

Introduction

Race, Gender, and Public Health: Social Justice and Wellness Work

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The three tasks of becoming actively antiracist are to name racism, ask “How is racism operating here?” and organize and strategize to act.

—Camara Jones (2016, p. 3)

Dr. Camara Phyllis Jones, former president of the American Public Health Association (APHA), constructed her national platform as a call for action to fight racism in order to achieve health equity. Dr. Jones (who holds MD, MPH, and PhD degrees) spent the duration of her 2016 tenure as a national leader fighting for social justice; her APHA platform offers a fundamental framework for how this book approaches the topic of race, gender, and public health.

Jones (2014) wrote in the journal *Medical Care* that “equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health disparities will be eliminated when health equity is achieved” (p. S74). This book is comprised of essays that directly address the chal-

lenge Jones issued in her leadership, scholarship, and service to the field of public health. Authors share research and strategies to name, locate, and change inequitable systems. As a research collective, we present a scholar-activist discussion of social justice wellness work.

Black Women and Public Health: Strategies to Name, Locate, and Change Systems of Power seeks to create an interdisciplinary dialogue that bridges gaps between researchers, practitioners, educators, and advocates. Black women's work in public health is a regenerative practice with a rich history. Just as Anna Julia Cooper wrote in her 1892 essay "Womanhood: A Vital Element in the Regeneration and Progress of a Race," we look backward, inward, and forward as we work to improve the quality of life for ourselves and others. Dr. Cooper, a historian and educator, argued that those who wish to advance society must look back for wisdom, look inward for strength, and look forward for hope. In her articulation of "social regeneration," the concept of conscious progress, she centered Black women as both recipients of social service and agents of change (Cooper, 1998).

Regeneration is a helpful theoretical framework by which to best understand Black women's history, practice, and planning in public health. Black women's life stories, scholarship, and community engagement represent a continuum of insight—what Cooper (1998) called "retrospection, introspection, and prospection" (p. 61). As Cooper argued in *A Voice From the South: By a Black Woman of the South* (1892), social justice is the desired goal of education, and we all have a responsibility to work in our individual capacities toward the common good. This collection of researchers represents an ongoing dialogue to improve education, training, and practice in public health by centering race and gender in order to advance health equity.

This project, as a deliberate submission to the SUNY book series *Black Women's Wellness*, also answers a call from mental health policy researchers Daniel Dawes and Keisha Brathwaite Holden of the Morehouse School of Medicine, who recently published a book chapter titled "Transformative Mental Health Policy" in *Black Women's Mental Health: Balancing Strength and Vulnerability*. Dawes and Holden call for culturally appropriate wellness tool kits that center Black women's voices. As the lead editor of that volume, as with this present collection, Stephanie Evans was mindful of the need to include policy experts to shape recommendations for next steps. Dawes and Holden (2017) call for culturally relevant measures to improve access to and quality of health-care service: "Researchers, clini-

cians, public health professionals, and policymakers have a responsibility to implement action-oriented steps that may be a catalyst for changes in diverse communities. In particular, we must: Design and establish innovative models and wellness tool-kits for prevention of mental illness and the promotion of stigma reduction in ethnically and culturally diverse communities” (p. 278). By centering Black women’s history, theory, identity, academic disciplinary expertise, and various locations, *Black Women and Public Health* advances extant literature in public health, mental health, and related fields. The design for a wellness toolkit is grounded in Black women’s intellectual history, including Camara Jones’s articulation of the relationship between personal behaviors, social determinants of health, and social determinants of equity. For every public health question—from wellness practices to family planning and from vaccines to housing and policing—centering Black women’s experience and articulation of both the problem and solutions is essential.

Community-centered public health involves asking, What does your research *do*, how does your work center perspectives of those who are being researched, and who is the research meant to impact? Though leaps and bounds have been made in the discipline over the past four decades, unfortunately, public health research, policy, and programming is too often offered from a perspective that does not center or benefit Black women. This is often the case even when Black women are the imagined audience.

Frequently, we take the “public” out of public health and allow the practice to become extremely narrow, limited to experts telling the public what’s best for them. But in reality, there are not enough public health educators to treat and teach the public. This means that people—the public—must participate in a much more active way. . . . Who, then, does the work of public health? We all do. (Avery, 2002, p. 571)

There is no lack of access to Black women intellectuals and experts, but rather a lack of commitment to representation at all levels of inquiry, research, analysis, practice, application, and assessment in higher education institutions. Ideas matter, and Black women’s reflective writing is at once abstract and applicable, specific and universal. Thus, a holistic approach to public health must include an expressed appreciation of Black women’s robust historical contributions to the intellectual inquiry, applied history, and creative practice of public health.

