



GUIDING PRINCIPLES TO ACHIEVING EQUITY IN PRETERM BIRTH

WELCOME

March of Dimes leads the fight for the health of all moms and babies.

As a leading organization in maternal and child health, March of Dimes is working to support healthy moms, healthy pregnancies and reduce the preterm birth rate. With a focus on populations and regions that need our help most, we are providing resources and programs to help moms before, during and after pregnancy.

About this document

The purpose of this document is to ensure that participants of the March of Dimes Prematurity Collaborative have a common understanding of the principles and terms used in conversations about equity and health equity. This is a first attempt by the Collaborative's Health Equity Workgroup to outline concepts and terms so that all Collaborative participants have a common understanding. This document offers a systematic, consistent and unified way to ensure that a health equity perspective is incorporated into all of the Collaborative's work.

The Health Equity Workgroup began compiling the Guiding Principles in February 2017. The final version draws upon the *What is health equity* brief by the Robert Wood Johnson Foundation (Braveman, Arkin, Orleans, Proctor & Plough, 2017). In this way this document builds on established work from nationally-recognized experts in health equity.

March of Dimes Prematurity Collaborative

Launched in March 2017, the March of Dimes Prematurity Collaborative is a network of more than 500 organizations and individuals dedicated to achieving equity and demonstrated improvements in preterm birth. The March of Dimes launched the Collaborative to accelerate progress by advancing the implementation of policies, strategies and services to improve equity and reduce preterm birth.

The Collaborative consists of a steering committee and six workgroups whose efforts are guided by a strategic map that includes five major tracks:

1. Clinical and Public Health Practice
2. Research
3. Health Equity
4. Policy
5. Communications
6. Funding and Resources

For more information about the Collaborative, visit **marchofdimes.org/collaborative**.

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OVERVIEW OF HEALTH EQUITY IN PRETERM BIRTH

Preterm birth (birth before 37 weeks of pregnancy) is a reflection of America's health. It contributes to infant death within the first year of life, childhood disease and disability, and adult chronic disease. Helping all babies stay in the womb until full gestation is one of the most impactful steps in our pursuit to achieve health equity. Every baby should have the opportunity to be born healthy and have the healthiest life possible.

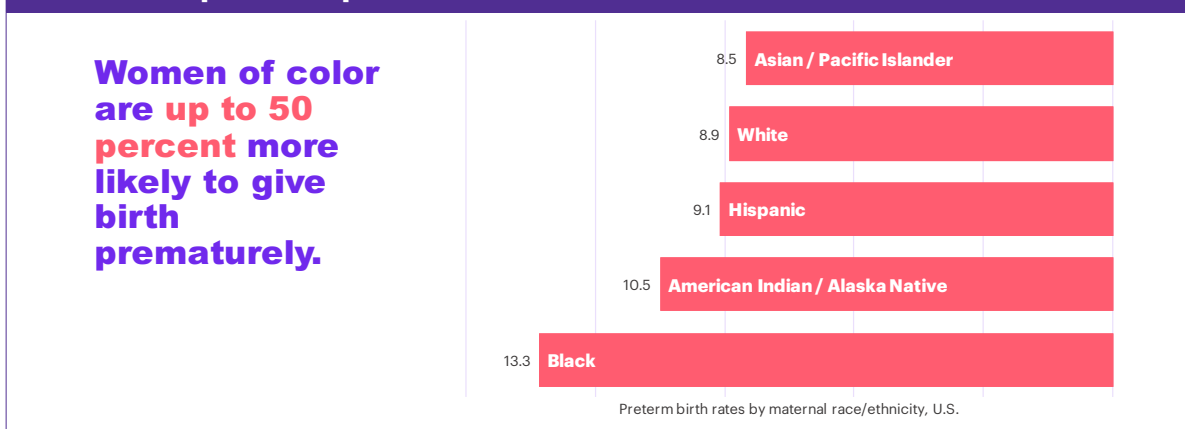
Reducing child mortality and improving maternal health are two areas of focus in the United Nation's Sustainable Development Goals, which seek to mobilize efforts to end all forms of poverty, fight inequalities and tackle climate change (United Nations [UN], Oct 2018).

Reducing preterm birth and infant mortality remain a challenge for the United States. According to the Human Development Index, the U.S. ranks among the most highly developed countries in the world (UN Development Programme, 2018). But in 2014, 35 countries had lower infant mortality rates than the U.S. (March of Dimes Perinatal Data Center, July 2017). Although the preterm birth rate in the U.S. had declined

steadily from 2007 to 2014, the rate increased in the last two years (2015 and 2016) (Martin, 2018).

