



# **Statement on Women's Health\***

**Student National Medical Association**

Health Policy and Legislative Affairs Committee

# Statement on Women's Health\*

## Fourth Revision

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## INTRODUCTION

Founded in 1964 by medical students from Howard University School of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation's oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians. Additionally, the SNMA is dedicated to practices leading to better health care for minority and underrepresented communities. As these communities are disproportionately subject to the consequences of discriminatory practices, including those against women, the SNMA not only strongly opposes any legislation or practices that create or maintain barriers to health care access for women, but also supports legislation, such as the Affordable Care Act (ACA), that decreases disparities in women's health. \*INCLUSION STATEMENT: The SNMA acknowledges that "women" and "maternal" health may pertain to individuals who do not identify as women or female gendered, and we encourage gender-inclusive interpretations of this document.

Women's health is an expansive field of medicine that focuses on diseases that affect a woman's holistic well-being. Through a social justice lens, it is imperative we examine health disparities within women's health sub-topics such as breast cancer, reproductive justice, maternal mortality, and labor and delivery outcomes. Breast cancer is the most common non-cutaneous malignancy and the second most lethal form of cancer among women in the United States (US).<sup>1</sup> As the breast cancer mortality rate for White women decreases, we see a steady increase in the mortality rate for minority women, especially within the Black/African American and Hispanic/Latinx population.<sup>1</sup> The Affordable Care Act (ACA) offered a package of women's preventive services which included: Pap tests, mammograms, and some contraceptives without copays for women. Despite this progress in 2018, about 10.8 million women remained uninsured.<sup>2</sup> In addition, Non-Hispanic Black Women are three to four times more likely to die from pregnancy-related causes than Non-Hispanic White women.<sup>3</sup> Women from underserved backgrounds face detrimental effects from racial and ethnic health disparities, thus greatly

reducing their health outcomes.

The SNMA is committed to centering the experiences of past, present, and future underserved women patients. We call attention to these tragic health disparities and urge stakeholders to assist in cultivating unique solutions that will empower the lives of women with marginalized identities. We push for the implementation of culturally humble training for medical students and physicians, early detection breast cancer screenings for minority women, stronger policies that bring comprehensive reproductive health care packages to minority women, and quality improvement in the treatment of pregnant Black women through all stages.

## **BACKGROUND**

Health disparities are defined as “differences in the quality of care that are not due to access-related factors or clinical needs, preferences or appropriateness of the intervention.”<sup>4</sup> The history of healthcare disparities among women of color dates back centuries. Prather et al. (2018) explored the health outcomes of Black/African American women from the time of slavery through the post-Civil Rights era. They found, over the course of nearly 400 years, Black/African American women have been subjected to a myriad of harrowing personal and healthcare experiences, both of which in turn have contributed to past and present day disparities, including public nude physical auction examinations to determine reproductive ability, nonconsensual gynecological and reproductive surgeries performed without anesthesia, compulsory sterilization, rape, stereotypes and negative media portrayals, and generational poverty. While many of the former are not actively occurring in the present day, many of the latter are still relevant. Despite the advances made in healthcare since the eras of slavery, Jim Crow, and Civil Rights<sup>5</sup>, women of color still suffer from a poorer quality of life in comparison to their White counterparts. Ikemoto explains that although many efforts have been made to shed light on health disparities related to racism and socioeconomic status, the specific health needs of women of color have failed to be addressed.<sup>6</sup> Women of color disproportionately suffer with respect to reproductive health outcomes,<sup>7</sup> breast cancer,<sup>8</sup> HIV/AIDS,<sup>9</sup> diabetes mellitus,<sup>10</sup> cardiovascular disease,<sup>11</sup> and access to care,<sup>12</sup> to name a few documented inequities. The

remainder of this position statement will focus on specific examples of the aforementioned health problems and define the position of the SNMA on the topic of health disparities and how it afflicts women of color.

