CENTER FOR ANTIRACISM RESEARCH FOR HEALTH EQUITY

SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF MINNESOTA

Centering Antiracism to Achieve Reproductive Justice

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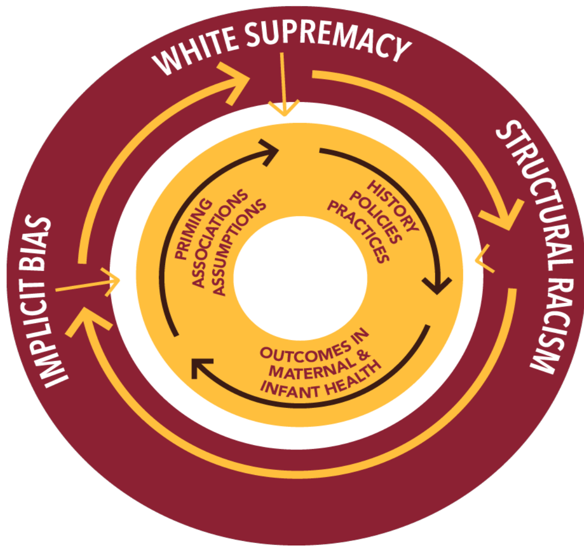
In health research and services, **antiracism** is a revolutionary framework grounded in the understanding that **racism, not race, is a fundamental cause of health inequities**. It explores how **systems**, **policies**, **social structures**, and **historical influences** create the conditions for health inequities rather than placing the responsibility solely on individuals. The approach puts the people who are grappling most with these issues at the center of research design and decision making. Ultimately, antiracism will **produce antiracist research**, **change narratives**, **inform equitable policy solutions**, and **influence community interventions**.[1]



The Root of the Problem[1]

- **Racism**, not **race**, is the root of racial inequities in reproductive health.
- Racism and **white supremacy** were adopted as a means of justifying slavery.
- For over 400 years white supremacist ideologies have shaped the cultural beliefs, institutional and systemwide policies, and interpersonal rules and behaviors. This has created and continues to create unfair advantage for white people and corresponding unfair cumulative and chronic disadvantage for Black communities.

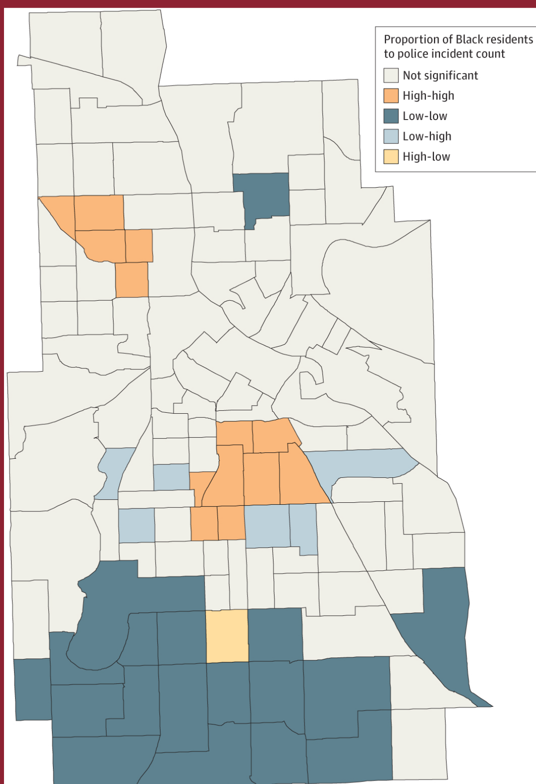
Measuring the Problem: Antiracism in Data Analysis[3]

PREMISE: We developed a **Multidimensional Measure of Structural Racism (MMSR)** by consolidating five unidimensional measures of structural racism (including Black-white residential segregation, inequities in education, employment, income, and homeownership) evaluated at the Public Use Microdata Area (PUMA) using a latent class model.

FINDINGS: We identified three PUMA classes, each representing a multidimensional structural racism profile. Our research offers a new approach to measuring structural racism as a multidimensional determinant of health.

MEANING: Evaluating population health patterns by unidimensional measures of structural racism may not be able to capture the interaction between dimensions and their joint effects on health. Structural racism is complex and multidimensional, so our analyses need to be too.

Spatial Autocorrelation for the proportion of Black residents and police incident count by census tract in Minneapolis, 2012 to 2016



Antiracist Research in Action: Policing & Preterm Birth[4]

PREMISE: Police contact may have negative psychological effects on pregnant people, and psychological stress has been linked to preterm birth. Existing knowledge of racial disparities in policing patterns and their associations with health inequities suggest redesigning public safety policy could contribute to health equity.

FINDINGS: In this cross-sectional study of 1059 Minneapolis residents who gave birth to a live singleton in 2016, the odds of preterm birth (i.e., birth before 37 weeks gestation) for pregnant people living in a neighborhood with high-police-presence was significantly higher compared with the odds of their racial counterparts in a low-police-presence neighborhood (90% increase for White individuals, 100% increase for US-born Black individuals, and 10% for Black individuals born outside of the US). Secondary geospatial analysis also found that the higher the proportion of Black residents in the neighborhood, the greater the number of police incident reports.

MEANING: Greater police presence in Black vs white neighborhoods may contribute to the persistent Black-white preterm birth disparity in Minneapolis. Racialized police patterns borne from a history of racism in the United States may contribute to racial disparity in preterm birth.

