Liberty University

Changing the Narrative: Developing Evidence-Based, Communication Strategies to Address Health Disparities of Black Women in the United States

A Dissertation Submitted to
the Faculty of the School of Communication
in Candidacy for the Degree of
Doctor of Philosophy

by
Emmerline Francesca Nelson-Rogers

Lynchburg, Virginia
04/2024

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Abstract

Black women experience health issues at disparate rates when compared to their racial counterparts. Although these health disparities can be linked to health behaviors, they are deeply rooted in historic, racial systems that govern our lives today. More often than not, changes in health behaviors are at the forefront of addressing these health disparities rather than historical health trends of Black women in the U.S. This study aims to discuss why the change needed is a change in the narrative for why these health disparities exist and persist as well as a change in narrative about the role Black women have historically played in their health planning and the role healthcare providers play in persistence of these disparities as well.. The goal is to develop evidence-based communication strategies that will improve health outcomes for Black women.

Keywords: Black women, health disparities, health behavior, health outcomes, communication

Dedication

First and foremost, I want to give thanks to the awesome God that I serve! Whenever I sit and think about how good God has been to me, I look up to Him and cry. The God that I serve gave me the physical and mental strength and guidance that I needed on my journey to achieving a PhD. The God that I serve sat with me as I struggled through late nights and filled my mind with good thoughts when I doubted myself. The God that I serve showed me that this day would come. And here we are!

This study is dedicated to all Black women and girls. Especially the women who contributed to this study by sharing lived experiences with the U.S. Healthcare System and healthcare providers, thank you for your vulnerability. Your testimonies are powerful, relative, and hold the key for understanding about the state of Black women's health in America as well as understanding about how best to address disparities. I am forever grateful for you. This study could not have been completed with you. For far too long our voices have been ignored and have gone unheard. The narrative of the Black woman has been determined by social norms and institutions that influence inequitable health outcomes for our people. We must change the narrative.

To my parents, Louisa Nelson Rogers and Emmanuel Rogers, thank you for your sacrifices and support. I pursued this degree for you. We settled in the United States in the 1990s as refugees. We came here with nothing but you managed to give us, all of your children, the world. From an early age, you instilled the importance of education in your children and gave us the autonomy to explore career paths aligning with our passions and skills. Words will never suffice to express how thankful I am for you. There would be no me without you; literally. Mommy, we almost lost you last year. When you were on life support, daddy and other members of the family often reminded me that you would not leave this world without seeing me graduate and enjoying life as a grandma with my children. So this is 1 for 2!

To my siblings, Abegirl, Eugenic, Dream, Kim, Young, Emmanuel Jr., and Chase, thank you for being my biggest cheerleaders through this journey. Mommy and daddy have always taught us to love, care for and respect each other as siblings and have created spaces for us to foster close and authentic relationships. The love, care, and respect we have for each other is unmatched and I pray that we only continue to grow stronger as a unit.

To my Aunt Shelah, my mother's oldest sister, you may not have birthed me or my siblings but you have always considered us to be your own. Thank you for sharing your life and heart with me. Thank you for believing in me. Thank you for supporting me. And thank you for always being there, no matter the circumstance. May God continue to bless you and pour back into you all that you have poured into us!

To my first cousins, Arthur, Gregory, Lovetta, and Samara, thank you for the invaluable guidance, love, and support. We were raised as siblings and continue to regard each other as such. We often discuss our goals and dreams and hold each other accountable to the heights we talk about achieving. This was one thing I talked to you all about and I hope I made you all proud!

To my sister-friends, Akila, Alexis, Lisa, Maxlyn, Olayinka, Osayi, Salmaha, and Trisha, I do not know where to start! I met you all at different junctures of my life and you became the friends that I never knew I needed. There is no mistake to God's timing and alignment. I suffered mentally and emotionally from childhood traumas, such as rape and suicidal ideations, and you all stepped in and helped me in understanding that my traumas did not define me. You are irreplaceable and I am looking forward to more years of sisterhood, traveling, and more godchildren!

Last but not least, thank you to my village. There are too many names to mention in this short paragraph. Nor can this short paragraph capture the true essence of the amazing people I have in my corner. My village nurtures me. My village clothes me. My village feeds me. My village shelters me. My village celebrates me. My village supports me. And, most importantly, my village prays for me. You know who you are!

Acknowledgements

My journey to joining the estimated 4% of Black women PhD holders proved to be challenging, but not impossible. Dr. Kami Anderson, I could not have asked for a better chair to journey with me. Requesting you was no coincidence. My research focuses on the health of Black women in the United States and relativity and views from an afro-perspective are essential aspects of this dissertation. You are a brilliant thought partner, genuinely encouraging, and highly informative. There are lessons learned from you that I will carry for the rest of my life! Thank you for making this a positive experience for me. There were many moments that I thought about giving up because I stopped believing in myself. Yet, you never stopped believing in me. Although this journey has come to an end, I pray that we maintain contact and co-write one day!

I would also like to thank the other members of my dissertation committee; Dr. Carol Hepburn, Dr. Richard Previte, and Dr. Robert Mott. Thank you for your prayers, diligence, and willingness to ensure all students in the PhD program produce quality work. Your feedback is never anything short of invaluable and has always driven me to dig deeper. I pray that we remain in contact as well.

Just as we begin every meeting with prayer, I'd like to begin this dissertation with prayer. *Lord, we did it! The road was rough and the journey was long but it was well worth reaching this destination. Thank you for the beautiful spirits you planted in my life who supported me and cared for me through it all. Thank you for your presence and your grace which is reflected through how wonderful you have been in my life. As I continue to grow and put my studies into practice, I pray that I remember why I started this research and connect with the people I started it with because it/they are a part of the foundation of where life takes me from here. In your name I pray… Amen!*

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Chapter 1: Introduction

Background[1]

In the early morning of Monday, December 28, 2020, I received a call from my cousin, Darte Lamptey. Hysterically crying, she struggled to utter the words “Korkor is gone.” Odakor Gloria Lamptey, affectionately referred to as “Korkor” by family and “Coco” by friends, was a 37-year-old bright soul who, as mentioned in her obituary, “was always a source of positivity for her many family members and friends and always remembered your birthday.” In 2012, Korkor won her battle with non-Hodgkin's Lymphoma and developed an affinity for life. She was passionate about giving back to her community through leading fundraising efforts with the Leukemia & Lymphoma Society (LLS) and volunteering at Memorial Sloan Kettering in Cancer Center and Dalton High School, her alma mater. Korkor also loved learning about and experiencing new cultures, visiting nearly 40 countries.

Two days before Christmas of 2020, Korkor alerted parents and 3 siblings of a high fever and body aches but asked that her family not be alarmed. Initially, everyone thought Korkor had contracted COVID. Adversely, unsure of what she had, Korkor was afraid to go to the hospital because she was in remission from cancer and high risk of COVID contraction.

Korkor’s fever shot up to over 100 degrees on Christmas Eve. She was unable to eat and had trouble relieving herself. Although Korkor’s uncertainty about her condition continued to fuel her unwillingness to allow her family to visit her at home, her sister went to care for her in her Manhattan apartment. Korkor ate little bites of food here and there but was still unable to eat a full meal.

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[1] Typically the background section is a third-person account of the importance of the research, however, personal narratives in ethnographic research give life to the body of work by providing context to the specific topic of focus (Arnault et al., 2021).

Her father planned to travel to his home country, Ghana, on Christmas day but considered canceling his flight to be there for Korkor. However, she urged her father to go, saying "I'll be fine."

On Christmas day, her father left for Ghana and Korkor's fever began to subside. She had taken Tylenol and seemed well. She was talking and coherent. The family was even more convinced that Korkor had COVID and would get well soon. Korkor asked her sister to go be with the rest of the family at their parent's home for Christmas. Her sister believed that Korkor would be okay and left for their parent's home.