Equally troubling are the significant disparities (differences) between birth outcomes of white women and those of black, American Indian/ Alaska Native and other women of color. Although declines in the infant mortality rate have been observed for both black and white infants over the past few decades, the 2015 infant mortality rate for black infants in the U.S. is higher than the rate for white infants 30 years ago. Preterm birth and associated conditions are the largest contributors to infant mortality (Matthews, MacDorman & Thoma, 2015). Racial and ethnic disparities in preterm birth are worsening and black women have a preterm birth rate that is about 50 percent higher than other women (see Figure 1). Understanding the root causes of these disparities can help drive comprehensive approaches to reversing these trends. Ensuring the health of all babies can help ensure the health of our future economy. One economic study of disparities among minorities showed a \$229.4 billion reduction in direct medical expenditures from 2003 to 2006 (National Academies of Sciences, Engineering and Medicine, 2017).

FIGURE 1. Disparities in premature birth



Analysis by March of Dimes using 2013-2015 natality data from National Center for Health Statistics.



KEY HEALTH EQUITY TERMS

While some definitions of health disparities and health inequities refer to any health differences between unspecified groups, a wide consensus believes that these terms should refer specifically to differences that are unfair, avoidable and unjust (Braveman, Arkin, Orleans, Proctor & Plough, 2017; World Health Organization, 2017). Human rights principles provide guidance on societal obligations to work towards eliminating health disparities and inequalities. This requires fulfilling rights for all, including rights to be free of discrimination.

The following terms are fundamental to understanding health equity.

EQUITY Justice and fairness. Equity implies equal rights but it is not the same as equality. Equity will require directing more resources to groups that have greater needs because of a history of exclusion or marginalization.

“Equity is the fair treatment, access, opportunity and advancement for all people, while at the same time striving to identify and eliminate barriers that have prevented the full participation of some groups. Improving equity involves increasing justice and fairness within the procedures and processes of institutions or systems, as well as in their distribution of resources. Tackling equity

issues requires an understanding of the root causes of outcome disparities within our society.”

Source: [Why diversity, equity and inclusion matter](#)

HEALTH Health status, including physical and mental health and wellbeing. Health does not refer to health care. Source: [What is health equity? And what difference does a definition make?](#)

HEALTH DISPARITIES “A particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion.” Source: [Healthy People 2020 glossary for phase I report U.S. Department of Health and Human Services, 2008.](#)

“Health disparities/inequalities are how we measure progress toward health equity. Health equity is the underlying principle that motivates action to eliminate health disparities/inequalities.” Source: [What is health equity? And what difference does a definition make?](#)

HEALTH EQUITY The attainment of the highest level of health for all people. “A desirable goal/standard that entails special efforts to improve the health of those who have experienced social or economic disadvantage.... It requires continuous efforts focused on elimination of health disparities, including disparities in health care and in the living and working conditions that influence health, and continuous efforts to maintain a desired state of equity after particular health disparities are eliminated.” Source: [Healthy People 2020 glossary for phase I report U.S. Department of Health and Human Services, 2008.](#)

“[Health equity] requires removing obstacles to health, such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.” Source: [What is health equity? And what difference does a definition make?](#)

HEALTH INEQUITIES “...a particular kind of health disparity that is not only of concern for being potentially unfair, but which is believed to reflect injustice. There will be different views of what constitutes adequate evidence [of injustice]. Some will argue that to call a disparity an inequity, it is essential to know its causes and demonstrate that they are unjust. Others would maintain that regardless of the causes of a health disparity, it is unjust not to take concerted action to eliminate it, because it puts an already socially disadvantaged group at further disadvantage on health, and good health is needed to escape social disadvantage. Where there is reasonable (but not necessarily definitive) evidence that underlying inequities in opportunities and resources to be healthier have produced a health disparity, that disparity can be called a health inequity; it needs to be addressed through efforts to eliminate inequities in the opportunities and resources required for good health. Inequity is a powerful word; its power may be diminished if it is used carelessly, needlessly exposing health equity efforts to potentially harmful challenges. It should be used thoughtfully.” Source: [What is health equity? And what difference does a definition make?](#)

SOCIAL DETERMINANTS OF HEALTH (SDOH) “Complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.” Source: [Health Equity Resource Toolkit for State Practitioners Addressing Obesity Disparities](#)

“The social determinants of health are nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health.” Source: [What is health equity? And what difference does a definition make?](#)

STRUCTURAL RACISM “A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with ‘whiteness’ and disadvantages associated with ‘color’ to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist.” Source: [Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis](#)

SYSTEMIC RACISM “In many ways ‘systemic racism’ and ‘structural racism’ are synonymous. If there is a difference between the terms, it can be said to exist in the fact that a structural racism analysis pays more attention to the historical, cultural and social psychological aspects of our currently racialized society.” Source: [Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis](#)



GUIDING PRINCIPLES

In 2017, the Robert Wood Johnson Foundation established 9 guiding principles to advance health equity (Braveman, Arkin, Orleans, Proctor & Plough, 2017). For each principle, the Health Equity Workgroup recommends potential activities for individuals, groups and organizations within and beyond the Collaborative to apply in their own work to address disparities in preterm birth. The guiding principles are used here with permission from the Robert Wood Johnson Foundation.