Health-disparity research by bodies like APHA clearly shows how interpersonal and institutional inequities impact Black women disproportionately. In fields like legal studies that are adjacent to public health, Kimberlé Crenshaw's intersectionality research advances understanding about how oppressive and inequitable systems are formed. Professor Crenshaw explains how the law fails to adequately address how race, class, and gender compound to place Black women in violent situations and exacerbate disempowerment through legal dispossession. In addition to understanding community involvement and the goal of promoting health in communities, during her tenure as the president of APHA, Dr. Camara Jones advanced understanding about the social determinants of health and how health systems constitute another area of disproportionate power. *Black Women and Public Health* builds on these foundations of inquiry and activism.

Accordingly, this book is a research collective of scholars who investigate how to "prevent disease, prolong life, and promote health" in ways that specifically impact Black women (Winslow, 1920). According to the American Public Health Association (APHA, n.d.), "Public health works to track disease outbreaks, prevent injuries and shed light on why some of us are more likely to suffer from poor health than others. The many facets of public health include speaking out for laws that promote smoke-free indoor air and seatbelts, spreading the word about ways to stay healthy and giving science-based solutions to problems." Dr. Jones has made significant advancements in the discussion of racism and public health. Her detailed approach and program coordination literally put racism on the map as a subject of interest for public health professionals: Her tenure as leader of APHA focused squarely on providing resources to institutionalize discussions in the profession. In multiple talks around the nation, Dr. Jones has demonstrated how racism fosters internalized, personally mediated, and institutionalized oppression. After clearly delineating the personal, social, and structural impact of racism, she has shown how various positionalities, such as gender, economic class, sexuality, and disability, also follow the same patterns.

Dr. Jones's definition of racism as a public health issue is in line with the Centers for Disease Control and Prevention's initial assessment of their National Intimate Partner and Sexual Violence Survey (NISVS) of 2010 (Black et al., 2011). Both racism and sexual violence are duly recognized as preventable social diseases. Jones proposes three steps of "health equity" as a way to address the disease of violence: (1) value all

individuals and populations equally, (2) recognize and rectify historical injustices, and (3) provide resources according to need. In line with Jones's vision of health equity and the 2010 CDC NISVS report, *Black Women and Public Health* offers a tool kit to center Black women's voices, unearth and counteract roots of violence against Black women (restorative), and provide resources useful for culturally sensitive counseling of survivors of violence (curative) as well as resources to construct alternate futures that reduce this violence (preventative).

African American women have a deep history in public health, dating back to nineteenth-century professionals. Though we highlight the intellectual leadership of Dr. Camara Jones, multitudes of Black women have historically contributed to the work of public health, including Mary Eliza Mahoney, Dr. Rebecca Lee Crumpler, Dr. Rebecca Cole, Dr. Susan Smith McKinney Steward, and Dr. Eliza Grier in the nineteenth century. Twentieth-century innovators include Dr. Bessie Delany, Dr. May Chin, Dr. Helen Dickens, Dr. Dorothy Boulding Ferebee and Alpha Kappa Alpha Sorority's Mississippi Health Project, Byllye Avery, the Center for Black Women's Wellness, Black Women's Health Imperative, Dr. Edith Irby Jones, Dr. Rosalyn Epps, Dr. Patricia Harris, Dr. Jocelyn Elders, Dr. Jewel Plummer Cobb, Dr. Mae Jemison, and Dr. Gayle Helene. These women are part of an international community of global wellness workers such as Mary Seacole, Dr. Wangari Maathai, Dr. Princess Nothemba Simelela, and Maria de Jesus Bringelo (Dona Dijé). Whether trained medical professionals, community activists, university professors, or a combination of these identities, Black women have been at the center of the push for healthy individuals, families, communities, and nations.

As Sarita K. Davis clearly outlines in her review of the origins of public health in her editor reflections later in this chapter, race clearly matters in how the field is developed, practiced, and advanced. Black women's voices are too often left out of the discussion of curative, restorative, and preventative solutions to the public health issue of violence. In addition to scholarship produced by and about Black women within the field of public health, disciplines such as history, African American studies, and women's studies have advanced discussions about the meaning and implications of practice and policy. Prime examples of cross-fertilization between science, social science, and humanities include Susan Smith's *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890–1950*, Marie Jenkins Schwartz's *Birthing a Slave: Motherhood and Medicine in the Antebellum South*, Rebecca Wanzo's *The Suffering*

Will Not Be Televised: African American Women and Sentimental Political Storytelling, and Deirdre Cooper Owens's *Medical Bondage: Race, Gender, and the Origins of American Gynecology*.