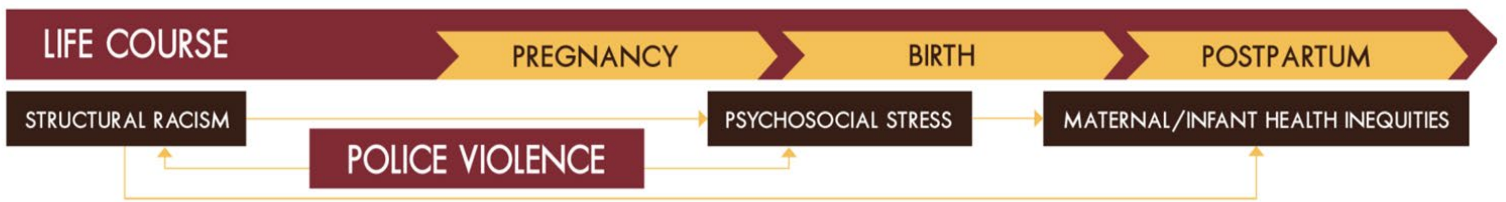


FIGURE 7: Police Violence Conceptual Model; developed by Dr. Rachel Hardeman and Dr. Maeve Wallace

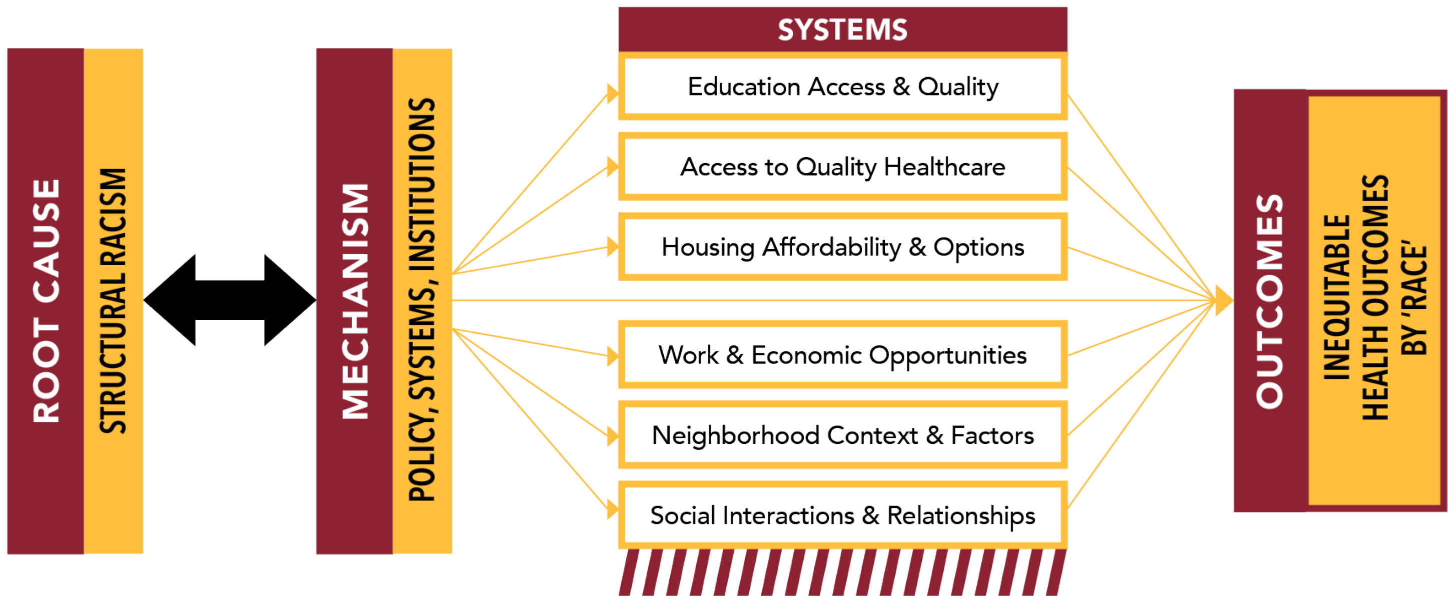
Antiracism in Models of Care

Structural racism creates unfair barriers to resources, opportunities, and power for Black people. For a Black birthing person, the physical burdens of structural racism begin before they are even born and continue throughout the life course. Health professionals can help counteract the burdens of structural racism with **antiracist models of care**.

CENTERING CULTURE: Research conducted in partnership with the Minneapolis-based Roots Community Birth Center (Roots) demonstrated that culturally- and relationship-centered care improves health outcomes for Black birthing people and their babies.[6] Cultural identity is an *asset*, not a liability, for Black birthing people, and centering culture in care has been shown to increase feelings of respect and autonomy for Black clients.[7]

DESEGREGATING THE WORKFORCE: Research analyzing births in Florida found that Black babies die less often when they receive care from Black physicians.[8] Steps towards desegregating the workforce—including antiracist hiring and retention practices, investing in diversity in education and training, and reforming racist institutional policies—could benefit Black people receiving care.

ANTIRACISM AS A CORE PROFESSIONAL COMPETENCY: Health service providers and researchers must consider antiracism as a core professional competency.[1,2] Structural racism impacts intersecting institutions, affecting where Black people live, work, play, and age. Health professionals must center this context when providing care and creating policies.



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