In 1985, the first report on the national health of minorities was published by the Department of Health and Human Services (HHS). The grim results prompted the formation of the Office of Minority Health in 1986<sup>13</sup>, with the goal of eliminating minority health disparities through the development of health policy and programs. While some improvements were made, minority women continue to face<sup>14</sup> declining health in comparison to their White counterparts. In order to address this, the ACA has introduced provisions to help combat health disparities. One of the methods to help reduce health disparities calls for continued reporting of health information by race, ethnicity, and, in some cases, language to aid in evaluating health status and healthcare needs.<sup>15</sup> An important provision of the ACA seeks to reinforce increasing diversity in medicine, nursing, mental health, and other healthcare professions. This provision is further supported by collecting and publicly reporting data on workforce diversity, increasing diversity among primary care providers, increasing diversity among dentists, and investing in Historically Black Colleges and Universities (HBCUs), among other actions.<sup>15</sup> These initiatives aim to increase the amount of physicians that practice in underserved communities and to decrease cultural and/or language barriers.<sup>15</sup>

Additionally, the ACA has provisions to ensure that all healthcare providers are trained to be culturally competent. Methods to accomplish this provision include developing and evaluating cultural competence (CC) curricula and initiating a loan repayment preference for experience in CC.<sup>15</sup> Other propositions to decrease health disparities revolve around research, prevention, and insurance reform. With respect to research, areas of interest include increasing support for collaborative research on cultural competence, postpartum depression, and pain management. Examples of proposed prevention efforts include oral health campaigns focused on minorities, maternal and child home visits for at-risk communities, and culturally appropriate health education material. Lastly, in order to address health disparities through health insurance reforms, the ACA proposes enrollment outreach for low-income populations. This will provide coverage summaries that are culturally appropriate and incentivize a payment structure that

reduces disparities.<sup>15</sup> The aforementioned provisions are only a few examples of how the ACA attempts to eliminate healthcare disparities, and it is important for all healthcare providers to become familiar with its full-scope.

The role legislation plays in addressing such disparities cannot be discounted. Bills such as the Stephanie Tubbs Jones Uterine Fibroid Research and Education Act of 2021 and the Black Maternal Health Momnibus Act of 2021 are two of the most recent Acts of Congress that were put in place with Black/African American women in mind in an effort to address these issues and make tangible impact. It is the hope that such discussions continue to be had at the national level as long-term change still requires much progress to be made.<sup>16</sup>

## **SCOPE OF THE PROBLEM**

### ***Access to Healthcare***

Access to healthcare plays a major role in women of color's experience interfacing with and navigating within the US healthcare system. Hispanic/Latinx and Black/African American women are consistently more likely to be uninsured or use Medicaid as compared to their White counterparts, who are more likely to utilize employer-issued health insurance. Furthermore, Hispanic/Latinx women were more likely to have gaps in healthcare coverage, followed by Black/African American women, and then White women.<sup>17,18</sup> In addition to fewer financial resources to afford healthcare, women of color were also less likely to consult a doctor when necessary, less able to visit a specialist as needed, more likely not to have necessary prescriptions filled due to cost, more likely to encounter transportation and child care challenges, and less likely see a doctor because they could not get time off of work.<sup>19,20,21</sup> Another barrier to access of care is cultural and linguistic incongruence. The failure to tailor healthcare to the patient's social, cultural, and spoken and written communication needs has been identified as a compounding factor, leading to discrepancies in the delivery of quality healthcare.<sup>21, 22</sup>

### ***Reproductive Healthcare***

Health disparities are also noted in female reproductive wellness outcomes. Early detection of dysplastic cells through the use of Pap Smear tests is associated with decreased mortality from cervical cancer. However, some minority groups are less likely to receive Pap smear tests and are prevented from receiving the proven benefits of this risk reduction. Groups that have notably suffered from high rates of cervical cancer are Black/African American, Vietnamese, Alaskan Native, and Hispanic/Latinx women. Additionally, Black/African American women have higher incidence and mortality rates from cervical cancer in comparison to White women.<sup>23,24</sup>