Comprehensive research projects, particularly the Boston University Black Women's Health Study presented in section 2, provide abundant data on areas from epidemiology to environmental justice. Several resources exist via the Black Women's Health Imperative, the CDC, and the American Psychological Association. Black women on the APHA Executive Board have included Ayanna Buckner, U. Tara Hayden, Ella Greene-Moton, Linda Rae Murray, and Deanna Wathington. The history and experience of Black women in public health can most readily be seen in the work of Byllye Avery and in a grassroots movement of Black women organizing for healing, health, and wellness.

Black Women's Public Health Project: The Living Legacy of Byllye Avery

Susan Smith wrote a groundbreaking history of African American public health initiatives titled *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890–1950*. This outstanding book chronicles the advocacy and organizing efforts of women groups like Alpha Kappa Alpha Sorority's Mississippi Health Project and collective efforts to raise health awareness and expand care options in rural areas, especially in the South. Byllye Avery's work with the Gainesville Women's Health Center in 1974, the Black Women's Health Project in the 1980s, and the development of the Black Women's Health Imperative (BWHI) and Center for Black Women's Wellness (CBWW) built on a long history of collective action by Black women to improve their own health and the quality of life in their own communities highlighted in Smith's work.

Avery, a public health scholar-activist, created a model of Black women's health that centered narratives and storytelling. In an article titled "Who Does the Work of Public Health?" published in the *American Journal of Public Health*, she reminisced about the 1983 national meeting she held for Black women's health at Spelman College in Atlanta, Georgia, "We were moved by what happened, but even more, it dawned on me that that conference defined the true meaning and spirit of public health. When women make their stories public, without the shame and embarrassment

that keep us silent about our health, we become active participants in our health, and those who listen to them and support them benefit as well” (Avery, 2002, p. 573).

One of the most widely known Black women’s health activists, Bylye Avery was raised in DeLand, Florida, and graduated from Talladega College and the University of Florida. She became an activist in the 1970s and remains active as a cornerstone of continuing movements, including the CBWW in Atlanta and BWHI in Washington, DC. Self-care is a fundamental part of her mantra about health activism; she acknowledges that there is no “rest” in seeking justice and resources for proper health care, but there are two ways that activists can ensure sustainability: first, pay attention to your own needs, and second, pass the baton to a new generation of activists (Our Bodies Ourselves, 2011).

Avery is the personification of a quest for wellness on all levels of social location. Her experiences in her Florida community led to her advocacy for those around her and blossomed into lifelong activism for women’s health and reproductive rights.

CBWW in Atlanta was established in 1988, and empowerment is a central theme in its mission. The clinic offers programs to broaden awareness, positively impact maternal and infant health, help youth and adolescents develop healthy habits, and promote Black women’s economic self-sufficiency. The gynecological services (including Pap tests, pelvic exams, HIV testing, and mammograms) are supplemented with prevention programs, so the facility fills in health care gaps for the most vulnerable family and community populations (CBWW, n.d.).

Several publications emerged from the Black Women’s Health Project that were spearheaded by BWHI: *The Black Women’s Health Book* (1990), *Health First! The Black Woman’s Wellness Guide* (2012), and *IndexUS: What Healthy Black Women Can Teach Us About Health* (2016). *The Black Women’s Health Book* captures the agenda of many women intimately involved in the 1980s activism and community organizing. *Health First!* built on the first collection by providing in-depth data-driven research about the top ten health risks Black women face at every stage of their lives (Hoytt & Beard, 2012). *IndexUS* is a forward-thinking report: it is “the first health index focused exclusively on healthy Black women. It’s based on 20 years of data from the Boston University Black Women’s Health Study (BWHS), specifically, information from 38,706 BWHS participants who reported their health as excellent or very good” (Black Women’s Health Imperative,

2016, p. 3). In 2013, when participants responded to questions about their health, the average age of women in this study was in the mid-fifties. As stated in the introduction to the report, “IndexUS is the first time Black women’s health story is being told from a position of strength. Instead of studying what makes us sick, IndexUS takes more than two decades of research in the Black Women’s Health Study and explores what keeps us healthy” (Blount, 2016, p. 4).

BWHI’s *IndexUS* report is a contemporary example of the efforts of twentieth-century women’s groups to impact their communities. Advancements including the election of the first Black woman president of APHA, Dr. Jessica Henderson Daniel, in 2017, come as a direct result of work done over a century ago. The ongoing research in Black women’s public health is making important strides to better understand underlying aspects of health, health disparities, and optimal health.

