Using the Public Health Critical Race framework, this article explores the lasting effects of systemic racism on the health outcomes of Black women across the lifespan. A case study and specific strategies are presented to examine how clinicians, educators, and policymakers can work with Black women to mitigate and eliminate health inequities.

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The COVID-19 pandemic heightened the world's awareness of disparities, particularly in healthcare.[1] The combination of inadequate healthcare systems and deep-rooted structural racism has been the center of recent discussion. Immediate action is necessary to address the causes of disparate health outcomes. The evidence is clear that Black people are most affected and are the first-line casualties in all areas of mortality and morbidity from birth to death.[1]

Keywords: Black women, health disparity, healthcare inequity, racism, systemic racism, research, education, policy, practitioners, public health critical race

PHCR principles[2] (adapted)

Race consciousness: Understanding of racial dynamics in the social world and personal relationship to these. Must address systemic and institutional racism. **Example:** Do clinicians' perceptions of Black women on Medicaid influence how they refer them for appropriate follow-up after abnormal mammogram results and ensure they can access services?[4]

Primacy of racialization: The role of racial stratification on social inequities. **Example:** Lack of access to healthy foods in predominantly Black neighborhoods with food deserts can lead to increased chronic health conditions.[5]

Race as a social construct: Reflects social, political, and historical forces; requires careful examination to explore impact on health. **Example:** How does historical assignment of Blackness as an inferior race affect current medical standards of care for Black women (for example, adjusted glomerular filtration rate for Black Americans)?[6]

Ordinariness of racism: Permeates all of society to the extent that it is easily missed, especially by the majority group. **Example:** Using race to determine medical treatment by stating that Black people have a higher tolerance for pain and that they therefore require less pain medication.[7,8]

Structural determinism: Macro-level forces influence and preserve existing hierarchies and resulting inequities. **Example:** Faculty in nursing education is predominately White, reflecting white supremacy.[9]

Social construction of knowledge: The development of knowledge is socially constructed by those who ask the questions and conduct research. Questions important to one group may be ignored by others. **Example:** The underrepresentation of marginalized groups in research leads to the lack of generalizability in clinical practice and bias in decision making.[10]

Critical approaches: Questions dominant approaches and power differentials; exposes assumptions. **Example:** Having open and often uncomfortable conversations about racism and inequities in educational settings to dismantle structural racism.[11,12]

Intersectionality: Nothing occurs in a vacuum; crossroads of where "-isms" (such as racism and sexism) meet. **Example:** The inequities women of color face in academia ("woman" + "non-White") can affect salary, tenure decisions, and so on.[10]

Disciplinary self-critique: Careful internal examination by members of a discipline to assess how personal assumptions and usual behaviors contribute to and sustain inequities. **Example:** Implicit bias training for nurses can decrease inequities in patient care through self-awareness.[13,14]

Voice: Privileges marginalized people's contributions to understanding the issues. **Example:** Intentional recruitment and inclusion of marginalized people in research studies.[15]

The purpose of this article is to explore reasons for disparate health outcomes between Black women and women of other races as well as to suggest opportunities for change in clinical practice, education, research, and policy. The Public Health Critical Race (PHCR) praxis guides this article in terms of the historical context and lasting effects of racism, recommendations for change, and discussion.[2]

We acknowledge that not all humans assigned as female at birth identify as girls or women and that gender is a social construct. We also acknowledge that many individuals in our care reflect a variety of identities. For clarity's sake, in this article, the words "woman" and "women" will be used to refer to individuals who were assigned female as their biological sex at birth.