Guiding principle 1

“Achieving health equity requires societal action to remove obstacles to health and increase opportunities to be healthy for everyone, focusing particularly on those who face the greatest social obstacles and have worse health. It also requires engaging excluded or marginalized groups in identifying and addressing their health equity goals.”

- Empower families and communities from marginalized groups through authentic engagement in research, programs and advocacy.
- Use an asset-based approach to understand strengths, challenges and opportunities for

advancing equity. An asset-based approach that builds on the protective factors that support health in the community (such as skills and talents of residents and civic and cultural organizations) rather than deficits. Gather input directly from the community.

- Activate families, communities and systems towards policy change that will result in a more equitable distribution of power, money and resources.

Guiding principle 2

“Policy, systems and environmental improvements have great potential to prevent and reduce health inequities, but only if they explicitly focus on health equity and are well designed and implemented. Otherwise, such interventions may inadvertently widen health inequities. For example, public health anti-smoking campaigns inadvertently led to widened socioeconomic disparities in smoking because the untargeted messages were picked up and applied more rapidly by more educated, affluent people.”

- Ensure access to quality, culturally-competent preconception, prenatal, postpartum and intrapartum care.

- Monitor and assess adequate availability and effective utilization of community health resources.
- Create opportunities for development, support and expansion of evidence-based practices that are effective for selected populations, while recognizing that not all are effective across diverse sub-populations.
- Review programs that facilitate the above recommendations.
- Promote tools/interventions that allow medical and non-medical service providers to examine their own implicit biases that could result in unequal treatment of their patient/client populations.
- With their permission, share the personal stories of women who have experienced an infant loss; leverage this influence to encourage others to address the root causes of prematurity and infant mortality.
- Target assistance to those who are in most need; distribution of money, power and resources should be commensurate with need.

Guiding principle 3

“Opportunities to be healthy depend on the living and working conditions and other resources that enable people to be as healthy as possible. A population’s opportunities to be healthy are measured by assessing the determinants of health — social and medical — that people experience across their lives.”

- Address the social and structural determinants of health.
- Address barriers to access, such as lack of transportation and childcare.
- Use data segmented by race/ethnicity to further understand what different communities may experience. Different groups have unique — inequitable — experiences in education, the workforce and other areas pertaining to the social determinants of health.

Guiding principle 4

“Pursuing health equity entails striving to improve everyone’s health while focusing particularly on those with worse health and fewer resources to improve their health. 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.”

- Expand access to critical services, particularly for those populations where the burden is greatest, including low income, underserved urban and/or underserved rural communities.

Guiding principle 5

“Approaches to achieving health equity should build on and optimize the existing strengths and assets of excluded or marginalized groups.”

- Engage community leaders and those most affected by inequities.
- Provide to the March of Dimes Prematurity Collaborative Health Equity Workgroup a summary of Collaborative member organizations and their focus areas related to health equity to broadly share information and resources

Guiding principle 6

“Piecemeal approaches targeting one factor at a time are rarely successful in a sustained way. Approaches are needed that both increase opportunities and reduce obstacles. Successful approaches should address multiple factors, including improving socioeconomic resources and building community capacity to address obstacles to health equity.”

- Engage and coordinate with other sectors such as education and housing to eliminate barriers in social and structural determinants of health.
- Increase awareness and education about how to navigate the health system, including mental health services.

Guiding principle 7

“Achieving health equity requires identifying and addressing not only overt discrimination but also unconscious and implicit bias and the discriminatory effects — intended and unintended — of structures and policies created by historical injustices, even when conscious intent to discriminate is no longer clearly present.”