The day after Christmas, Korkor called her mom crying. Her body pains had become unbearable. She was unable to walk and experienced uncontrollable bowel and urinary movement. Her mom insisted on going to care for her daughter but once again, uncertain of her condition, Korkor did not want to put her mom at risk. Another one of her sisters decided that she should be the one to go and care for her sister. She worked in a hospital setting and was aware of COVID protocols when dealing with someone who may have contracted the virus. When Korkor's sister asked how she was feeling, she replied "Imagine working out for a month straight and not stretching."

Korkor called her primary doctor to make her aware of the pain she had been experiencing but learned that her primary was not in town. The on-call doctor ordered a COVID and flu test for Korkor from the lab associated with the healthcare facility where Korkor received cancer treatments. Her sisters accompanied her to the clinic where they used a wheelchair to get their sister inside. The clinical physician who attended to Korkor swabbed her nose. That was the treatment. Nothing was ruled out because the on-call doctor did not order any other tests. No blood drawn, no analysis, no questions asked, nor were considerations made despite Korkor's health record and underlying health issues listed in her chart. Both the COVID and flu tests returned negative. She was prescribed naproxen sodium for the pain.

Korkor's sister recalls her making jokes about all of the potholes they drove over on their way back to her apartment despite the body aches she felt. The sisters laughed all the way home. Korkor's sisters and boyfriend helped her upstairs where she was able to drink a bowl of soup. She then joined a telehealth chat with the on-call doctor and explained all of the symptoms she had experienced over the past few days. The doctor's response was "We will assume your COVID test result is a false negative." Korkor's sister left to pick up the prescribed medicine but the pharmacy was closed. That night, Korkor's sisters told her they loved her and left. The next morning, Korkor's boyfriend picked up the medication from the pharmacy and gave it to her. He stayed with her all day. When Korkor's family tried reaching her she expressed that she needed to be left alone so that she could rest. Korkor's sister recalls her sister sounding "out of it". Darté expressed to her family that she did not believe Korkor was experiencing COVID symptoms. "I've seen COVID." Darté said.

Korkor's boyfriend called her sister after midnight to let the family know that Korkor's breathing had become very faint. He called EMS to transport her to the hospital. When EMS arrived, they knew Korkor would not make it. Korkor passed away around 4 am on December 28, 2020. The autopsy revealed that her death was due to kidney infection. Her white blood cell count was way below average, disabling her body from fighting off the infection. Korkor suffered cardiac arrest due to the kidney infection spreading to and poisoning her blood - known as sepsis. According to the Center for Disease Control and Prevention (2022), "Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body.

Infections that lead to sepsis most often start in the lung, urinary tract, skin, or gastrointestinal tract. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death" (para, 1). Although Korkor met with a doctor a few months prior to her death, the infection was either non-existent at the time or never caught. However, when she visited the clinic, results from a urine test could have detected the kidney infection.

Williams et al. (2019) argues that there are racial inequities in health pertaining to access that one may have to quality healthcare. Although race is not the sole determinant of fair healthcare treatment, it is important to note how race can play a detrimental role in human interaction. This issue will be discussed later in this dissertation. The on-call doctor was a White woman who was described as "disinterested". The clinical physician was Hispanic and, if she had just listened to Korkor and done additional, normal tests or even consulted medical records before prescribing medication, Korkor would be here today. Korkor's primary physician, a White woman, reached out to the family upon return from vacation. She expressed confusion because Korkor's underlying health issues were included in her chart. She also informed the family that naproxen, Korkor's prescribed medication, can cause damage to the kidney.

Research shows that doctors have poorer communication with patients of underrepresented groups than with others (Ashton et al., 2003). Butler and Sheriff (2021) highlight how poor communication is failing the healthcare system and point out Black women, especially as the marginalized group, experience poor communication during interactions with healthcare providers as they are *talked at* rather than *talked with*. "Talking at someone" refers to the lack of exchange of ideas or a conversation with the other person and can imply a lack of consideration for the thoughts and opinions of the other person(s). "Talking with someone" refers to mutuality in a conversation between one or more people. DeAngelis (2019) offers that poor communication may lead to inadequate levels of care for patients and, subsequently, distrust in the healthcare system. This study will link health communication to the factors that contribute to health disparities faced by Black women in the United States. As defined by the Centers for Disease Control, health disparities are “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.” The CDC acknowledges social determinants as factors influencing health disparities. For this study, health disparities faced by Black women at disproportionate rates will acknowledge social determinants at a systemic level by addressing racial institutions linked to Black women’s health disparities. As defined by the Centers for Disease Control (2017), health disparities are “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.” The CDC acknowledges *social determinants* as factors influencing health disparities. For this study, health disparities faced by Black women will acknowledge social determinants at an individual and institutional level by addressing racial institutions linked to Black women’s health disparities.

Health communication is a specific focus within the study of communication. According to the Society for Health Communication (2017), health communication can be defined as “a multidisciplinary field of study and practice that applied communication evidence, strategy, theory, and creativity to promote behaviors, policies, and practices that advance the health and well-being of people and populations.” However, although health communication refers to improving health outcomes, it fails to account for inequitable, racial, and systemic implications that lead to miscommunication of information (Ishikawa & Kiuchi, 2010). Systemic oppression, including intersectionality of race and gender, nurtures inequitable experiences that result in disparate health outcomes for Black women in the United States. Bekalu (2014) notes that there is a link between communication inequalities and health disparities. Communication inequality, as defined by the National Cancer Institute, refers to "differences in individual or group-specific exposure to health communication messages and in the capacity to access, process, and act upon the information received." Inequality, the lack of equality in status, rights, and opportunities, is a communication issue. Williams and Rucker (2000) offer that "racial disparities in medical care should be understood within the context of racial inequities in societal institutions." The socialized misrepresentation of Black people influences a narrative of inferiority and contributes to unfair treatment and unfair access to improved health opportunities. The term "exacerbate" can be simply defined as a factor that worsens an already undesired condition. This study is positioned to challenge and change the scope of health communication by telling the chronological story of Black women's health in the United States, highlighting trends of surface-level resolutions that fail to adequately address root of the issue, the inequitable experiences of Black women that fuel the persistence of health disparities, and creating a new narrative based on the evaluation of lived, healthcare experiences of Black women in the United States.

Situation to Self

I am a Black woman who was misdiagnosed by a healthcare provider because my pain was considered "normal". What I did not understand at the time was that my pain was considered "normal" because of my race and gender. At 11-years-old I experienced my first menstrual cycle and the trauma that oftentimes accompanies it. Menstrual cramps disrupted my everyday life, causing excessive saliva, vomiting, constipation, school absence at least once a month, and visits to the emergency room. At 16-years-old, I began *begging* doctors to conduct more comprehensive exams to find the cause(s) of my severe menstrual cramps. For years, I was advised that menstrual cramps are inevitable and that I needed to learn how to live with it. In fact, I was often prescribed birth control for pain which ultimately led to weight gain and an irregular menstrual cycle. At age 20, when I graduated from college, I became more intentional about seeking the opinion of a Black, female gynecologist (GYN). A GYN is a doctor who specializes in female reproductive health. Ironically, my general physician's office brought in a Black, female GYN. During our first appointment, she informed me of the susceptibility of fibroids as a Black woman. She sent me to get an ultrasound which later proved that I had three uterine fibroids. According to the Center for Women's Health, menstrual cramps can be worsened by the presence of uterine fibroids. Uterine fibroids are growths in women of a childbearing age (U.S. Drug and Food Administration, 2023). Eltoukhi et al. (2014) found that "African ancestry is considered a key risk factor for the development of fibroids" (pp 2). Since the diagnosis, I have taken necessary steps to ensure my fibroids are monitored. My current GYN advised that I not worry about putting my body through surgical removal of the fibroids because they are small in size. She encourages health eating and taking a pain relief tablet before menstrual cramps start to avoid having to take more tablets once the pain starts. Although I see a new GYN, she too is a Black woman who speaks to me from her knowledge and proximity to Black women's health.