The lead editor for this project, Stephanie Evans, came to the work of public health through her interest in Black women’s intellectual history and mental health in memoirs. While investigating race, gender, and wellness through the threshold concept of what she calls historical wellness, she was heavily influenced by Bylye Avery, who clearly articulated the relationship between mental health and public health in works such as *Health First! The Black Woman’s Wellness Guide*. The coeditors and author of the afterword who were invited to help shape this current book project—Sarita K. Davis, Leslie R. Hinkson, Deanna J. Wathington, and Jasmine Ward—have all committed their careers to public health through social justice scholarship, advocacy, and community organizing for the greater good. Below, the members of the editorial team share their reflections about how this new volume contributes to public health work.

Editor Reflections: Collectively Defining the History, Practice, and Planning of Public Health

Race, class, and gender violence impact health outcomes. This disciplinary evidence in public health supports findings in other areas, including women’s studies and higher education. As a prime example, we can consider the widely reviewed, critically acclaimed, and provocatively titled *Presumed Incompetent: The Intersections of Race and Class for Women in Academia* (2012). The editors of *Presumed Incompetent* argue that intervention is imperative to counteract negative results women of color face when sim-

ply striving to operate in a constantly hostile environment: “Mounting public health evidence suggests that chronic stress—like the pressure of being continually misperceived or belittled or having to fight off micro-aggressions—can result in higher levels of hypertension, cardiovascular disease, and coronary heart disease” (Harris & González, 2012, p. 7). In the foreword to the book, Bettina Aptheker (2012) notes, “We are in the university. We are in the labs. We are in the law schools and courtrooms, medical schools and operating theaters. We prevail, but sometimes it is at enormous costs to ourselves, to our sense of well-being, balance, and confidence” (p. xi). As academic women, the editors of *Black Women and Public Health* band together to contribute to the ongoing discussion of scholar-activists dedicated to impacting wellness inside and beyond the academy. If carefully studied, historical, educational, and several other disciplinary models have much to offer public health research and practice.

As the editors demonstrate, these topics include mental health and wellness as a social justice issue (Evans), unpacking social constructs (Wathington), and the right to quality medical and health care (Hinkson). In her chapter contribution as well as her summary reflection, Davis summarizes the meaning of this collection by showing how self-definition is an essential part of self-determination in challenging and changing oppressive systems that maintain health inequality.

Sarita K. Davis: Framing Black Women and Public Health

In March of 2020, a dual public health crisis ravaged Black and brown communities in the United States. A highly contagious and deadly virus had developed through animal-to-human transmission. Called the *novel coronavirus*, the resulting condition was known first as COVID-19 and later as SARS-CoV-2. The second public health crisis that emerged during this same period was the antipolice protests. Protestors took to the streets across the United States and the globe to make their discontent known about the unwarranted police brutality that took the lives of unarmed Black citizens like Tony McDade, Breonna Taylor, George Floyd, and countless other Black people who have been killed at the hands of law enforcement officers. In a CNN podcast episode with Dr. Sanjay Gupta on June 5, 2020, on the two viruses—the pandemic and police violence—Dr. Camara Jones, epidemiologist and former president of the APHA, said that Black people in the United States are at disproportionate risk of sickness and death from both COVID-19 and systemic racism in policing. Jones said, “We have to

protest . . . because we are not okay” (Gupta, 2020). At the heart of both of these public health crises is the long-standing disregard for Black life.

The failure of the federal government under the Trump administration is in large part responsible for the devastation visited upon our communities during this pandemic, from both anemic responses to states’ needs for coronavirus testing, contact tracing, and personal protective equipment and capitalist-driven desires to “reopen” states while the rates of COVID-19 continued to rise—along with the administration’s militarized response to peaceful protestors against police brutality. The result is the indisputable fact that racism must be recognized as a systemic public health issue that requires brutally honest conversations about public health history, policy changes, and practices on a national level.

Historical research like Deirdre Cooper Owens’s work *Medical Bondage: Race, Gender, and the Origins of American Gynecology* documents foundational negative encounters with public health officials. In popular discourse, some associate this history with higher levels of medical mistrust—a particularly devastating consequence in the middle of a pandemic that necessitates prompt medical care and testing. In addition to the complicated history with the medical field, the complicated history of police and community patrols exacerbates public health challenges. The deaths of unarmed Black citizens like Ahmaud Arbery, Floyd, McDade, and Taylor brought many Americans and global citizens onto the streets in protest against systemic racism and police brutality. Amidst great concern and personal risk, protesters took to the streets en masse and showed that masked demonstrations could be very effective in bringing about local and national change in short order.

Still, many health experts are debating the risk of transmission against the need for public protests in light of irrefutable social injustices. If we are totally honest with ourselves, we must acknowledge that people are willing to risk their lives to protest their fears about systemic racism in public health and police brutality. The people have issued a decree stating that they are no longer willing to endure disproportionate mortality and morbidity from police brutality or flawed public health practices that devalue Black lives.