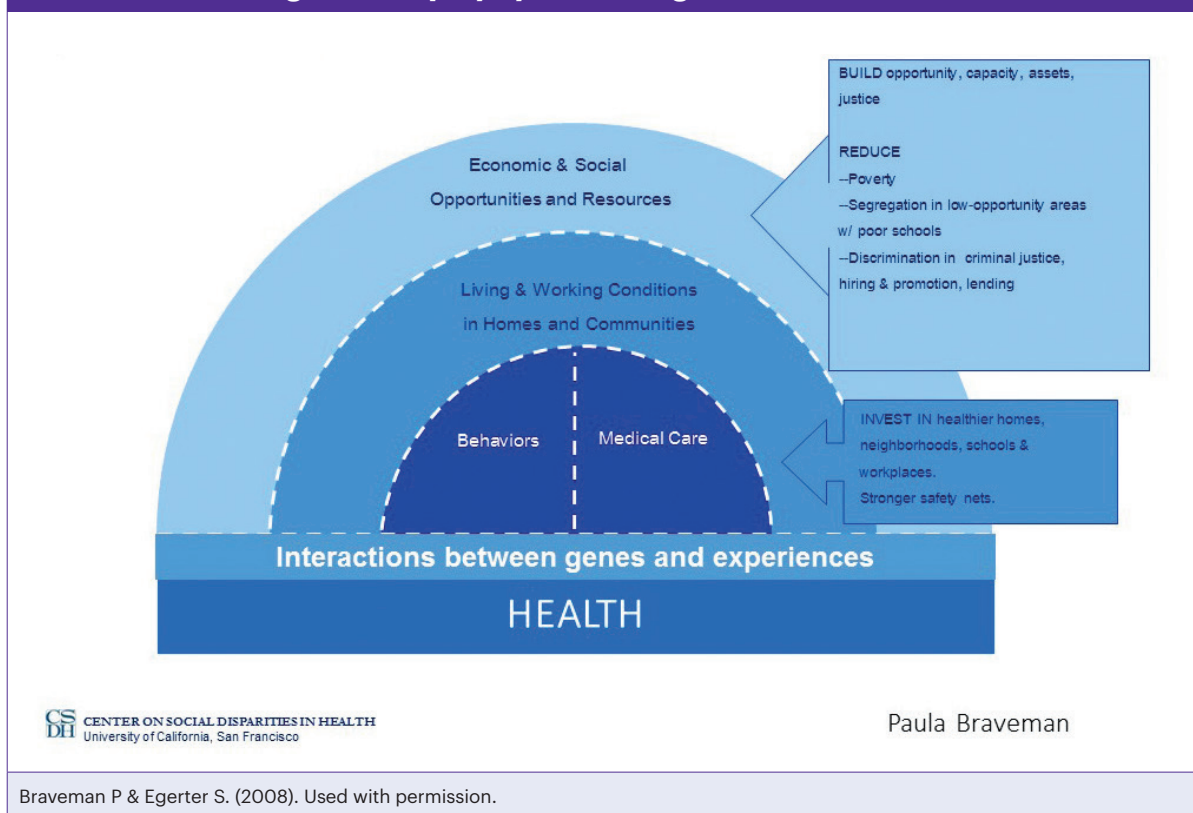
- Communicate how racism, in its multiple forms, contributes to inequities and disparities in preterm birth rates.
- Provide an opportunity for health and social service providers to “experience” what racism feels like. Use virtual experiences, such as implicit association tests, to test implicit bias. Visit Project Implicit (2011) at <https://implicit.harvard.edu/implicit/takeatest.html>.

Guiding principle 8

“Measurement is not a luxury; it is crucial to document inequities and disparities and to motivate and inform efforts to eliminate them. Without measurement, there is no accountability for the effects of policies or programs.”

- Use shared definitions and metrics to track, analyze and report health disparities related data to the extent possible. Metrics may include information related to social determinants by race and ethnicity and other descriptors of a specific population.
- Recognize the value of national, local, quantitative and qualitative data in understanding a community.
- Understand the value of separating out data by its component parts; without measurement that includes the proper level of disaggregation, there is no accountability to ensure that needs within a specific population are being addressed.
- Reference the social determinants of health equity measurement framework (Figure 2).