Although I have long been conscious about health disparities facing Black women in the U.S. through stories of misdiagnosis and fatalities, Korkor's story ultimately served as the catalyst to this research. It was through Korkor's story that I came to the realization that my own story is a part of *the stories* of Black women across our nation that have resulted in health disparities faced by Black women in the U.S. However, these stories do not begin and end with the healthcare experience. These stories begin with the social and systemic conditions and racial individual and institutional interactions, from the days of slavery, that have led to negative health outcomes for Black people in this country. And in Korkor's story, and the stories of countless of Black women, their ending was fatal. These women left us with a legacy and with a chance to speak up. And that is what this research is about.

I discovered plentiful research targeting the rate of individual health disparities facing Black women in the United States along with literature targeting negative health behaviors contributing to these health disparities. However, there is little to no research that targets the root of the existence and persistence of health disparities facing Black women in the United States beyond healthcare experiences nor solutions that target the root of the health disparities. This study will employ the ethnographic design to uncover how the lived experiences of Black women interviewed can be linked to historical research about this issue and, furthermore, lead to evidence-based communication strategies for addressing health disparities faced by Black women in the United States.

Overview

Communication can be simply defined as the exchange of information, ideas, and emotions. It is a means of interaction and connection in interpersonal relationships between two or more people. The earliest forms of written communication can be traced back to the BC era (Schmandt-Besserat, 2014). The oldest known form of written communication is cave paintings by early humans, also known as cavemen, of the prehistoric time (Little, B., 2021). With rocks and minerals, cave walls were painted as a means of expression of feelings and daily activities. For example, drawings of animals, animal routes, and hunting techniques depicted their livelihood of hunting. Over the years, the rise of technological advancement innovatively changed how information was transferred (World Economic Forum, 2020). Learning from the contributions of American philosopher Walter Ong (2012), the evolution of communication from early forms of written information to primary orality, speech and written forms of communication, to literacy, use of vocabulary, and then later to second orality, the preservation of speech and written forms of communication, serves as a framework of knowledge exchange today as there is now an inclusive approach of traditional and modern methods of communication (Ong, 2012, p. 57). These shifts in communication are a testament to change that compliments the evolution of time.

Adler and Roman (2021) emphasize the importance of understanding human behavior in communication processes and how communication studies integrate knowledge from both communication and behavioral science disciplines. With time, communication became more than just the simple act of information exchange but included the effectiveness of this exchange of information through communication studies. Communication studies combine human communication and human behavior to uplift *understanding* as an important part of information exchange (Malikhao, 2020). Through this lens, this study not only considers information exchange through the expression of feelings and informing of daily activities between cavemen but can see the complexities of information exchange through predicting how each caveman may have mapped out different animal routes based on hunting experience, how competition may influence hunting technique support between cavemen, and even how hunters interacted with marginalized subgroups who were not allowed to hunt.

Relevant to health communication, the Hippocratic Oath, established by Greek physician and philosopher Hippocrates, was a promise to ethical medical practice recited by graduating medical school students (Hajar, 2017). It was the standard for patient care. According to Miles

(2004), although there is no exact proof of when the document was written, a reasonable estimate is 400 BCE (p. 18). The opening of the Oath, "I swear by Apollo the physician…" (National Library of Medicine, pg 2) sets a basis for logical thinking in medical treatment (as Apollo is the god of reasoning) and implies the inhabited values of healthcare providers and the moral culture of the practice of medicine. However, its stance in regards to slavery and modern-day women's reproductive care is antithetical to adequately addressing the health needs of Black women in particular. Yet, it served as the precedent of expected accountability and moral responsibility of healthcare providers to their patients and was the foundation of what is understood to be health communication today (Weiner, 2018). Until the late 1990s, the Hippocratic Oath served as an imparting of information related to ethical patient interaction based on values healthcare providers were expected to have. In 1973, the U.S. Supreme Court dismissed the oath as a guide to medical ethics and practice. It was stated that the oath was "incapable of covering the latest developments and methods of medical practice and research" (Indla & Radhika, 2019, p. 775). According to the Association of American Medical Colleges (AAMC), although the original language in the Hippocratic Oath is not used today, medical students recite a range of oaths of ethics. However, this notion of reasoning and logic to what is deemed ethical remains subjective because of human behavior and the individual values and beliefs of healthcare providers.

By the mid-1900s, efforts to improve health communication in the United States prioritized targeted provision of educational materials promoting healthy lifestyles to marginalized communities (Nutbeam, 2000). However, this form of health advocacy failed to address the root influences of health issues in the United States that led to unhealthy lifestyles in marginalized communities. For example, let us consider environmental justice. The U.S. Environmental Protection Agency (2024) defines environmental justice as "the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment". Yet, food apartheid exists and refers to systemic disparities in access to healthy and affordable food based on race, income, and geography (Forsythe, 2022). It acknowledges the deliberate structural inequalities and discriminatory policies that contribute to unequal access to nutritious food. It highlights the intersection of race, class, and geography in shaping food access and emphasizes the need for community-driven solutions to address systemic inequities in the food system (Forsythe, 2022). Chapter 2 delves deeper into health disparities specific to Black women, including obesity, diabetes, and heart disease, which can all be linked back to food intake. Health inequities can give rise to health disparities (Graham, 2004). Health disparities are a result of inadequate access to healthier foods and/or living conditions and are exacerbated by racial systems and social structures.

Although providing Black communities with educational materials to promote healthy lifestyles was acknowledged as an attempt to address health disparities with this population, it failed to address the systemic and racially rooted foundation of health communication and why it continues to fuel health disparities (Bryan & Austin, 2018). Imagine sharing literature that educates on healthier food alternatives to people who lack access to or are unable to afford healthier foods. Imagine sharing information about the importance of daily exercise and self-care routines with people who work odd hours. Imagine suggesting regular medical check-ups to people who do not have adequate health insurance or who need to prioritize funds for groceries over a copay. Imagine the response to the provision of health literature to groups with distrust in health institutions.

It was not until the emergence of behavior change theories in the late 1900s that health advocacy became explicitly inclusive of social and economic factors contributing to health behaviors (Drenowski & Specter (2006). Theories of behavior change provide explanations for changes in human behavior (Davis et al, 2015). Such theories are the theory of planned behavior, social learning theory, and the health belief model theory. The theory of planned behavior, a cognitive theory developed by Icek Azjen in 1991, links belief to behavior to predict and understand the change in and intention of behavior. Social learning theory, developed by Albert Bangura in 1977, considers environmental factors like observation and imitation to behavioral change. The health belief model theory, developed in the 1950s by social psychologists Godfrey Hochbaum, Irwin Rosenstock, and Rosenstock and Kirscht, accounts for the cognitive processing of decision-making regarding health behavior. Although these theories move closer to improved interventions for addressing public health issues, I found that these theories failed to address the systemic and racially rooted foundation of decision-making. They, inadvertently, hold people accountable for behaviors that are linked to historical, systemic injustices that influence how people communicate or respond to their environment and their *behavior*.

Existing research identifies systematic oppression, bias, and unequal treatment of Black women as correlators to disparate health issues affecting this population (Braveman et al., 2017). Racial differences in education, employment, and area of residence are among the demographics that cause segregation and discrimination. In the United States, Black women experience health issues at a disparate rate. These disparities persist because inequality exists. As previously stated, inequality is a communication issue. The exchange of information, ideas, and emotions can result in the highlighting of differences amongst people. Our knowledge and emotions are linked to our past, present, and future interactions. What humans learn and/or experience can cause the biases that fuel inequality today.