Public Health Critical Race praxis

Race and racism adversely impact Black people in many ways. The concept of race was once believed to occur naturally and to provide a framework for understanding and justifying human differences.[3] Race has evolved to be more effectively understood as socially constructed; however, the residual impacts of race classifications manifest in oppression systems rooted in racism.[3] Racism, defined as marginalization and/or oppression of people of color, privileges White people as the top of the racial hierarchy.[3] Racism is multilayered. Structural racism is pervasive, aggressive, and effective at oppressing Black people, and it constitutes an aggregation of systems, institutions, and other factors that disadvantage and cause widespread harm to Black people.[3]

The PHCR provides a thoughtful approach to examining issues related to societal racism.[2] Although proposed as a framework for research, we have adopted it for consideration in all aspects of health-related activities. The focus of this framework goes beyond simply documenting health disparities and moves toward eliminating them. Characteristics include 1) racialization, or imposed societal positioning by ascribed racial and ethnic categories; 2) race consciousness, or understanding the impact of racial factors on inequities;

3) social location, or one's position in society based on a number of factors, including race, and the impact of privilege versus marginalization on health outcomes; and 4) the goal of eliminating inequities.[2] The 10 key principles of this framework can help in understanding the impact of racism on healthcare delivery, pedagogical methodologies, research approaches, and policy development (see *PHCR principles*).

The PHCR principles may explicate how structural racism disproportionately impairs quality of life for Black people. For example, PHCR uses social determinants of health (SDOH) to understand the circumstances that impact risks and outcomes of both health and quality of life. According to the US Department of Health and Human Services, the five SDOH domains are 1) economic stability; 2) education access and quality; 3) healthcare access and quality; 4) neighborhood and built environment; and 5) social and community context.[16] There is considerable correlation between SDOH domains and the structural racism that causes disparities.[16] One way to describe this correlation is by considering the PHCR framework principle of ordinariness of racism, which normalizes racism.[2] Distribution of wealth along racial lines disproportionately impacts the economic stability of marginalized groups. Economic stability is a determinant of health outcomes through its direct correlation with ordinariness.

The complexity of structural racism may also be explained through the concept of intersectionality, a term coined by Critical Race Theory scholar Kimberlé Crenshaw. Historically, attorneys chose either race or gender to prove discrimination through the lens of single identity. However, cases included situations where neither Black men nor White women experienced the same discrimination as Black women.[17] Crenshaw argued that the intersection of the two oppressed identities ("Black" plus "woman") created a uniquely oppressive experience. She asserted that the experience of a person with multiple oppressed identities is uniquely challenging and that Black women at the intersection of racial and gender oppression have a unique lived experience and exposure to health inequity.[17]

The evolution of health inequities among Black women

When examining the effects of systemic racism on the health of Black women, a journey through the literal manifestations at every stage of life illustrates the pervasiveness of this problem. In nearly every report that measures health outcomes through data filtered by race and gender, Black women suffer disproportionately in comparison to their counterparts.

In utero, Black babies may endure disadvantages in response to repeated encounters with racism and discrimination.[18] It is posited that this is a result of maternal stress responses. Black women have the highest rate of preterm birth in the US.[19] While the root cause for this phenomenon is still not completely understood, racism and discrimination are hypothesized to play a role.[19]

Precipitates of the social determinants of health for Black women. The results of a recent prospective study showed strong associations between SDOH and both fetal intrauterine growth and infant birth size.[5] The Child Opportunity Index 2.0 was used to generate evidence that favorable environmental conditions resulted in better maternal mental health and diet, reduced risk of intrauterine fetal growth restriction, and longer and heavier infants.[5] Black babies have 2.3 times higher mortality than non-Hispanic White babies, and Black children have a higher prevalence for all chronic physical health conditions than other racial groups (25.3% among Black children compared with 19.8% and 18.6% for White and Hispanic children, respectively).[20,21] A recent systematic review determined that as Black babies grow into childhood, they are often unintended victims of racism.[22] Black youth in the US experience high levels of negative racial stereotypes from the adults who either work or volunteer with them.[23] Stressors from a racist justice system negatively impact the mental health of Black female youth.[24] For example, paternal incarceration is found to be associated with poorer school outcomes, increased aggression, and overall problematic behaviors in children.[25] In a systematic review, Paradies et al. reported that racism significantly correlates with depression, psychological stress, anxiety, posttraumatic stress disorder (PTSD), somatization, internalizing, and suicidality.[7] The suicide attempt rate among Black adolescent females in grades 9–12 was 60% higher than that of White adolescent females.[20]