FIGURE 2. Achieving health equity by addressing SDOH



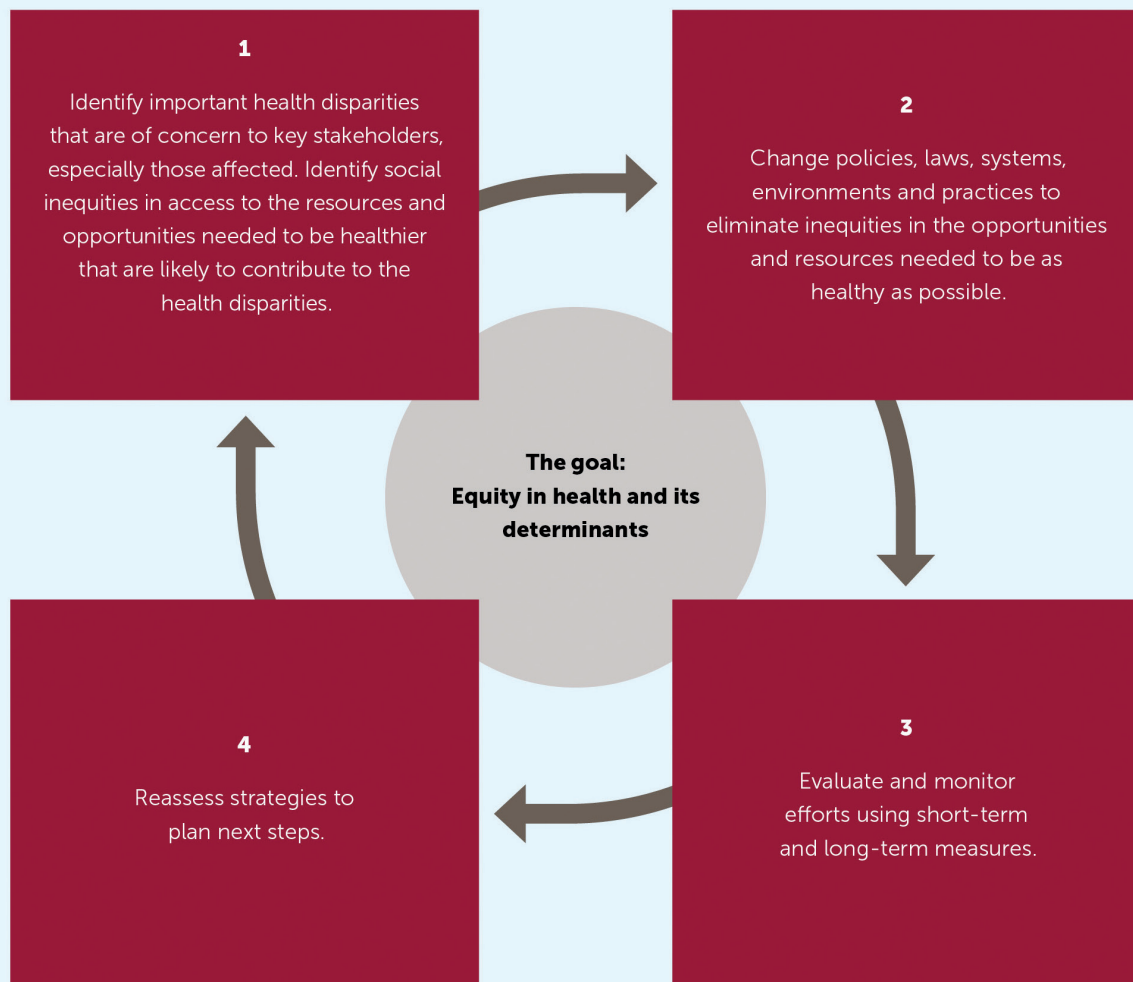
Guiding principle 9

“The pursuit of equity is never finished. It requires constant, systematic and devoted effort. A sustained commitment to improving health for all — and particularly for those most in need — must be a deeply held value throughout society.”

- Bring others, such as faith communities and government agencies, into the Collaborative. We cannot do this work alone. To join, visit marchofdimes.org/collaborative.
- Achieving equity requires a long-standing commitment and continuous reassessment of action steps is required (Figure 3).

FIGURE 3. Key steps to advancing health equity

A strategy to achieve greater health equity may be most effective when it includes steps moving systematically from identifying health disparities to action to achieve greater health equity. (The steps may not always occur in the order depicted below.)



Braveman, Arkin, Orleans, Proctor & Plough, 2017. Used with permission.

FULL HEALTH EQUITY GLOSSARY

TABLE 1. Overview of terms	
Terms used to describe cultural norms of groups or society as a whole	<ul style="list-style-type: none"> • Cultural representations • Diversity • Ethnicity • Intersectionality • National values • Opportunity • Race or racial group
Terms that describe the physical and social environment (what's around you and how your community affects you)	<ul style="list-style-type: none"> • Life course perspective • Social determinants of health
Terms that describe racism, sexism and privilege or the ideal world in which these do not exist	<ul style="list-style-type: none"> • Critical race theory • Discrimination • Equity • Implicit bias • Individual racism • Institutional racism • Progress and retrenchment • Racial equity • Racism • Sexism • Social exclusion or marginalization • Structural racism • Systemic racism • White privilege
Terms related to health and health outcomes	<ul style="list-style-type: none"> • Birth equity • Health • Health disparities • Health equality • Health inequalities • Health inequities