Gaps in Research

Strides are being made in the growing awareness of this issue and advocacy efforts to create policy change to put Black women and girl's health issues to the forefront. There is extensive research regarding the great contributions of health communication in shedding light on the root causes of health equity and health disparities of Black women. Existing studies also focus on individual health disparities faced byBlack women, preventative methods, environmental and social catalysts of these health issues, bias in datasets, and cultural competency training of healthcare providers. Yes, understanding preventative methods for environmental and social catalysts of health issues is a strategy to address these disparate health issues faced by Black women in the United States. This includes raising awareness of the environmental and social factors that influence the health disparity of Black women and the racial roots of the disparity as well. Concerns of individual health issues that disparately affect Black women are important to the linkage of historical findings and present outcomes to identify trends of these health issues and why Black women are disparately affected (Chinn, 2021). Ultimately, there is a domino effect of racial history, environment, health issues, and inadequate treatment or care.

Unveiling bias in current data can provide adverse guidance for effective data collection moving forward. That is, current data can be used to help identify gaps in research by considering research from a different lens (Nyanchoka, 2020). Instead of solutions based on the rate of the disparity, solutions should be based on the root of the disparity which goes beyond the realm of specific health concerns and is inclusive of a historical, racial system of inadequate health treatment of Black women. Understanding that although cultural competency training of healthcare providers is important, it straddles the fence of unwillingness or disinterest among some practitioners to learn about susceptible health conditions of different cultures or ethnic groups or even implementing learnings during real-time interaction with patients because of the learned behavior of the healthcare provider. However, most importantly, there is much need for a communications lens that changes the narrative of the Black woman by providing historical context and of Black women's health and honoring the voices of Black women prior to tragic events resulting from an encounter with the healthcare system. Our findings and themes from the stories of women interviewed for this research will show what this line of communication should look like and what the new narrative should be.

Problem Statement

Health disparities of Black women in the United States exist because of racial and social constructs but persist because of a communication issue. Data about health disparities of Black women are considered without a deeper look at the historical context of Black women's health in the United States and the voices of Black women and their experience with our healthcare system and healthcare providers today. The health concentration of the field of communication is used to understand, explain, and predict health beliefs, attitudes, intentions, and behaviors of patients and healthcare providers. The ultimate goal is to improve quality of life. Yes, promotional health materials are verbal and nonverbal means of health enhancement of individuals and communities and are critical to advancing solutions in health care and public health. However, the field of communication strengthens the act of health promotion by compelling researchers and curriculum developers to take a deeper look at *understanding* as a barrier to the effectiveness of health-related promotional material. This is why health communication also considers the ability of healthcare providers and advocates to understand barriers attributing to health disparities and lack of health knowledge as well as barriers influencing personal health choices as structural supports for developing promotional health information and for health interactions as well. It is imperative to highlight these barriers and *change the narrative* attached to Black women and Black women's health in order to develop the comprehensive strategies needed to address the issue of health disparities of Black women in the United States. Focusing on the healthcare provider lens, and response to the racial root cause, health disparities of Black women in the United States can be linked to the cultural incompetency and cultural insensitivity of healthcare providers working in the United States healthcare system. Cultural competence and sensitivity refer to communication between the healthcare provider and patient where the healthcare provider understands and considers sociocultural contributions to healthcare disparities of their patient during treatment (Stubbe, 2020). Such socio-cultural contributions can be environmental racism and the implicit biases of healthcare providers that greatly influence health communications between themselves and their patients. Acknowledging and understanding these factors is equally as important as being able to manage communication with patients during treatment despite personal feelings, values, and experiences of the healthcare provider as well as understanding the root systemic causes as well.

Purpose of Study

The purpose of this study is to develop evidence-based, communication strategies to address health disparities of Black women in the United States. There are three phases in which these evidence-based, communication strategies will be developed. First, the chronological story of Black women's health in the United States will be explored to clearly identify and define paradigms and outcomes of these health disparities and highlight lineal consideration of why health disparities in Black women exist. Second, an analysis of existing data will be done to highlight trends of resolutions that address root, inequitable experiences of Black women and subsequently fuel health disparities (as explored in the *Overview* section). Third, Black women will be interviewed and their stories, about their healthcare experience(s), will be used to create a new narrative of Black womanhood and develop evidence-based, communication strategies to address health disparities of Black women in the United States.

Research Questions

It is believed that racism is a fundamental source of racial/ethnic disparities in health and poor health outcomes for racial/ethnic minorities (Williams et al., pg 106). Race has long been an indicator of character traits, privilege, freedom, access and opportunity. Race is an important component to this body of work because it provides both a quantitative, types of race, and qualitative, racial experience, measure of understanding disparities faced by Black people as a whole but Black women specifically. A disparity can simply be defined as an unfair difference. From a historical standpoint, racism has long been a belief that human traits and capacities are determined by skin color. It creates a divide and reserves privilege, freedom, access, and opportunity for the "superior" skin color. Colorism refers to treating people unfairly and discriminating against them because of the color of their skin. It is "rooted in and perpetuates White supremacy and racism by privileging and upholding Eurocentric beauty standards. Eurocentric physical features (e.g., lighter skin, narrower nose, straighter hair) are afforded greater value and considered more desirable than Afrocentric physical features (e.g., darker skin, broader nose, more coarse hair)" (Comrie et al., pg 74). American writer and civil rights activist, James Baldwin, once said, "The reason people think it's important to be White is that they think it's important not to be Black." Race is the common denominator between slavery, the civil rights era, and unfair policies and practices that determine social conditions and lead to disparities today. These policies and practices are rooted in the racial foundation of this nation and thrive through human exchanges, determined by skin color and in social structures.. The phrase “The System Isn't Broken. It's Working Exactly As Intended", or variations thereof, is a common phrase in conversation about disparities within the Criminal Justice System but is also relevant to how race plays a role in all systems. According to the Vera Institute of Justice, low-income communities of color experience greater rates of arrests and incarcerations due to the disproportionate racial impact of certain laws and policies as well as biased decision-making by actors in the judicial system. According to the U.S. Government Accountability Office (2020), racial composition of the highest poverty schools was 80% Black or Hispanic. An article from the Economic Policy Institute reported that Black workers are twice as likely to be unemployed as White workers (Williams and Wilson, 2019).

There is a consistency in data and narratives that highlights the role that race plays in systemic and social structures today. It is no coincidence that marginalized groups continue to experience inequitable outcomes and access to opportunities. Race matters because color, culture, religion, racism, and the intersection of gender as explored in chapter 2, has long constricted the wellness of and regard for the health of Black women and is embedded in health communication that causes health disparities of Black women to persist. R The following questions guide research to effectively describe the connective tissue between Black womanhood in the United States, the relevance of Black womanhood to how Black women are seen and communicated with, and the result of health disparities of Black women in the United States.

RQ1. What are the root and current exacerbators of health disparities faced by Black women in the United States? What are these health disparities?

RQ2. Why is the communication lens essential to unveiling historic and existing methods of addressing exacerbators of health disparities faced by Black women in the United States?

RQ3. How can existing data and shared experiences be leveraged to develop evidence-based, communication strategies to address health disparities of Black women in the United States?

The first question guides the exploration of health disparities faced by Black women in the United States and provides perspective into why these health disparities continue to persist. By identifying the exacerbators of the persistent health disparities faced by Black women, this study will establish a clear picture of the issue by filtering the target population from the general population to highlight disparities. This study will then further the argument by highlighting the effects of these health concerns to create an arena of importance and need for action to remedy this issue.