Black women face the highest rates of maternal mortality and morbidity in the US.[26] Data from the National Vital Statistics System highlighted continued racial disparities: the maternal mortality for Black non-Hispanic women was 37.1 deaths per 100,000

pregnancies in 2018, compared with 14.7 for White non-Hispanic women.[27] In a 2019 analysis of the CDC Pregnancy Mortality Surveillance System report for 2007–2016, researchers concluded that maternal mortality of Black women is not improved by economic or educational advancement.[26,27] In fact, college-educated Black women had higher mortality than White women with less than a high school diploma.[26,27] Additionally, Black women are perceived to have a higher threshold for pain and are often ignored when reporting symptoms.[28] The account of tennis icon Serena Williams is one example.[28] Her strength, wealth, and fame did not protect her from a near-miss medical incident. Her reports of increased dyspnea after giving birth were initially ignored until she insisted that her provider perform additional testing. Tests revealed pulmonary emboli in need of immediate intervention. This is an example of how structural racism prevented her voice from initially being heard and impeded early identification of a life-threatening condition.[28]

The detrimental impact of racism on health outcomes for Black women is further validated by the incidence of many other chronic conditions. Black women have the highest obesity rates of all racial groups and, compared with White women, are 15 times more likely to have AIDS, nearly 60% more likely to have high BP, and twice as likely to have a stroke.[20] Although they are as equally diagnosed with breast cancer as White women, Black women are about 40% more likely to die from the disease.[7,20]

The struggle for health justice for Black women: Exacerbating circumstances. Although it is outside of the scope of this article to explore fully the effect of systemic racism on transgender and gender-diverse individuals, it is important to recognize that these individuals experience stigma that creates barriers to healthcare access and adverse mental health outcomes. Although studies investigating the healthcare experiences of Black nonbinary people assigned as female at birth in the US are limited, some evidence suggests that negative health outcomes and experience of multiple forms of discrimination may disproportionately affect this population.

In a study aimed at understanding facilitators of and barriers to cervical cancer screening for Black lesbian, bisexual, and queer women, Agénor and colleagues identified racism, classism, and heterosexism as barriers for this group.[29] Participants disclosed experiences of discrimination that were related to race/ethnicity, socioeconomic positions, and sexual orientation.[29]

Results of a mixed methods study on the characteristics, prevalence, and correlates of barriers to healthcare access showed that Black transgender women experienced significantly higher polyvictimization, PTSD, and depression symptoms when barriers to healthcare access existed.[30] Results also indicated that even in gender-affirming settings, participants experienced discrimination and mistreatment by healthcare providers.[30]

Velez and colleagues' cross-sectional study found an association between sexist and racist workplace discrimination and psychological distress in Black women.[31] Heightened vigilance and the threat of potential exposure to racism also have a negative impact on mental health.[9,31] These experiences and behaviors have been found to have a positive correlation with depressive symptoms.[32] Internalized experiences of racism can also be detrimental to mental health. In a 2017 secondary analysis conducted by Mouzon and McLean, internalized racism positively correlated with serious psychological distress and depressive symptoms among Black people.[33] Additionally, there is a possible dose-response relationship between experiences of racism and the extent to which a person experiences mental health issues over time.

Geronimus' concept of weathering posits that Black women's physical health deteriorates over time, beginning as early as young adulthood, because of the stressors of a constantly oppressive society.[18] Alteration of genes over generations causes predisposition to cardiomyopathies, diabetes, and hypertension.[34] Socioeconomic disadvantage, food deserts, dietary factors/choices, weight control, and lifestyle, among other factors, likely also play a role.[18] These conditions result from generations of oppression that often manifest in individuals with age due to decompensation from continued insults.