Another grave issue within reproductive health is the high rates of maternal and infant morbidity and mortality in women of color. Non-White women have higher rates of preterm birth, low birth weight, and infant mortality than their White counterparts, with rates of infant mortality for Black/African American women up to three (3) times greater than their White counterparts.<sup>25,26</sup> Black/African American and Hispanic/Latinx women are also more likely to initiate prenatal care later than White women<sup>3</sup>, thereby missing critical periods for health interventions and increasing the risk of pregnancy-related complications.<sup>27</sup> Furthermore, maternal mortality rates due to pregnancy complications are three (3) times higher in Black/African American women and twice as high for Native Americans and Alaskan Native women in comparison to White women.<sup>28,29</sup> Although Black/African American women were not shown to have a significantly increased prevalence of potentially fatal pregnancy complications, they were three (3) to four (4) times more likely to die from complications than their White counterparts.<sup>30</sup> Of note, these inequalities are still observed when education and socioeconomic status are controlled for, suggesting they may be rooted in Black/African American mothers' experiences of race, class, and gender, rather than genetic biological factors.<sup>31</sup> Consistent with this belief, women of color are more likely to report perinatal mood and anxiety disorders, such as postpartum depression, but are less likely to receive treatment.<sup>31</sup>

### ***Breast Cancer***

Breast cancer is the most common cancer diagnosed and the second leading cause of death among women in the US.<sup>32</sup> Breast cancer has also plagued minority groups at different

rates than Whites patients. African American women have a 31% breast cancer mortality rate – the highest of any US racial or ethnic group – about 42% higher than their White counterparts.<sup>1</sup> The age-specific annual incidence rate of breast cancer is 125.6 and 123.3 in White and Black/African American women, whereas the mortality rate is 19.8 and 27.6, respectively.<sup>33</sup> These drastic differences can in part be attributed to barriers to healthcare access, late-stage diagnosis of breast cancer,<sup>33</sup> and obesity (risk factor for breast cancer). Furthermore, Black/African American women are more likely than White women to be diagnosed with breast cancer below the age of 45.<sup>1</sup> Despite the similar rate of screening between the two groups (51% for Black/African American women v. 52% for White women),<sup>34</sup> some of the discrepancies in advanced staging and higher death rates may be due to irregular intervals between screenings, delayed follow-up for abnormal test results, and unequal access to advanced cancer treatment.<sup>1,6,8</sup>

### ***HIV/AIDS***

HIV/AIDS has had a devastatingly deadly impact on the Black/African American population. While representing only 13% of the nation's population, Black/African American individuals accounted for 42% of HIV infection cases in 2019<sup>35</sup> and represented 43% of all deaths of people diagnosed with HIV in 2018.<sup>36</sup> The incidence of HIV/AIDS in Black/African American women, specifically, is more than fifteen times the rate in White women.<sup>12,37,38</sup> According to the U.S. Department of Health and Human Services, the prevalence of AIDS in the population of Black/African American women is fifteen times higher than for White women, and Black/African American women are 14.5 times more likely to die from HIV infection than their White counterparts<sup>35</sup>. There are few evidence-based HIV prevention and care interventions in place for Black/African American women.<sup>37</sup> Several factors, including HIV stigma, access to treatment and care, and medical distrust stemming from years of experimentation must be addressed in order to change the course of the impact of HIV/AIDS on Black/African American women.<sup>38</sup> .

### ***Diabetes***

Approximately 40% of adults in the US have diabetes or prediabetes. This is projected to double by 2050 with its current trajectory. While diabetes is a common comorbidity across racial and ethnic groups, the adjusted rate of prevalence is nearly double for Black/African American and Hispanic/Latinx patients when compared to their White counterparts.<sup>39</sup>

Age-adjusted incidence of diabetes was found to be highest among Native Americans/Alaska Natives (15.1%), non-Hispanic Blacks/African Americans (12.7%), and people of Hispanic/Latinx ethnicity (12.1%).<sup>40,41</sup> Higher rates of diabetes-related complications—predominantly amputations and kidney disease—were found in Black/African American, Hispanics/Latinx, Asian, and Native American populations compared to the non-Hispanic White population.<sup>42</sup> One study also showed greater rates of diagnosis of gestational diabetes mellitus (GDM), which is pregnancy-induced diabetes, in Asian, Hispanic/Latinx, and Black/African American women compared to White women, with percentages of 6.8%, 5.4%, 5.5%, and 3.1% reported, respectively.<sup>43</sup>