BIRTH EQUITY “The assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort.” Source: [National Birth Equity Collaborative](#)

CRITICAL RACE THEORY An iterative methodology for helping investigators remain attentive to equity in general and racial equity in particular, while carrying out research, scholarship and practice. It also urges scholars to work to transform the hierarchies they identify through research. Source: [Critical race theory, race equity and public health: Toward antiracism praxis](#)

CULTURAL REPRESENTATIONS

“Popular stereotypes, images, frames and narratives that are socialized and reinforced by media, language and other forms of mass communication and “common sense.” Cultural representations can be positive or negative, but from the perspective of the dismantling structural racism analysis, too often cultural representations depict people of color in ways that are dehumanizing, perpetuate inaccurate stereotypes and have the overall effect of allowing unfair treatment within the society as a whole to seem fair or ‘natural.’” Source: [Glossary for understanding the dismantling structural racism/ promoting racial equity analysis](#)

DISCRIMINATION “...includes but is not limited to racism. Prejudicial treatment has been based on a wide range of characteristics, including not only racial or ethnic group but also low income, disability, religion, lesbian, gay, bisexual, transgender, queer (LGBTQ) status, gender and other characteristics that have been associated with social exclusion or marginalization.” Source: [What is health equity? And what difference does a definition make?](#)

DIVERSITY The presence of a range of backgrounds and races within a group or population. “In many cases, the term diversity does not just acknowledge the existence of diversity of background, race, gender, religion or sexual orientation.” Source: [Glossary for understanding the dismantling structural racism/ promoting racial equity analysis](#)

ETHNICITY OR ETHNIC GROUP “...a group of people who share a common culture (beliefs, values or practices, such as dress, diet or language). This usually involves sharing common ancestry in a particular region of the world. Some people use the term ethnicity or ethnic group to encompass both racial and ethnic group, based on recognition that race is fundamentally a social rather than biological construct.” Source: [What is health equity? And what difference does a definition make?](#)

EQUITY Justice and fairness. Equity implies equal rights but it is not the same as equality. Equity will require directing more resources to groups that have greater needs because of a history of exclusion or marginalization.

“Equity is the fair treatment, access, opportunity and advancement for all people, while at the same time striving to identify and eliminate barriers that have prevented the full participation of some groups. Improving equity involves increasing justice and fairness within the procedures and processes of institutions or systems, as well as in their distribution of resources. Tackling equity issues requires an understanding of the root causes of outcome disparities within our society.” Source: [Why diversity, equity and inclusion matter](#)

HEALTH Health status, including physical and mental health and wellbeing. Health does not refer to health care. Source: [What is health equity? And what difference does a definition make?](#)

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“Health disparities/inequalities are how we measure progress toward health equity. Health equity is the underlying principle that motivates action to eliminate health disparities/inequalities.” Source: [What is health equity? And what difference does a definition make?](#)

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“[Health equity] requires removing obstacles to health, such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.” [Source: What is health equity? And what difference does a definition make?](#)

HEALTH INEQUALITIES See health disparities. This term is used more frequently outside the United States.

HEALTH INEQUITIES “...a particular kind of health disparity that is not only of concern for being potentially unfair, but which is believed to reflect injustice. There will be different views of what constitutes adequate evidence of injustice. Some will argue that to call a disparity an inequity, it is essential to know its causes and demonstrate that they are unjust. Others would maintain that regardless of the causes of a health disparity, it is unjust not to take concerted action to eliminate it, because it puts an already socially disadvantaged group at further disadvantage on health, and good health is needed to escape social disadvantage. Where there is reasonable (but not necessarily definitive) evidence that underlying inequities in opportunities and resources to be healthy have produced a health disparity, that disparity can be called a health inequity; it needs to be addressed through efforts to eliminate inequities in the opportunities and resources required for good health. Inequity is a powerful word; its power may be diminished if it is used carelessly, needlessly exposing health equity efforts to potentially harmful challenges. It should be used thoughtfully.” [Source: What is health equity? And what difference does a definition make?](#)

IMPLICIT BIAS “Also known as implicit social cognition, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual’s awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness. Rather, implicit biases are not accessible through introspection. The implicit associations we harbor in our subconscious cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance. These associations develop over the course of a lifetime beginning at a very early age through exposure to direct and indirect messages. In addition to early life experiences, the media and news programming are often-cited origins of implicit associations.” [Source: Understanding implicit bias](#)

INDIVIDUAL RACISM (OR INTERPERSONAL RACISM) “...covert actions toward a person that intentionally or unintentionally express prejudice, hate or bias based on race.” [Source: Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)