PHCR in action

Eliminating health disparities requires a multipronged approach, including intentional strategic action steps aimed at combating racism across research, education, and practice. The four foci of the PHCR praxis are outlined below.[2]

- Focus 1: Contemporary patterns of racial relations. Regardless of the issue, it is critical to understand the nature of these relationships. Who is marginalized; how?

- Focus 2: Knowledge production. How does racialization influence the goals of a project? What is being examined; who holds knowledge about that, and are their voices heard?
- Focus 3: Conceptualization and measurement. What context frames the scenario? Who conceptualizes what is important and decides how it will be measured?
- Focus 4: Action. What processes will be used to address the PHCR principles? How will effectiveness be measured?

A theoretical case study is provided to examine how the PHCR foci can be applied to practice, education, research, and policy (see *Application of PHCR foci to practice, research, education, and policy*). Though noncomprehensive, it may help to improve health inequities through its application to specific settings and issues. This scenario provides an opportunity to work within teams to discern possible causes of disparities through the lenses of practice, education, research, and policy.

Practical recommendations for the future

Application of the PHCR framework to practice. *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*, a consensus study from the National Academy of Medicine, places nurses at the forefront of the movement toward health equity.[38] One of the report's recommendations underscores the need for action to advance health equity, which is highly relevant for Black women. Every nursing organization should initiate work to develop a shared agenda for addressing SDOH and achieving health equity. This agenda should include explicit priorities for nursing practice, education, leadership, and health policy. Using the PHCR principles to address the recommendations presented in *The Future of Nursing 2020-2030*, changes to health inequities could begin.

Diversification of the workforce. Intentional diversification of the healthcare workforce to reflect society accurately is essential for reducing health disparities and fostering health equity.[38] Interventions to address the discrepancy between diversity in the nursing workforce and diversity in the US go far beyond nursing education. A comprehensive longitudinal approach from academia to organizational and practice levels is essential. Aurilio and colleagues described an internship program entailing thoughtful mentorship and community involvement opportunities as a successful intervention for diversifying the nursing workforce.[10] Examples of actions that could be taken at the institutional level for diversifying the nursing workforce include advertising employment to target groups; diversifying interviewing teams; providing internship opportunities to support new nurses' transition to practice; focusing on retention and engagement; facilitating leadership development opportunities; and cultivating a culture of inclusivity and belonging.[10,38,39]

Bias mitigation. Healthcare professionals are encouraged to perform a self-inventory of personal biases prior to caring for traditionally marginalized people. This process offers an opportunity to interrupt bias-influenced decision making and approach person care from a humanitarian perspective. Additionally, healthcare practitioners should adopt a trauma-informed approach, recognizing the impact of traumatic experiences on a person's life and well-being.[39] This approach provides a strategy for practitioners to reframe their focus from "what is wrong with this person?" to "what happened to this person?"[39] This approach emphasizes the impact of trauma on a person's behavior, coping skills, and ability to trust or interact with healthcare providers. Heightened awareness of the effects of trauma can improve communication and reduce the potential for triggering a trauma response in patients.[40]

Additional measures. Additional strategies providers can adopt to improve care include:

- asking culturally and medically appropriate questions that are relevant to individualizing care;
- practicing cultural humility, a shift from solely demonstrating cultural competence, which implies reaching a specific level of mastery of various cultural practices (rather, cultural humility demands a change in power dynamics by shifting the role of "expert" to the patient and requires the provider to commit to a process of lifelong learning and continuous self-reflection to improve patient relationships and communication);
- developing collaborative partnerships with Black patients and their support systems; and
- building a trusting relationship through intentional involvement of patients in developing plans of care (that is, asking what is important to prioritize).[41]

Application of the PHCR framework to research. Historically, Black women have been underrepresented in scientific research, which has led to a lack of generalizability of findings.[13] Several factors have contributed to the lack of inclusion of marginalized groups