This book, *Black Women and Public Health*, is poised to explore the long and fraught history of systemic inequality and biased treatment of Black girls and women as it pertains to public health in the United States. The historical narrative about racial inferiority has exacerbated discrim-

inatory health care practices, in turn negatively affecting the quality and types of health care provided to Black women. The book contains essays, research, and analyses that serve as a pointed critique on the state of Black women's health in America by Black women scholars, researchers, medical professionals, social workers, and public health advocates who acknowledge America's continuing gendered and racial disparities and advocate for interdisciplinary reforms.

The Public Health Crisis Among Black Women and Girls

The politically charged times in which we currently live demand unprecedented leadership from Black women laboring in and around the field of public health. At a time when Black women are disproportionately experiencing health crises in heart disease, maternal and infant mortality, breast cancer, and HIV, scholar-activism is not an option—it is a mandate (Abdou & Fingerhut, 2014; Earnshaw et al., 2013; Jones, 2000; Wyatt, 1997). The research clearly shows that Black women in the US are in a health crisis. For example, Black women are disproportionately subject to various factors—from poor-quality environments in impoverished neighborhoods to food deserts to a lack of access to health care—that make them more likely to contract life-threatening diseases, from HIV to cancer. Nationally, Black women account for 66 percent of new cases of HIV among all women. HIV/AIDS-related illness is the leading cause of death among Black women ages 25–34 (Centers for Disease Control and Prevention [CDC], 2017). There are also drastic gaps in access to high-quality, culturally competent health care for Black women, meaning the diseases they contract are more likely to be life threatening. While Black women have a lower rate of breast cancer diagnosis than White women, they have a substantially higher rate of mortality as a result of the disease. The breast-cancer death rate for Black women ages 45–64 is 60 percent higher than for White women (CDC, 2016).

Many people assume that the educational gains and the professional statuses of Black women mitigate these health concerns. They are wrong. Advanced degrees and professional success have not translated into good health for Black women. The stress of anti-Black racism and sexism, coupled with the stress of serving as the primary caretakers of their communities, may have taken a toll on Black women's health even if they have the economic privilege to send their children to good schools, have more

professional career options, and live in a wealthy neighborhood. In fact, well-educated Black women have worse birth outcomes than White women who haven't finished high school. Some researchers, like Cooper Owens (2017) and Dorothy Roberts (1997), have concluded that the primary issues plaguing the health of Black women today are linked to the deeply embedded sexist, racist, and discriminatory systems built into the very fabric of this country, including the origins and evolutions of the public health system. These facts place Black women public health scholars and researchers in the crosshairs of the conversation. We are simultaneously researcher and victim, thus making our point of view uniquely qualified to initiate this conversation. In moving forward in framing this discussion, we must address a few fundamental questions. First, what was the foundational goal of public health? Second, how has racism influenced the public health agenda? And third, how is the historical treatment of Black women's bodies linked to contemporary public health issues?

The Origins of Public Health

In the late 1700s, public health emerged as a field of practice and study out of concern for how communities treated and managed contagions threatening the population. The primary goal of public health was to reduce exposure to disease and death among the broad community (Tulchinsky & Varavikova, 2014). The history of public health tells a story about the search for ways of securing health and preventing disease in the population. Epidemic and endemic infectious disease stimulated thought and innovation about how to prevent disease on a practical level, oftentimes before the cause was scientifically identified. The prevention of disease in populations revolves around defining diseases, measuring their occurrence, and seeking effective interventions.

The evolution of public health is based on trial and error and has often involved controversial testing methods rooted in natural disaster, war, and racism. The need for organized public health is anchored in urbanization and social reform. Public health is arguably fueled by religious and societal beliefs, which have influenced approaches to explaining and attempting to control communicable disease by sanitation, civil planning, and provision of medical care (van Brakel et al., 2017). Religions and social systems have also viewed scientific investigation and the spread of knowledge as threatening, resulting in the inhibition of developments in

public health, including the modern examples of opposition to sexual and reproductive rights, immunization, and food security.

Scientific controversies, such as the contagionist and anticontagionist disputations during the nineteenth century and opposition to social reform movements, were ferocious and resulted in long delays in adoption of the available scientific knowledge. Such debates still continue into the twenty-first century despite a melding of methodologies proven to be interactive, incorporating the social sciences, health promotion, and translational sciences, bringing the best available evidence of science and practice together for greater effectiveness in policy development for individual and population health practices.