INSTITUTIONAL RACISM “...policies and practices within and across institutions that, intentionally or not, produce outcomes that chronically favor or put a racial group at a disadvantage. Poignant examples of institutional racism can be found in school disciplinary policies in which students of color are punished at much higher rates than their white counterparts, in the criminal justice system, and within many employment sectors in which day-to-day operations, as well as hiring and firing practices can significantly disadvantage workers of color.” [Source: Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)

INTERSECTIONALITY The interconnected nature of social categorizations, such as race, class and gender as they apply to a given individual or group, which can create overlapping and interdependent systems of discrimination or disadvantage. Sources: [Collins, 1990](#); [Crenshaw, Golanda, Peller & Thomas, 1996](#); [The Complexity of Intersectionality, 2005](#)

“Intersectionality views race and gender identities and the discrimination resulting from those identities as closely related organizing properties that ubiquitously influence interpersonal engagement, status, and power experiences that inform stress exposure and appraisal. From this conceptual framework, race-specific and gender-specific role strain, racism, and sexism are described as relational, interlocking and interactive categories that function to produce stress.” Source: [Jackson, Rowley & Owens, 2012](#)

LIFE COURSE PERSPECTIVE “...offers a new way of looking at health, not as disconnected stages unrelated to each other, but as an integrated continuum. This perspective suggests that a complex interplay of biological, behavioral, psychological, social and environmental factors contribute to health outcomes across the course of a person’s life. It builds on recent social science and public health literature that posits that each life stage influences the next and that social, economic and physical environments interacting across the life course have a profound impact on individual and community health.” Source: [MCH life course tool box](#)

NATIONAL VALUES “...behaviors and characteristics that we as members of a nation are taught to value and enact. Fairness, equal treatment, individual responsibility, and meritocracy are examples of some key national values in the United States. When looking at national values through a structural racism lens, however, we can see that there are certain values that have allowed structural racism to exist in ways that are hard to detect. This is because these national values are referred to in ways that ignore historical realities. Two examples of such national values are ‘personal responsibility’ and ‘individualism,’ which convey the idea that people control their fates regardless of social position, and that individual behaviors and choices alone determine material outcomes.” Source: [Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)

OPPORTUNITY “...access to goods, services and the benefits of participating in society. There are many different kinds of obstacles to access in addition to financial barriers and geographic distance; obstacles can include past discrimination, fear, mistrust, and lack of awareness, as well as transportation difficulties and family caregiving responsibilities. To measure not only potential access but the real opportunities that different social groups have, that is, their realized access, we need to assess which groups actually have the relevant goods, services, and benefits. Because of past and ongoing racial discrimination in housing, lending, and hiring policies and practices, there is great variation in the quality of the places where people of different racial or ethnic groups live, work, learn, and play; these differences in places often correspond to very different opportunities to be as healthy as possible.” Source: [What is health equity? And what difference does a definition make?](#)

PROGRESS AND RETRENCHMENT “...the pattern in which progress is made through the passage of legislation, court rulings and other formal mechanisms that aim to promote racial equality. Brown v. Board of Education and the Fair Housing Act are two prime examples of such progress. But retrenchment refers to the ways in which this progress is very often challenged, neutralized or undermined. In many cases after a measure is enacted that can be counted as progress, significant backlashes — retrenchment — develop in key public policy areas. Some examples include the gradual erosion of affirmative action programs, practices among real estate professionals that maintain segregated neighborhoods, and failure on the part of local governments to enforce equity oriented policies such as inclusionary zoning laws.” Source: [Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)

RACE OR RACIAL GROUP “...belonging to a group of people who share a common ancestry from a particular region of the globe. Common ancestry is often accompanied by superficial secondary physical characteristics such as skin color, facial features, and hair texture. Given the extensive racial mixing that has occurred historically, these superficial differences in physical appearance are very unlikely to be associated with fundamental, widespread, underlying differences in biology. This does not rule out the possibility of there being some highly specific genetic differences associated with ancestry that could affect susceptibility

to particular diseases (for example, sickle cell disease, other hemoglobinopathies, Tay-Sachs disease) or treatments. These highly specific differences, however, are not fundamental and do not define biologically distinct racial groups; they generally occur in multiple racial groups, only at different frequencies. The primary drivers of health inequities are inequitable differences in opportunities to be healthier. Scientists, including geneticists, concur that race is primarily a social — not a biological — concept.” Source: [What is health equity? And what difference does a definition make?](#)

RACIAL EQUITY “...what a genuinely non-racist society would look like. In a racially equitable society, the distribution of society’s benefits and burdens would not be skewed by race. In other words, racial equity would be a reality in which a person is no more or less likely to experience society’s benefits or burdens just because of the color of their skin. This is in contrast to the current state of affairs in which a person of color is more likely to live in poverty, be imprisoned, drop out of high school, be unemployed and experience poor health outcomes like diabetes, heart disease, depression and other potentially fatal diseases. Racial equity holds society to a higher standard. It demands that we pay attention not just to individual-level discrimination, but to overall social outcomes.” Source: [Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)

RACISM “...prejudicial treatment based on racial or ethnic group and the societal institutions or structures that perpetuate this unfair treatment. Racism can be expressed on interpersonal, structural/institutional or internalized levels.