Application of PHCR foci to practice, research, education, and policy

Case study

A WHNP and CNM work together on a healthcare team in a rural Level I hospital clinic associated with an academic center an hour away. They regularly have nursing students (basic and advanced), medical students, and OBGYN residents in their setting. Both are adjunct faculty at the academic center and have leadership roles in the hospital. Most clients receiving services at this clinic are factory workers from the local area. The COVID-19 pandemic has led to many changes in the area. The clinic has also been affected. Recently, four office assistants, three nurses, and three providers left the clinic. While reviewing the yearly statistics for the office, the WHNP and CNM note that the percentage of patients registering for prenatal care in the first trimester has fallen over the past year from 70% to 50%. The number of prenatal visits has dropped from an average of 8 to 6. They reviewed the demographic characteristics and find that the greatest changes are among Black women and those who live in a specific township in their geographic location. They are aware that the preterm birth rate in this setting is 15%.

PHCR foci	Application
• Contemporary patterns of racial relations (ensure that structural racism is addressed, both at the institutional and personal level) • Knowledge production (whose voices will be heard and how will they be solicited?) • Conceptualization and measurement (what questions will be asked and how will measures be applied?) • Action (how will decisions be made on what actions to take and who holds the power in the setting?)	PRACTICE: Prenatal care is associated with improved outcomes.[5,20] The ACOG recommends a prenatal visit for uncomplicated pregnancies every 4 weeks until 28 weeks, every 2 weeks until 36 weeks, and then weekly until delivery.[35] It is important to assess SDOH that may be contributing to the decreased rates of prenatal care visits; possible SDOH include transportation issues and housing insecurity.[36] The facility should also assess how the COVID-19 pandemic has impacted prenatal visits, as most health facilities reported a decrease in in-person prenatal visits with an increase in virtual visits.[1,5] Here are a few questions for the providers to consider: • What can be explored to understand the reason for the change in attendance that goes beyond demographic characteristics? • Is there something about the factory that is influencing the decrease in attendance? Could there be a mobile prenatal care clinic at the factory? • Why have so many staff members left recently? • Has there been an associated change in outcomes?
	RESEARCH: This scenario provides an excellent opportunity to gather data to understand the problem. • This could be a quality improvement project, which is often more action-oriented and quicker to accomplish than a study but could also be done in partnership with researchers at the academic center. The healthcare team members in the setting (nurses, NPs, physicians, midwives, students, administrators) and the voices of those who receive care should be involved in conceptualizing the problem and applying the PHCR principles to developing the questions for consideration. • Future research studies should include mixed methods approaches to triangulate data. This will help to include the voices of those being studied to place the quantitative data in the context of their lived experience.[13,14]
	EDUCATION: Having students in the setting can be an advantage. Involving them in exploration of the problem, data collection, and analysis is important. • Nursing faculty must find ways to incorporate educational materials related to structural racism, systemic inequity, and discrimination as a common thread throughout all levels of nursing education.[15] • Documenting the process and disseminating the material will assist other healthcare facilities with similar experiences or concerns and will enable faculty to share this information with students in the future.
	POLICY: Future questions and resources to consider for policy development include: • How will the findings of this exploration be turned into action and future policies? Who is involved in making those policy decisions? • How will those policies be evaluated in the future for effectiveness? • The World Health Organization Health Equity Assessment Toolkit may be used to build health equity into policy planning and to evaluate efficacy and change.[37]

Abbreviations: ACOG, American College of Obstetricians and Gynecologists; CNM, certified nurse-midwife; OBGYN, obstetrics and gynecology; SDOH, social determinants of health; WHNP, women's health NP.

in research: they include, for example, marginalized communities' reluctance and distrust of healthcare professionals based on past unethical practices and fear of exploitation. Cultural differences and researchers' overall limited study of issues affecting marginalized communities also contribute.[14]

The PHCR framework can be used as a guide for all future research, especially those studies that involve Black women. It is imperative that, for scientific studies related to human health, researchers develop critical consciousness of the impact of racialization, race and racism, and socialization on health inequities. The National Institutes of Health (NIH) has implemented programs and initiatives to increase inclusivity and negate structural racism.[14] The NIH-wide Diversity Program Consortium consists of three integrated initiatives to build infrastructure, foster mentoring, and encourage coordination and evaluation. In addition, the NIH's Health Disparities Research Loan Repayment Program aims to increase the number of highly qualified researchers who conduct health disparities research.