The evolution of public health is a continuing process; pathogens change, as do the environment and the host. In order to face the challenges ahead, it is important to have an understanding of the past. Although there is much in this age that is new, many of the current debates and arguments in public health are echoes of the past. Experience from the past is a vital tool in the formulation of health policy, especially regarding marginalized populations such as Black women. An understanding of the evolution and context of those challenges as they pertain to Black women can help us to navigate the public health issues past, present, and future.

Racism and the Public Health Agenda

According to scholars, marginalized communities including Indigenous communities, enslaved Africans, women, prisoners, disabled people, LGBTQIA communities, and youth have rarely been included in the broad public health agenda (Washington, 2008). In her book *Medical Apartheid*, Harriet Washington points to pathologic public health responses to two issues affecting the Black community: tuberculosis (TB) in the early 1900s and HIV in the 1980s. In both instances, when poor, gay, and Black people were identified as vectors of the disease, they were treated as a threat of infection to Whites and often as criminals, locked up and isolated in prisons. Regarding the response to TB, Washington says, Whites and Blacks demonstrated different approaches:

In the 1930s and 1940s, African American public-health advocates following in the footsteps of Booker T. Washington promoted such initiatives as Negro Health Week to provide

tuberculosis prevention and care to blacks who rarely gained entrée to quality medical care. But white support of such initiatives was predicated on concerns that the black domestics who cared for their children, cleaned their homes, drove their cars, and prepared their meals might import tuberculosis into white households. (p. 326)

Washington goes on to point out a similar public health response to HIV. While the legal restraints initially applied to gay white men in the early 1980s have been relaxed, they were forcefully applied to Black men in the 1990s. Testing laws are now rigorously applied to pregnant women and prisoners. According to Washington, twenty-nine states punish or incarcerate those who pass the virus on to others. A statement by Dr. Walter Shervington, a New Orleans psychiatrist and former president of the National Medical Association, said of the practice, “It has bothered me that when more punitive laws have come up, it is black people who are affected” (qtd. in Washington, 2008, p. 337).

The pathologizing response to public health issues in the Black community favors criminalization over treatment, further relegating infected and affected people to the margins of inequitable health care. Historically, public health has failed to recognize the social, historical, and cultural determinants of health, thus rendering it silent on issues related to access to medical care and treatment, inequitable economic and human-rights issues, and biases in medical practices.

In 1984, Margaret Heckler, then secretary of the US Department of Health and Human Services, dissatisfied with the way health disparities were being reported to Congress, provided the first comprehensive review of health disparities endured by Black and minority groups compared with Whites; the report laid the foundations for action to eliminate these disparities through health education and promotion and access to health care. One of the most significant outcomes of the 1985 *Report of the Secretary's Task Force on Black and Minority Health*, also known as the Heckler Report, was the creation of the Office of Minority Health (OMH) in 1986. The mission of OMH was to improve the health of racial and ethnic minority populations through the development of health policies and programs to eliminate health disparities. The Heckler Report called health disparities among minority groups an affront to public health ideals and American medicine (Heckler, 1985; OMH, n.d.).

Thirty-six years after the Heckler Report was released, Blacks still endure unacceptable health disparities and lack the power over policy and actions that could enable the changes to eliminate such disparities. We must be willing to challenge the inequalities and racial bias woven into the fabric of public health theory, practice, and policy. Otherwise, the lofty goals of community well-being and equal access for all will never be met. The sheer number of Black women who live below the level of poverty, live in food deserts, have limited access to health clinics, suffer maternal and infant mortality across socioeconomic lines, and have the highest risk of HIV among all women should force us to reconsider and reimagine the public health paradigm.

The Link Between History and Black Women's Contemporary Health Issues

Many researchers exploring the health and well-being of Black women and girls have suggested that there is a link between historical health-related experiences and our contemporary health issues. The race-based mistreatment of Black women is well documented over the four hundred years spanning enslavement, Jim/Jane Crow, the civil rights movement, through contemporary times. The inability of enslaved and freed Black women to exercise agency over their bodies resulted in violence, sexual exploitation, rape, childbearing for profit, medical experimentation, and forced sterilization. Often, the poor treatment Black women experienced was codified into law and public health practices, further disenfranchising Black women from the “common good” mission on which public health was founded.

A CDC report authored by Prather et al. (2018) links the historical antecedents of racism experienced by Black women to current health outcomes. The authors link the historical time periods from enslavement to now, including the personal experiences of Black women that contribute to disparities in sexual and reproductive health, with the parallel health care experiences of Black women over time. The authors concluded that the field of public health must examine the root causes of health inequities from multidisciplinary angles that include historical and cultural lenses in order to address the health inequities affecting Black women.