The second question introduces the role of communication, specifically health communication, in the persistence of health disparities faced by Black women in the United States. The main argument is that evidence-based, communication strategies addressing health disparities of Black women in the United States do not exist and can not exist without effective health communication, specifically through interactions with healthcare providers. The goal of health communication is to enhance health through communication strategies. Delving deeper into root issues of health disparities faced by Black women will assist in identifying key players, creating a timeline of efforts to enhance health for this population by bringing relevant social, economic, and political communication to the forefront and considering health outcomes of Black women as a result of these efforts.

The third question aims to identify patterns between historical and present contexts and establish a connection between root and current issues of health disparities faced by Black women in the United States. This will be done through a scour and analysis of existing research and through themes collected from interviews focusing on the lived experiences of Black women.

Limitations

Research limitations refer to weaknesses within the study design that may affect results and conclusions. Limitations to consider here are researcher bias, sample size, time consumption, confirmation bias, and lack of existing research. Researcher bias occurs when the researcher's beliefs or expectations influence the research design or data collection process. The researcher’s proximity to the targeted population and research topic are flagged for researcher bias. It is, however, important to regard the concept of reflexivity (Creswell) as the researcher is well aware of the bias they bring to the qualitative research study. One sub-limitation to include here is the limitation of value judgment in data coding. Although coding will be further discussed in Chapter 3, it is important to identify the possible hindrance coding, specifically thematic coding, may cause. Qualitative data will be sectioned into themes which leaves room for value judgment and results in unreliable conclusions. Value judgment is an assessment of what is relative or useful to the research. When themes are identified, it is possible that some information may be excluded based on researcher bias, or judgment, of what is relative or useful.

Next, time consumption may be a limitation. The researcher will conduct qualitative interviews. The influx of data from the interviews may make the analysis and interpretation time-consuming. Another limitation is confirmation bias. The researcher's presence during interviews may affect the responses of the subject. Lastly, the lack of relevant existing research may limit the scope of discussion. As previously mentioned, existing research identifies systematic oppression, bias, and unequal treatment of Black women as correlators to disparate health issues affecting this population (Braveman et al., 2017). Yet, there is not much research that explores solutions, at institutional and individual levels, to highlight historical and address social, economic, and political faults in the persistence of disproportionate health disparities of Black women in the United States. In some ways, the lack of information works in favor of the research study as the gaps amplify the need for innovative resolutions. However, since research includes comparison and contrasting of historical and current issues and resolutions, lack of existing research may cause foundational concerns to the study thus invalidating conclusions being made.

Operational Definitions

To provide a clear path of understanding for readers, important terms are defined below. This section is essential to ensuring readers understand these terms and concepts as they are being presented in this study.

Black Women - Women of African descent who are at least 18 years of age at the time of the study. Colorism is not condoned in this work. Black women of all shades will be included in data collection.

Colorism - the term used to describe the unequal treatment of and discrimination against individuals based on their skin tone.

Communication - Communication is defined as the exchange of information, ideas, and emotions. For this study, communication considers not only the exchange of information, ideas, and emotions, but also the way two or people interact, factors that influence behavior and interaction, factors that influence interpretation of behavior and interaction, and factors that influence responses as well.

Communication Strategies - Communication strategies refer to methods for exchanging information, ideas, and emotions. For this study, effective communication relies on an inclusive communication strategy. It is important to consider the complexity of intersectional influences when developing a communication strategy. For example, businesses develop communication strategies for effective internal communication of information to and between employees and also for external communication with stakeholders and target populations. These strategies are based on collected data from historical and new perspectives used to filter out patterns and create pathways for improvement based on these complex, intersectional factors. The goal is to meet the needs and wants of the target. The same should be done for daily human interaction. Such complexities are relative to race, cultural and social understanding, environment, economy, and even politics. Without the inclusivity of these influences in conversations about the disparities in Black women's health, pathways for improvement will continue to be ineffective.

COVID-19 Pandemic - The COVID-19 pandemic is the global effect of the novel Coronavirus, an infectious disease that killed millions of people around the world. For this study, the COVID-19 pandemic is used to create an understanding of the disproportionately negative effects of COVID-19 on Black women during the height of the COVID-19 pandemic.

Cultural competence - The American Psychological Association defines cultural competence as the "*ability to understand, appreciate and interact with people from cultures or belief systems different from one's own*" (DeAngelis, 2015). According to Ting-Toomey (1999), it is also necessary to consider cultural competence as a measure whereas behavior is oriented based on how an individual is conditioned to interpret or interact with cultures or belief systems different from one's own. This is key to cultural competence - especially if this orientation incorrectly describes specific cultural or belief systems. Cultural competence is important to this work as it can lead to the identification of gaps in understanding of the influences of racism in culture and belief systems in the United States and of Black people. Cultural competence can also be leveraged to prove how interactions without this level of understanding can be linked to the persistent issues of health disparities among Black women in the United States.

Disproportionate - Disproportionate refers to the difference in proportion when comparing two factors by an added descriptive value. This study focuses on the health disparities of Black women in the United States In the conversation of women's health, compared to any other identified race of women in the United States, Black women experience health disparities at disproportionate rates.

Evidence-based strategy - Evidence-based can be simply defined as a strategy deriving from scientific evidence. The goal of this study is to develop evidence-based, communication strategies to address persistent issues of health disparities of Black women in the United States Through data collection and analysis, this study aims to develop evidence-based communication strategies that improve health outcomes for Black women and result in spaces of positive interaction between Black women and others regarding understanding of the racial influence in Black women's health disparities.

Exacerbate - Exacerbate can be simply defined as a factor that worsens an already undesired condition.

Health - According to the World Health Organization (WHO), "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Health Communication - According to the Society for Health Communication (2017), health communication can be defined as “a multidisciplinary field of study and practice that applied communication evidence, strategy, theory, and creativity to promote behaviors, policies, and practices that advance the health and well-being of people and populations.” This study redefines the understanding of health communication by reinforcing inclusion of relevant, historical factors that influence the persistence of disproportionate health disparities of Black women in the United States. Historic and current means of addressing this issue have not effectively responded to the racial and unequal foundation of Black women’s health. Health communication is more than just about health information, literacy, and choices, but also the bigger and more comprehensive picture about the deeply rooted racial and unequal foundation of the United States for Black women which also impacts Black women’s health.

Health Disparities - As defined by the Centers for Disease Control (2017), health disparities are “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.” The CDC acknowledges *social determinants* as factors influencing health disparities. For this study, health disparities faced by Black women at disproportionate rates will acknowledge social determinants at a systemic level by addressing racial institutions linked to Black women’s health disparities.

Healthcare providers - A person who receives education, training, and licensing in the health occupation, and thus provides medical services to maintain the health of human beings. This may also be an entity that renders medical care or treatment.

Healthcare system - The Compendium of U.S. Health Systems (2016) defines a health system as an entity that consists of at least one hospital and at least one group of doctors that offer comprehensive care, including primary and specialty care, and who are affiliated with the hospital through shared ownership or joint management (AHRQ, 2016).

Institutional-level Racism - Institutional-level racism refers to the use of institutional systems to uphold, maintain, and perpetuate racial hierarchies within the United States

Individual-level Racism - Individual-level racism refers to racial discrimination an individual has in response to their assumptions about a racial group.

Persistence - Persistence refers to continued action. The issue of disproportionate health disparities of Black women in the United States is persistent because there is a need for addressing systemic influences to this persistence.

Racism - Harvard Scholar, Dr. David R. Williams has done research on the adverse effects of racism on health. This definition of racism is most closely aligned with this body of research. Dr. Williams defines racism as “an organized social system in which the dominant racial group, based on an ideology of inferiority, categorizes and ranks people into social groups called “races” and uses its power to devalue, disempower, and differentially allocate valued societal resources and opportunities to groups defined as inferior” (Williams et al., pg 106).