Although many studies have shown correlations between experiences of racism and health disparities, some scientific limitations exist. Study designs that are primarily cross-sectional limit generalizability of the findings and do not provide interpretation for causality.[42] Furthermore, self-report measures may potentiate response bias.[42] Research must include longitudinal studies to capture the long-term effects of racism on Black women as well as mixed methods to give voice to their experiences.

Application of the PHCR framework to education.

Equitable access to healthcare education programs. The advantages of having a culturally congruent healthcare workforce is well documented in the literature.[43] With the US facing another healthcare provider shortage, how can increasing the healthcare workforce be addressed while targeting increased numbers of Black nurses?[44] Increasing educational pathways to healthcare professions while decreasing barriers to success is paramount.[44] Drennan and Ross recommend building strategic partnerships between educational and clinical organizations to develop nurse education infrastructures in clinical settings.[45] Additionally, offering direct pipelines from high school and college to healthcare professions as well as intentionally recruiting systematically marginalized members of society is vital to increasing diversity in the workforce.[45]

Increasing access to various healthcare settings for students will leverage their expertise in public health nursing to better care for communities and eliminate inequitable policies and systems.[11] It is critical that students learn to address SDOH within their communities. Using the PHCR framework, students should identify essential content necessary for effective community-based practice.[11]

Targeted initiatives for marginalized groups. Resources and funding should be allocated to ensure sustainable support for underrepresented faculty and student groups. One example is the partnership established between New York University's Rory Meyers College of Nursing and Howard University's College of Nursing and Allied Health Sciences to further nursing research and education. This collaboration between a historically predominantly White university and a historically Black university is a promising initiative to increase opportunities for students from traditionally marginalized communities.[12]

Initiatives to increase diversity, equity, and inclusion in education begin with the admissions process. Holistic and unbiased admissions reviews that explore nontraditional methods of evaluating students' readiness, capabilities, and contributions are integral to increasing diverse student representation. Some schools no longer require standardized assessment exams as predictors for student success, which could propel diversification.[46] Achieving cultural congruence is also predicated on diversifying admissions committees. Ultimately, employing measures such as these will lead to a more culturally congruent healthcare workforce.[43]

The percentages of faculty of color in higher education remain low in comparison to White faculty, with nominal increases since the Black Lives Matter movement.[47] According to the National Center for Education Statistics, in fall 2020, nearly three-quarters of faculty were White. Specifically, 39% were White males and 35% were White females. The next largest racial/ethnic faculty group was Asian/Pacific Islander, where 7% were Asian/Pacific Islander males and 5% were Asian/Pacific Islander females. Faculty of color were shown to be disproportionally underrepresented; 4% of full-time faculty members were Black females, and 3% each were Black males, Hispanic males, and Hispanic females. American Indian/Alaska Native individuals and individuals of two or more races each made up 1% or less of full-time faculty members.[47] These statistics highlight the intersectionality of Black

female faculty and underscore the importance of allocating funds and resources to support them.