The overall number of newly diagnosed diabetes cases is projected to increase by 99% among White patients compared to the estimated increase of 200% for Black/African American patients by 2050.<sup>39</sup> Diabetes incidence is expected to increase more in women (220%) than in men (174%) within the same timeframe. This is even more true for women of color. It is expected that 49% of Black women will develop diabetes in their lifetime, compared to 31% of white women by 2050.<sup>39</sup>

### ***Cardiovascular Disease***

Cardiovascular disease is the number one killer of all Americans; however, health disparities have also been noted in incidence and mortality rates for women due to cardiovascular disease. Black/African American women are 40% more likely to die from cardiovascular disease than White women.<sup>44,45</sup> Minority women were also found to have more predisposing factors such as hypertension, diabetes, and obesity, which correlate with increased incidence of cardiovascular disease. In fact, three or more risk factors for a heart attack were present in 57%, 40%, and 32% of Hispanic/Latinx, Black/African American, and White women, respectively.<sup>44</sup>

The COVID-19 pandemic has further exposed cardiovascular and metabolic health disparities for Black/African American people, especially women. With conditions such as severe hypertension, type II diabetes mellitus, obesity, and increased cardiovascular mortality being more common among Black/African American women, there is an alarming gap in life expectancy for Black/African American women (78.1 years old) compared to white women (81.1 years old ).<sup>46</sup>

Through several initiatives, governmental and nonprofit entities have attempted to raise awareness of health disparities among the lay public and the healthcare community, and small improvements have been made to ensure that health disparities are eliminated.<sup>47</sup> The SNMA continues to provide valuable information to its members in hopes of encouraging all future healthcare providers to join the fight to eliminate health disparities across racial groups, sexes, and other disadvantaged populations.

### **STATEMENT OF POSITION AND RECOMMENDATIONS**

We, the members of the SNMA, recognize that advances in the healthcare field have increased the average lifespan and quality of life for most Americans. However, certain groups, particularly women of color, are not experiencing the same benefits as their White counterparts. The SNMA mission is grounded on the principle of increasing the number of socially conscious physicians capable of addressing the diverse needs of historically disadvantaged communities. Thus, we seek to empower our members to be at the forefront in eliminating health inequities for all women. For this reason, the SNMA supports the following measures:

1. The SNMA supports the protection of the Affordable Care Act (ACA) and the provisions that are intended to help decrease health disparities. We suggest our members demonstrate support to Congress through letter writing to advocate for the provisions discussed in this statement.
2. The SNMA supports primary and secondary prevention as effective tools to help citizens achieve an optimal quality of life. This includes health education and promotion related

to chronic conditions such as hypertension, diabetes, cancer, and HIV/AIDS, and increasing the availability of information and resources within each community is a necessary part of ensuring the success of these preventive efforts.

3. The SNMA supports equipping future healthcare providers with the most up-to-date health inequity information available. We encourage health organizations to take a more active role in engaging their providers in conversations and advocacy efforts centered around the aforementioned topics. An excellent cost-effective way to do so is to host training sessions and webinars free of charge for employees that address various health disparities. Additionally, organizations should consider creating committees focused on targeting the most prevalent inequities existing within the communities they serve.
4. The SNMA supports efforts to study and address the disproportionate rates of maternal morbidity and mortality affecting Black/African American women and other women of color. Pairing Black/African American women with doulas, nurses, and midwives would provide a more interdisciplinary approach to prenatal care and a greater sense of comfortability for pregnant Black/African American women.
5. The SNMA supports the growth of governmental, public health, and nonprofit entities (for example, the >AIDS Campaign)<sup>48</sup> whose goals are to spread awareness of health disparities and provide tools to help decrease the prevalence of diseases that are detrimental to the health of minority women. Partnerships with such organizations may yield a multitude of benefits for communities because the organizations often provide resources to help coordinate events such as health screening clinics, wellness and fitness classes, and donation drives.
6. The SNMA supports the recognition of social determinants of health as major contributors to poor health outcomes in minority women.

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