Social Injustice - Social injustice refers to inequality within social structures. This is relevant to this study because by identifying such inequalities, the root of social structures' contribution to inequalities can be uncovered.

Systemic Injustice - Systemic injustice refers to the failure of governing systems to create fair space for all regardless of social, economic, or political status. Systemic injustice can include social injustice stemming from how the foundation of our justice system can be linked to inequality within social structures.

Systemic Racism - Systemic Racism refers to racism embedded in systems within the United States

United States Healthcare System - The United States healthcare system is a network of private and public providers of health services within the United States This network includes healthcare providers, insurance companies, and locations that provide health services as well.

Summary

The goal of this study is to address issues of health disparities of Black women in the United States from the individual and institutional level and reimagines this issue as a communication issue based on how inequality has long influenced the exchange of information relative to Black women's health in America. Chapter 2 delves deeper into the legacy of the treatment of Black women in the United States and how that treatment has shaped how Black women are valued and how they value themselves. From the days of slavery to the Civil Rights Movement, to the present day there is a pattern of how racism plays a crucial role in the health of Black women in the United States. Addressing systemic contribution will help to link historic and current suppressors and explore relevant methods of advocacy across the time frame. By doing this and by uplifting experiences Black women have had with the healthcare system, this study aims to uncover barriers, change the narrative attached to Black women and Black women's health, and develop strategies to address health disparities of Black women.

Chapter 2: Literature Review

Introduction

Geographically, race and ethnicity merge into socio-cultural constructs that have manifested through social history. I can not discuss health equity among Black women without considering the influence of institutional- and individual-level racism against Black people as a whole and understanding the intersection of the historical context of gender and race as influences in Black women's health in the United States. When I consider factors of gender and race, the term *intersectionality* becomes key to understanding disadvantage. During an interview for the 20th anniversary of the African American Policy Forum, Kimberly Crenshaw reflects on over two decades of the term intersectionality as a "lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times that framework erases what happens to people who are subject to all of these things." Social institutions are racially charged through historical laws built on foundations of oppression of Black women and often subject Black women to disproportionate health conditions. Black women are then subsequently expected to trust receipt of services from a system that contributes to disparate health conditions and does not understand how Black women are affected and/or why Black women do not feel heard.

The key to developing evidence-based strategies to address health disparities of Black women in the United States is the identification of trends and contributors to health disparities of Black women in the United States. Identifying trends and contributors connects relevant situations with time and allows for a data-informed approach to research efforts. Health disparities of Black women in the United States are not a new phenomenon. These health disparities are deeply rooted in institutions and systems that plague the lives of Black women as intersectional, minority members in the category of race and characteristic of gender. In this section, I will explore historical and present trends and contributors, outline communication as the issue, and provide a theoretical framework to address and change the narrative of Black women's health disparities in the United States.

The Historical Context of Black Women and Healthcare in the United States

Exploring the historical context of Black women and healthcare in the United States is essential to addressing the first two research questions -

RQ1. What are the root and current exacerbators of health disparities faced by Black women in the United States? What are these health disparities?

RQ2. Why is the communication lens essential to unveiling historic and existing methods of addressing exacerbators of health disparities faced by Black women in the United States?

In the colonial era, 1600s to 1700s, healthcare was largely informal and based on home remedies, folk medicine, and the practices of local healers and midwives. During the days of slavery, White slave owners did not view enslaved people as human beings but rather as human capital. Unwashed clothing, infrequent bathing, inadequate dental treatment, and unlivable living conditions were all common among enslaved people. Bedbugs, ringworm, and body lice were common. Slave owners only hired a doctor as a last resort; in this instance, the medical report was sent to the slave owner without consulting the enslaved people about their care, condition, or symptoms. As enslaved women were sexualized and sexual abused from the time they were trafficked to America (Griffin, 1996), it is no surprise that the earliest form of health treatment of Black women in the United States were experimental, gynecological surgeries and childbirth practices by Dr J Marion Sims, a surgeon from Alabama, who is also known as the "Father of Gynecology". From 1845 to 1849, he operated on enslaved women involuntarily and without anesthesia (Wall, 2006).

It was not until 1847 that the American Medical Association (AMA) was founded and shaped the professionalization of medicine and medical education in the United States. Medical schools and hospitals began to emerge. Still, Black women faced significant obstacles in pursuing education and training in healthcare professions. Segregation and discriminatory practices limited their access to medical schools, nursing programs, and other healthcare training institutions. In the United States, healthcare for Black women in the 1800s and early 1900s was deeply influenced by the pervasive racism and discrimination of the era. Black women faced significant barriers to accessing medical care due to systemic racism and segregation. Many hospitals and clinics were segregated, with Black patients often relegated to inferior facilities or denied care altogether. Black women faced higher rates of maternal and infant mortality compared to White women throughout the 1900s. Factors contributing to these disparities included inadequate prenatal care, limited access to skilled birth attendants, and higher rates of poverty and chronic stress among Black communities. In the absence of access to formal medical care, Black women often relied on home remedies, folk medicine, and traditional healing practices passed down through generations within their communities. This included the use of herbs, plants, and other natural remedies for treating illnesses and injuries. Despite the challenges, Black communities often organized their own healthcare initiatives and support networks. Churches, mutual aid societies, and community organizations played important roles in providing healthcare services, support, and advocacy for Black women and their families. The Civil Rights Movement of the 1950s and 1960s brought attention to racial injustices in healthcare and spurred activism and advocacy efforts to address health disparities. There has been much advancement in healthcare since, however, Black women continue to experience health disparities today. The question of “why” can be answered with “race” and the dehumanization of Black people which is manifested in social structures throughout history and today.

Slavery and the 19th Century

To understand the depth of racism as a contribution to health disparities faced by Black women in the United States, it is important to consider the health of Black women transported from Africa as slaves. Sarah Baartman was a woman of the Khoikhoi indigenous group from the South African region. Her early years were plagued with loss. Sarah lost both of her parents at a young age. She married in her teens and had a child who died shortly after birth. When she was 16 years old, her husband was murdered by Dutch colonists. Sarah was bought into slavery by Pieter Willem Cezar, a Dutchman, who transported her to Cape Town where she worked as a domestic slave for his brother Hendrik Cezar. Sarah's name was changed to Saartjie, the Dutch form of the name Sarah. *Fascinated* by her *large buttocks*, Hendrik Cezar and Alexander Dunlop, a Dutch military surgeon and a collector and showman of animal specimens, planned to put her body on display in England and Ireland (Parkinson, 2016). Research says that Sarah had steatopygia, an accumulation of fat in the buttocks causing the buttocks to protrude, which is common for African women. She was reported to have an enlarged labia, a physical characteristic mockingly called a "Hottentot apron" (Ashley, 2021). Hottentot was a term used to reference the Khoikhoi people.

In 1810, although unable to read or write, Sarah signed an “employment” contract written by Alexander Dunlop. She was told that she would receive money for these exhibitions and could return home after five years. Some say that Sarah signed the contract because she believed it was her best option. Her story is considered an early form of human sex trafficking. In London, she was displayed as an attraction and her body was publicly examined and inhumanly exposed where she peeked at the sexual interest of spectators. They even poked her body with their walking sticks for their entertainment. She was dressed in tight, flesh-toned clothing with beads and feathers as she smoked a pipe.

In 1814, Sarah was taken to France and sold to S. Reaux, an exhibitor who showcased animals. He displayed Sarah to the public, almost completely nude, and urged her to perform stunts like those of a circus. She was called “Hottentot Venus”. It was reported that S. Reaux may have prostituted Sarah. He made a substantial profit from the public’s obsession with Sarah’s body. In 1815, Sarah died at the young age of 26, in Paris. The cause of her death is unknown. Parts of Sarah's body were saved by scientists after her death. Her remains were dissected and displayed for many years in a museum in Paris to support racist stereotypes about individuals of African origin. In 1994, Nelson Mandela requested that Sarah's body be returned to her homeland. In 2002, eight years later, Sarah's remains were finally returned (Gordon-Chipembere, 2006).