Organizational structure and curricular redesign. Nursing faculty must integrate structural racism, systemic inequity, and discrimination as topics for study into nursing program curricula.[38] This requires intentional recruitment of diverse faculty to develop and operationalize curricula. Critical Race Theory, which underpins the PHCR praxis, uses critical consciousness to examine the roots of structural racism, helping researchers remain cognizant of equity through knowledge production.[2] Bennett et al. posit that storytelling is a fundamental catalyst for conversation exploring the "unseen and unknown."[48] Students and educators must engage in self-reflection, examine personal biases, and be trained to respond to racial biases and microaggressions in the workplace.[48] Without learning and engaging in dialogue about race, healthcare practitioners are ill-prepared to address healthcare disparities and champion change.[49]

In 2021, the American Association of Colleges of Nursing (AACN) released the latest edition in its *Essentials* series, which reflects academic nursing's shift toward a competency-based curriculum.[15] The edition introduces 10 domains that the AACN and its member colleges deem essential for nursing education and practice at all levels, and within each critical domain, it identifies relevant critical competencies.[15] The AACN *Essentials* also offers an overview of the curriculum content required to achieve these competencies. Many domains and their associated competencies reflect the needs for diversification of the field and for implementation of active measures to reduce disparities in health outcomes for marginalized groups. Nurses should be educated to:

- engage in effective partnerships;
- advance equitable population health policy;
- demonstrate advocacy strategies;
- use information and communications technologies as well as informatics processes to deliver safe nursing care to diverse populations in a variety of settings; and
- use knowledge of nursing and other professions to address the healthcare needs of patients and populations.[15]

Application of the PHCR framework to policy. For decades, healthcare policies and practices deeply entrenched in structural racism have negatively impacted the social and economic stability of Black Americans.[50] Specifically, policies that impact education, healthcare, family support, employment, and housing have created disadvantages.[51] Public health policies that ensure equitable access to high-quality healthcare to promote the best possible health outcomes for all are critical. Implementing initiatives to eliminate health disparities will require a shift from simply highlighting disparities to a research agenda centered on achieving racial equity. Dismantling structural racism requires policies that eradicate structures and practices that perpetuate health disparities and inequalities.

Comprehensive, evidence-based policy initiatives are fundamental to understanding and addressing health disparities.[52] Maternal mortality is one health disparity that continues to garner public recognition. Black women and birthing people are disproportionately impacted and more likely to die during childbirth.[53] The Biden-Harris administration has championed policies to improve maternal health and equity. In December 2021, the White House held its first ever Maternal Health Day of Action to announce new resources, funds, and strategies to combat the alarming maternal mortality in the US.[54] These initiatives also focus on expanding postpartum coverage and addressing social factors that contribute to poor maternal health outcomes.[54] Policies that support early childhood development, high-quality daycare, youth employment, and other policies rooted in social contexts are also vital.

Healthcare workers worldwide must be involved in evaluating the influence of policy on disparities and inequities. It is important to amplify the voices of healthcare practitioners and members of traditionally marginalized groups and ensure they are actively involved in policy development and implementation. This may be facilitated by utilizing the World Health Organization Health Equity Assessment Toolkit.[37] This toolkit is often used to build health equity into policy planning prospectively. This is a helpful toolkit for informing policy development to eradicate health inequities and evaluate the efficacy of implemented policies.

Conclusion

Black people who are assigned female at birth begin their lives at a significantly more disadvantaged level than their White counterparts. This stems from generations of racism, discrimination, and oppression that have led to the physiologic restructuring of the Black

human mind and body, negatively impacting health and well-being across the lifespan. As providers gain a better understanding of the history of racism and its direct contribution to health outcomes, we recognize the need for expeditious change through a multipronged approach. Although the process of dismantling a structure thousands of years in the making seems daunting, it is imperative that we initiate and maintain a posture of perseverance. Advancing health equity requires healthcare professionals to concede to the veracity of racism. It is critical that racism is acknowledged as an SDOH and included as a component of research, healthcare education, and clinical practice for health inequities to be reversed and for optimal healthcare and health to become a reality for Black people across the lifespan.

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The authors and planners have disclosed no potential conflicts of interest, financial or otherwise.

Acknowledgment: The authors would like to thank Holly Powell Kennedy, PhD, CNM, FACNM, FAAN, Helen Varney Professor of Midwifery at the Yale University School of Nursing, for her contribution to this article.

DOI-10.1097/01.NPR.0000000000000001

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