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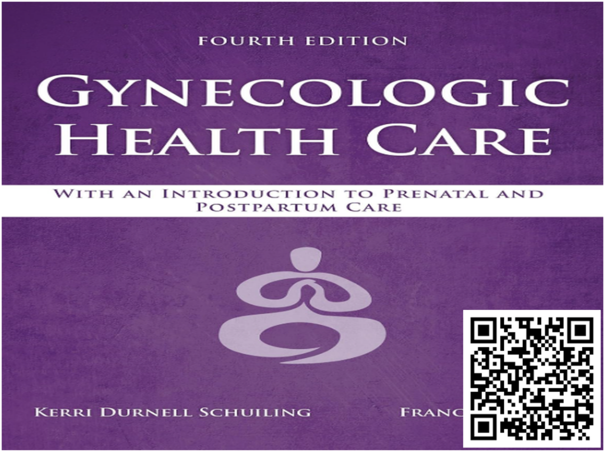

FOURTH EDITION

GYNECOLOGIC HEALTH CARE

WITH AN INTRODUCTION TO PRENATAL AND POSTPARTUM CARE

KERRI DURNELL SCHUILING

FRANC

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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;

Donovan, for his unconditional love and friendship;

Travis, for keeping me healthy;

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;

Ali, you could not be a better friend, and I am so grateful for you, Roberto, Santiago, Bobby, and Luci;

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

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SECTION

1

Introduction to Gynecologic Health Care

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CHAPTER 4
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CHAPTER 1

A Feminist Perspective of Women's Health

Lisa Kane Low

Joanne Motiño Bailey

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.

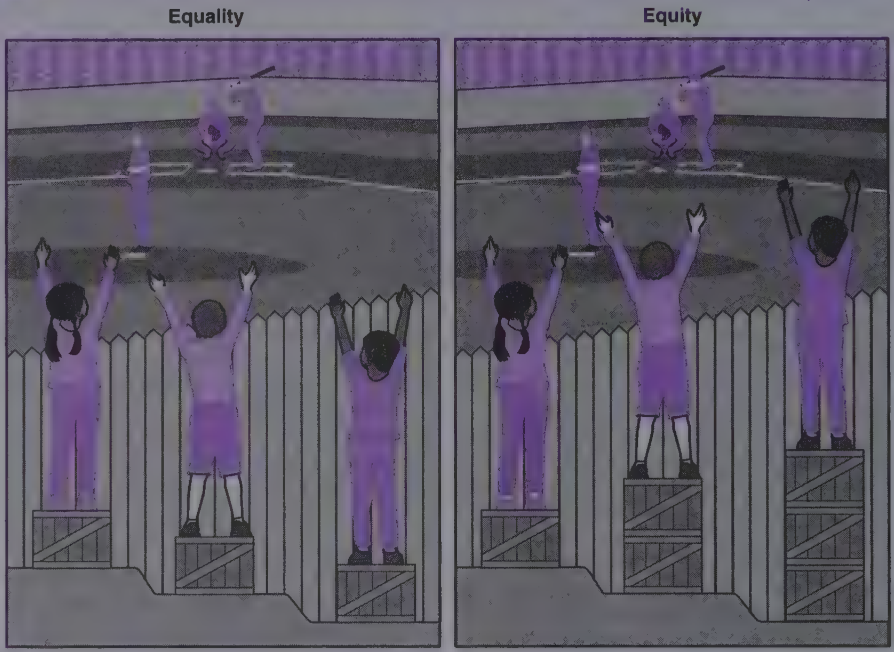
"Health equity is the ethical and human rights principle that motivates us to eliminate health disparities, which are differences in health or its key determinants (such as education, safe housing, and freedom from discrimination) that adversely affect marginalized or excluded groups. . . . Equity is 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