There are many stories similar to that of Sarah. Stories of Black women and our bodies have been structured through racial systems and historically accepted as our identification or DNA - so to speak. The historical influence here is racism which continues to influence inadequacies of healthcare through ineffective health communication. The intersection of racism and healthcare is known as medical racism. In many cases, Black women sought health treatments that resulted in them being, without consent, patients for medical trials or observation for research.

Through the Middle Passage, African men and women were forcibly transported from countries of western and northern regions of Africa, across the Atlantic Ocean, and to America, or the New World for historical context. According to an article from the National Park Service of the United States Department of the Interior (2021), the journey lasted about 80 days and resulted in the transport of approximately 12 million enslaved African people from their homes. It was also reported that enslaved African people were stripped naked and examined for health concerns before boarding the ships. Ironically, they were then subjected to horrendous ship conditions making them susceptible to extremely poor health outcomes. This was especially true for men as they were chained and crammed at the bottom of slave ships so much that they were forced to crouch or lie down.

Although women were also held below deck, they were given the liberty of being above deck as well and sometimes left unchained. However, above deck was where enslaved women experienced sexual abuse and assault from White men, including ship captains, aboard the ship. Acts of rape sometimes resulted in pregnancy and although some enslaved women bore their child, other enslaved women found ways to abort theirs as an act of resistance. There were consequences however - more sexual abuse, beatings, and living with scarring - especially when enslaved women planned uprisings as an act of resistance to captivity and unfair treatment (Griffin, 1996).

Acts of sexual abuse continued off the ship. Enslaved women were subjected to rape and sexual assault on plantations as well. According to a study by Prather et al (2018), a little more than half of all enslaved women aged 15-30 years old were sexually assaulted by slave owners and other White men. A deeper analysis of the impregnation of Black women by slave owners concerns the fact that these children were being born into slavery, a benefit of the slave owners because the child became their property. In fact, “Strong” enslaved women were sold specifically to bear children into slavery (Prather et al, 2018). Black women were sexualized and regarded mainly for their wombs. However, reproductive rights and an enslaved woman’s choice of sexual partner were non-existent. Furthermore, an enslaved woman's access to healthcare was limited.

And even when an enslaved woman received treatment, treatment more often than not took the form of a medical experiment. Many physicians used enslaved women in reproductive surgery trials, including procedures such as cesarean sections and ovariotomy, to perfect their procedures that would later be used for all women. Washington (2018) discusses this act of White institutions using Black people for medical experiments, starting from the days of slavery, as a medical apartheid. The issue of medical apartheid directly concerns the blatant disregard for the ethical treatment of slaves even at their weakest moments of seeking healthcare. Additionally, the ethical technique of informed consent was not yet in place. It was not until the ruling in Schloendorff v. Society of New York Hospitals in 1914 that medical consent became a requirement for treatment and sharing of medical information.

Another important context to the health of enslaved women is the understanding that the rights of all women were limited during this time. For instance, during the early 1800s in the US, women were denied the right to property. However, the disparity here is relative to the fact that enslaved women were sold to their slave owners *as* property. Considering property and laws that protect property, laws are in favor of the owner’s rights to their property and not the rights of the property because the property has no rights. Applying this thinking to enslaved women, there were no laws that protected them or their health but rather the protection of ownership of enslaved women. Harriett Tubman’s story of a life of pain and headaches from an untreated head injury is one example of protection of the ownership of enslaved women and not the protection of the person or their health. Harriett Tubman is a well-known abolitionist and social activist. She risked her life by taking 19 trips to lead about 70 enslaved women, men, and children to freedom (Balkansky, 2020). Harriett was born into slavery and, from an early age, risked her life to help enslaved Black people to freedom. When she was 12 years old, Harriett was hit in the head with a heavy, iron weight thrown by an overseer. She suffered a severe head injury but was forced to immediately go back to work. Enslaved women and men were forced to work when sick or after beatings (Wall, 2006). Harriett did not receive any medical treatment until much later in her life. She experienced a lifetime of headaches, pain, seizures, and sleep trauma. She also had visions which she described as being sent by God.

The Civil War, starting in 1861, was the beginning of the abolishment of slavery as the northern and southern states went head-to-head due to tensions regarding differences in views about national issues like slavery. Many enslaved women took the risk of fleeing from plantations, some with children in tow. Enslaved women were no strangers to resistance on plantations despite the severe consequences faced. Yet, escaped enslaved women were eventually met with a similar disregard for their health amidst their supposed freedom. This sense of freedom was quickly stripped when enslaved women arrived at Northern troop camps for refuge. Northern troops demanded services from women who escaped and found their way to the camps. Escaped women played the role of nurses and cooks and were at times prostituted. As the war progressed, the number of enslaved women who escaped from plantations increased as well. Camps became overcrowded and escaped women became more of a burden to Northern Troops as the demands they had for the women were already being satisfied in numbers. Overcrowded camps resulted in unsanitary conditions, hunger, poverty, and the spread of disease (West, 2021). Additionally, women were subjected to physical and sexual abuse from White soldiers at these camps - repeating the cycle of maltreatment and blatant disregard for enslaved women's physical, sexual, and mental health.

The Civil Rights Movement and The 20th Century

On January 1, 1863, the Emancipation Proclamation abolished slavery in the United States. However, it was not until two years later, after the Civil War, that all slaves were completely freed. Although the days of slavery were over, the days of inferior treatment of Black people persisted. Post-slavery, the South was segregated by communities, businesses, and schools and Black people were expected to have the same slave-master, hierarchy structure nurtured for almost 250 years. This social idea of racial inferiority has long been rooted in the legal structures of the United States.

Over 300 years after the start of slavery, during the Civil Rights era, the 1964 Civil Rights Act was passed as a governmental stance against resistance to desegregation that persisted and thrived in southern states. The act defended civil rights for all by prohibiting discrimination based on race, color, religion, sex, and national origin as well as racially influenced discriminatory acts in hiring, promoting, and firing employees. It also strengthened the enforcement of voting rights and the desegregation of schools (United States Department of Labor). There were many other attempts to address how segregation influenced the persistence of racial inferiority, such as federal court action to desegregate hospitals and the development of Medicare and Medicaid programs that pushed for adequate healthcare for all, which included African Americans (Byrd & Clayton, 2001).

Even though healthcare is now a human right and afforded to all, African Americans are still subjected to substandard healthcare by the underfinanced, inferior, public tier of the nation's dual, unequal, health system as a result of what is known today as environmental racism, the socially uneven distribution of pollution and resources along racial lines (Pulido, 2017). Segregation was firmly embedded in the foundation of legal and social institutions and fueled environmental racism by subjecting African American people to poverty-stricken and underserved environments that led to unequal access to food, schools, and medical care. As the inferior group, the resources and living conditions of African Americans were less adequate than that of their White counterparts. Anti-Black racism is the root of this inequality in the healthcare system as poor health status is linked to poor living environments, poor healthcare, and exploitation and abuse of patients. Here you can see the persistence of blatant disregard for ethical medical treatment for Black women from the days of slavery in the 19th century through the 20th century and after both the abolishment of slavery and the legal ruling of desegregation of the South.