Black women are frequently referred to as the “conscience” of this country because we know that when the rest of America gets a cold, Black folks get

pneumonia. This book, *Black Women and Public Health*, brings together the knowledgeable but often muted voices of Black women scholars and researchers who have been actively working in the trenches serving the health and medical needs of Black girls and women across the United States. Our goal is to amplify the voices of Black women who through their research and scholarship in health and wellness are seeking equity, dignity, and humanity for Black women and girls nationwide and across the globe.

After hundreds of years of social segregation and discrimination, existing health data confirm that Black women are the least healthy ethnic and gendered group in this country. Although the resources and policies to eliminate disparities exist in the United States, there has been inadequate long-term commitment to successful strategies and to the funding necessary to achieve health equity. Black women have not been in the fiscal nor political positions to assure the successful implementation of long-term efforts; the health of Black women has not been a priority for decision makers. For these reasons, Black women working at the intersection of health and gender need to assume positions of education, mentorship, advocacy, and leadership to lend our voices, experiences, and scholarship to the cause of social justice.

Deanna J. Wathington: Social Constructs, Lived Experience, and Science

Overall, I believe this work provides the opportunity to observe the effects of various social constructs (race, gender, class, etc.) on the health, beliefs, and behaviors of Black women. Even more telling is the opportunity to examine the effects of these constructs as a “prescription” for society and the health system as a whole in their interactions with Black women. In other words, the constructs weave a tale that allows others to feel comfortable in offering health promotion, preventive services, pharmaceuticals, and health care to Black women based for the most part on minimal amounts of correct knowledge and on stereotypes. These constructs have created a story wherein Black women can be seen as “other” and therefore not of the same value. As a physician and public health practitioner, I have often experienced and seen this in real time.

This book provides a space and a place to hear from Black women who are practitioners, researchers, academics, and scientists about how Black women are living within all the aforementioned social constructs and how their health is suffering from all of those constructs. We engage

in discourse about our health experiences and health outcomes and the acknowledgment that we are not a uniform or monolithic group.

The breadth of our voices and our experiences are presented here along with the opportunity to learn through our research, data, and practice. We acknowledge our painful history in this space, meet the myths and fallacies about who we are in this space, and urge the reader to see and understand the reality of who we actually are and can become. We acknowledge and affirm the World Health Organization's (2014) definition of *health* as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” while understanding there is much we and our society must do to achieve that goal for Black women (p. 1).

This book is significant to me because the scope of the contributions within touch and intersect with the practice and research I have engaged for much of my career. Reproductive health, maternal and child health, and LGBTQ health are cornerstones upon which my journey into public health began (these encompassed interpersonal violence and emerging STIs). Over the years, these have been shaped and built upon by the larger connecting pieces of disparities in health status; inequities in care; diversity in the health professions; policy advocacy; interprofessional education; and the social, structural, and environmental determinants of health—all while I have still actively practiced medicine and public health.

My present and future work still sits squarely within the health-equity framework, with a bigger focus on active policy advocacy and development. And I will continue to work tirelessly to increase the presence of our faces and experiences in the health professions through the creation of relevant academic programming and successful graduation and placement of my students. After over thirty years of engaging in such work, I am blessed to have mentored and taught Black women who are now graduates working in various health fields and am comforted by the knowledge that that they are fully engaged in providing the best care to current and future generations.

Leslie R. Hinkson: Ain't I a Woman?

As a Black woman from a low-income immigrant family, I can attest to the glaring differences between the life and opportunities I had as a child growing up in a very segregated Brooklyn and those my three daughters enjoy in a mostly White suburb of Washington, DC. As my life prospects

have improved, so has my environment and the resources I have available to me. This includes my access to quality health and medical care.

I had my first daughter right before starting graduate school. My obstetrician was one of the best in New York. His practice was in the most upscale neighborhood in Brooklyn at the time. However, he was affiliated with a nearby hospital in Brooklyn as well as a very posh one in Manhattan. I chose to give birth in the Brooklyn hospital. I knew it served a largely Black and Latino population, but, given its location in a wealthy neighborhood, I never questioned the quality of care I would receive there. I was wrong. While my doctor was excellent, the nurses who were charged with my care pre- and post-labor were not. While I had never given birth before, I didn't expect I'd be told to be quiet after yelling through my first push. If I were White, would I have been left in the delivery room for over twenty minutes surrounded by what looked like the detritus of battle until a kind custodian found me in there when she came to clean up and informed the nurse that I should be cleaned up and moved to my room? Would that same shushing nurse have brought my dinner to the delivery room where, surrounded by blood and tissue, she insisted that I eat? And when I made it clear that I would not eat in that environment, would she have informed me that I was not being a good mother? I don't know.