Interpersonal racism is race-based unfair treatment of a person or group by individuals; examples include hate crimes, name-calling or denying individuals a job, promotion, equal pay or access to renting or buying a home based on race.

Internalized racism occurs when victims of racism internalize the race-based prejudicial attitudes toward themselves and their racial or ethnic group, resulting in a loss of self-esteem and potentially in prejudicial treatment of members of their own racial or ethnic group.

Structural or institutional racism is race-based unfair treatment built into policies, laws and practices. It often is rooted in intentional

discrimination that occurred historically, but it can exert its effects even when no individual currently intends to discriminate. Racial residential segregation is an excellent example; it has tracked people of color into residential areas where opportunities to be healthy and to escape from poverty are limited.” Source: [What is health equity? And what difference does a definition make?](#)

SEXISM A form of gender oppression or discrimination. Gender discrimination and bias not only affect differences in health needs, health seeking behavior, treatment and outcomes but also permeate the organizational structures of governments and international organizations, the mechanisms through which strategies and policies are designed and implemented and the content and the process of health research.

Gender discrimination and the resulting bias can often masquerade as ‘natural’ biological difference. “Where biological sex differences interact with social determinants to define different needs for women and men in health (the most obvious being maternity), gender equity will require different treatment of women and men that is sensitive to these needs. On the other hand, where no plausible biological reason exists for different health outcomes, social discrimination should be considered a prime suspect for different and inequitable health outcomes. Health equity in the latter case will require policies that encourage equal outcomes, including differential treatment to overcome historical discrimination.” Source: [Unequal, unfair, ineffective and inefficient: Gender inequity in Health: Why it exists and how we can change it](#)

“Intersectionality views race and gender identities and the discrimination resulting from those identities as closely related organizing properties that ubiquitously influence interpersonal engagement, status, and power experiences that inform stress exposure and appraisal. From this conceptual framework, race-specific and gender-specific role strain, racism and sexism are described as relational, interlocking and interactive categories that function to produce stress.” Source: [Jackson, Rowley & Owens, 2012](#)

SOCIAL DETERMINANTS OF HEALTH (SDOH)

“Complex, integrated and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations and the world.” Source: [Health Equity Resource Toolkit for State Practitioners Addressing Obesity Disparities](#)

“The social determinants of health are nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health.” Source: [What is Health Equity? And What Difference Does a Definition Make?](#)

STRUCTURAL RACISM (See racism.)

“A system in which public policies, institutional practices, cultural representations and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with ‘whiteness’ and disadvantages associated with ‘color’ to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist.” Source: [Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)

SYSTEMIC RACISM “In many ways ‘systemic racism’ and ‘structural racism’ are synonymous. If there is a difference between the terms, it can be said to exist in the fact that a structural racism analysis pays more attention to the historical, cultural and social psychological aspects of our currently racialized society.” Source: [Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)

WHITE PRIVILEGE “Whites’ historical and contemporary advantages in access to quality education, decent jobs and livable wages, homeownership, retirement benefits, wealth and so on. The following quotation from a publication by Peggy Macintosh (1989) can be helpful in understanding what is meant by white privilege: ‘As a white person I had been taught about racism that puts others at a disadvantage, but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage... White privilege is an invisible package of unearned assets which I can count on cashing in every day, but about which I was meant to remain oblivious.’” Source: [Glossary for understanding the dismantling structural racism/promoting racial equity analysis](#)



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ACKNOWLEDGEMENTS

A special thank you to the members of the Health Equity Workgroup and the Health Equity Workgroup Co-chairs for leading this effort:

Fleda Mask Jackson, PhD
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Thank you to Paula Braveman, MD, MPH, Professor of Family and Community Medicine, Director of the Center on Social Disparities in Health, University of California, San Francisco and the Robert Wood Johnson Foundation.

Thank you to Lisa Waddell, MD, Senior Vice President of MCH and NICU Innovation, Deputy Medical Officer, March of Dimes and Kweli Rashied-Henry, MPH, Director of Health Equity, March of Dimes.

The Health Equity Workgroup is funded by the W.K. Kellogg Foundation.





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