I do know that I had my second daughter in Princeton, New Jersey. My second obstetrician was just as great as my first. What differed was where I gave birth. In a hospital that served a predominantly White, affluent clientele, there was no nurse to tell me I couldn't scream as loud as I wanted to considering I was the one giving birth. I was not forgotten as soon as I pushed the baby out and was stitched up. I had a private room. And a volunteer came around every afternoon with a sundae cart! The total cost of both births was nearly identical. The quality of care could not have been more different.

I share this story because while the literature in my field of study helps inform my empirical research, so does my lived experience. As a social scientist, I strive to attain as much objectivity as possible in how I approach my work. As a critical sociologist, however, I also understand that everything down to the way I frame my research question, to the ways in which I conceptualize and operationalize key concepts, and to the way I interpret my findings are all informed by the way I see and experience the world.

One of my primary research interests involves medical knowledge, particularly as it relates to race. Since its institutionalization as a profession in the late nineteenth century, medicine in the US, as a discipline and a practice, has been significantly informed by both the dominant scientific and popular discourses surrounding race of a given time. Even as those discourses change, remnants of scientific racism still haunt medicine. The fact that Black adults and *children* are less likely to have their pain taken seriously and treated adequately in emergency departments nationwide than their White counterparts, the fact that Blacks are still thought to have lower lung capacity than Whites due to some inherent difference—these are two examples of how medical practices and insights, developed by plantation doctors blind to the lived realities of slavery as anything other than beneficial to slaves, are still alive in medical practice today. To what extent have African Americans been under- or overtreated for certain diseases and conditions simply because of their race? To what extent are health disparities the result of structural constraints that determine not just access to and quality of care but kind of care?

As a sociologist, while committed to the use of empirical evidence in uncovering fact, I also understand that the interpretation of fact is reliant on one's lived experience and one's location within our stratified society. These differences in interpretation lead to the creation of different truths. Often, one's position within the social hierarchy determines whether their truth will be believed and embraced. That is why I am so excited to be a part of this volume. Black women in America are often unseen and unheard. This volume promises to add fuel to a small but growing movement in public health that recognizes the value of Black women and their health and wellness but also the value of Black women in leading the charge to improve Black women's health. This volume embraces the truth about Black women's health as written by Black women.

I remember, as a child, seeing the old news footage from the civil rights movement as I watched the documentary series *Eyes on the Prize*. I distinctly remember thinking to myself as so many men carried posters that read "I AM A MAN!" that none of the Black women had posters that read "I AM A WOMAN!" Each chapter in this volume declares in some way, "I AM A BLACK WOMAN!" By imagining a public health that puts the concerns of Black women front and center, by focusing on Black women not as defective Black men or White women but as the standard, the contributors to this volume help us to dream a world in which Black

women are afforded the care and consideration that will allow them to continue being the bedrock of their communities without sacrificing their mental and physical health to do so.

Stephanie Evans: Wellness as a Social Justice Issue

In the CDC's *Public Health 101* lecture series, the instructor, Susie McCarthy (2014), emphasizes that public health focuses on groups rather than individuals, and she argues that "at the core of public health, there is this principle of social justice, that people have the right to be healthy and to live in conditions that support their health." She cites C.-E. A. Winslow's portrayal of public health work as communities organizing to "prevent disease, prolong life, and promote health." I come to public health as a scholar of intellectual history seeking to insert Black women's visions of social justice into how communities are organized. In particular, my research centers Black women's memoir and autobiography as a source of information, evaluation, and planning. While individual responses are not sufficient evidence to create policy, a collection of narrative voices over time offer crucial insight into patterns and changes that can inform research questions and interpretations.

Social justice education is at the core of Black women's educational history and is the heart of Black women's studies. As Gloria Hull and Barbara Smith wrote, the goal of Black women's studies is "to save Black women's lives" (Hull et al., 1982, p. xxxi). It should be evident then, that Black women and public health are intertwined areas of critical race and gender research. Yet, as a survivor of sexual violence, I also have a deeply personal interest in deepening the commitment to social justice work in public health in ways that specifically save the lives of Black women and girls. Numerous memoirs (by authors like Maya Angelou, Tina Turner, Gabrielle Union, and Tarana Burke) demonstrate how personal reflections, when viewed collectively, can and should inform interpretation of public health problems and solutions.

The authors in this collected volume address multiple topics through variant research methods, yet all chapters center Black women's voices, and much of this work is grounded in personal experience. Life narratives as a source of health education that reinforce centering community perspectives in public health efforts and incorporating narrative analysis can certainly increase the efficacy of community interest, awareness, and collaboration. The power of collaborative work can be seen, for example,