Although Black people as a whole experienced the effects of environmental racism due to segregation as it relates to healthcare, it is important to acknowledge the intersectionality of race and gender as these two characteristics influence health disparities of Black women, an oppressed subgroup of the population of Black people in the United States In the days of slavery, White men controlled what White women, Black men, and Black women could or could not do - by exclusion in written law or by physical force. However, White women benefited from living in a White-dominated society and were never enslaved. Black men did not benefit from the White dominated-society and were enslaved but were granted basic human rights before Black women. The Fifteenth Amendment extended voting rights to men of all races in 1870. Not until 1965, almost 100 years later, were Black women allowed to vote after the passing of the 1965 Voting Rights Act. In other words, for the first 300+ years of Black history in America, the voice of Black women was excluded from laws regarding their reproduction and sexual health, their healthcare, their living, their employment, and their basic rights to live freely and equally as human beings. This pattern of Black women being granted the right to freedom from social and legal constraints but remaining denied equal access to the freedoms granted to them is a running theme throughout Black history in America. In terms of Black women's health, Anti-Black racism continued to dominate interaction between Black women and healthcare providers. In addition to making mention of the racial contribution, it is also necessary to make mention of how embedded this designation of Black inferiority is in social and political structures that drive understanding and respect, or lack thereof, of Black women's health as well as Black women's human right to make health decisions.

One notable case is the story of Henrietta Lacks. Just as enslaved women took the burden of mistreatment in health for other women to experience better health opportunities today, Henrietta Lacks fell victim to the unconsented collection and sharing of her health information - information used after her death to heal others. In 1951, after experiencing spotting between menstrual cramps, she sought medical attention.

Henrietta Lacks had only one hospital near her home that served Black people as patients and because of her race, she was subjected to inadequate health conditions. Johns Hopkins was the only hospital in proximity that welcomed Black patients for treatment. Segregation in hospitals did not end until 1965. Because Henrietta had no health insurance, little money, and was regarded as poorly educated, she was admitted to the unit of the hospital that was designated for “impoverished people". Generally, African Americans received poor education, most times in inadequate facilities with overcrowdedness and a limited number of teachers. It wasn't until 1957, six years after Henrietta's death, that schools in the south were integrated. Regarding insurance, African Americans were more likely to obtain health insurance from their employers (Taylor, 2019). Before her death, Henrietta worked as a tobacco farmer on the same land where her ancestors were enslaved.

Henrietta was diagnosed with epidermoid carcinoma, a type of lung cancer that destroys healthy tissue and may thin organ lining and was subsequently admitted into the hospital. She spent the next few months receiving radiation treatment, which failed to stop the cancer from spreading. She soon developed severe abdominal pain and was unable to hold her urine. She succumbed to the spread of cancer later that year at the age of 31.

While examining Henrietta's cervix, samples of her tissue cells were collected for further evaluation. However, collected specimens were also shared with the pathology department at Johns Hopkins, specifically with Dr. George Gey, without Henrietta Lack's consent (Sodeke & Powell, 2019). Dr. Gey renamed the collected tissue cells HeLa and shared them with scientists interested in cell research. In addition to requiring medical consent, the 1914 ruling of Schloendorff v. Society of New York Hospitals also enforced that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." (p. 2). Yet HeLa cell specimens were shared amongst doctors for cancer research without Henrietta Lacks' knowledge in 1951. Black women in America are historically denied the right to determine what should be done with their bodies despite legal structures.

Fannie Lou Hamer, a Mississippi native, was a well-known activist for civil and voting rights. She was a child of sharecroppers and worked on a plantation for most of her life. In 1961, a White doctor performed a hysterectomy on Fannie, without her consent, during surgery for the removal of a uterine tumor. A ploy to reduce the Black population and target low-income Black women, hysterectomies were widespread known as the "Mississippi appendectomy." A year after her nonconsensual hysterectomy, at the age of 44, Fannie learned about her right to vote - despite the 15th Amendment that granted African American men the right to vote in 1870 and the ratification of the 19th Amendment granted Black men the right to vote in 1920. Determined to secure her right to vote, Fannie repeatedly took the literacy test and finally succeeded in registering to vote in 1963. Fannie was dedicated to spreading awareness of voting rights and getting others to register to vote. She remained dedicated through unjust arrests, beatings, and suffering permanent kidney damage, a blood clot behind her eye, and a permanent limp all in response to her advocacy.

The intersection of race and gender continues to serve as determinants for the social governing of Black women as well as how historical, and racial contexts serve as a firm foundation of unfair treatment of Black women ultimately leading to health disparities. Harris et al (2020) make mention of stigmatization and a blame narrative for illnesses like HIV and COVID which data and society disparately attaches to marginalized groups despite system and institutionalized racism that are “fundamental determinants of disparities in health” (pp 6). The socialized meaning of a Black woman in the United States is constructed from historical references and warped into blame for being Black, enslaved, poor, uneducated, and rebellious - all of which are a result of or response to the oppressive systems and social structures built on racism.

The Narrative of Black Women

I have defined communication as the exchange of information, ideas, and emotions. The conversation of Black women’s health should be more than just about identifying the health outcomes but also considering the barriers associated with these outcomes and the exchange of information, ideas, and emotions relative to the health experiences of Black women as well. Such barriers can be aligned with tropes like *Strong Black Woman* or *Angry Black Woman* and “Mammy”, “Jezebel”, and "Sapphire” that depict a negative image and narrative of Black women. These figures originated from the days of slavery and still exist today in Western cultures as archetypes of Black women. Through social and economic conditions Black women are continuously failed by the system but expected to be *strong*. Just as in the days of slavery where a *strong* Black woman was able to bear children. *Strong Black Woman* is a result of White male thinking and expectations of Black women to withstand physical and mental obstacles set before us (Chinn et al, 2021). It can have a negative impact on the health of Black women and responses or empathy to our pain. This particular narrative of Black women associated with the qualities I attribute to strength, although may appear as a story of resiliency, is actually a story of oppression and control. It is how an “ideal” Black woman should act and it is normalized and embedded in the systemic and social structures of America. However, when a Black woman is *strong* but then enacts her innate right of free speech, especially for self-advocacy against oppression and/or control, she is then considered an *Angry Black Woman*.

Dr. Brittany Cooper, a tenured professor of Women and Gender studies at Rutgers University, said “Being a Black woman in America means realizing that doing everything right may not be enough.” Dr. Cooper introduced the phrase “eloquent rage” as the catalyst for feminism and feminism as the tool by which Black women emerge as heroes - an important understanding for changing the narrative. In fact, I will argue that *Angry Black Woman* is a defense mechanism cultivated by oppressors from fear of the Black woman's voice against years of oppression. *Angry Black Woman* holds a negative connotation because even through the unveiling and raised awareness of the trauma and plight of Black women at the hands of America, there is no true acknowledgement or accountability by the oppressive systems and social structures that have abused and silenced Black women. Anyone can be angry. Anger is an emotion. Yet, the rightful anger of Black women is somehow overdramatized as if Black women have nothing to be angry about. Dr. Cooper expressed that the anger of Black women is a response to systemic levels of injustice. It is an expression of anger towards a system that is operating true to its foundation and true to its continued legacy of disparate harm to marginalized people. In fact, during the days of slavery when Black women were given just a small amount of freedom, they took the opportunity to communicate and organize against slave traffickers and owners.

The Sapphire character gives a face to the Angry Black Woman through television, film, and media. Some words used to describe Sapphires are rude, aggressive, sassy, bitter, loud, destructive, stubborn, irrational, overbearing, and emasculating. Wade (2022) argued that the purpose of Sapphire is to silence Black women. That is, silencing the reality of a Black woman and amplifying the false narrative.

The Mammy caricature evoked an image of a content, Black, enslaved woman - a manifestation of White imagination. The wide grin is meant to show loyalty to servitude and humanity in the institution of slavery. According to an article by the National Museum of African American History and Culture, after the Civil War, the "grinning likeness" of the Mammy caricature was used as the face of "consumer goods from flour to motor oil." In 2021, all products of the well-known Aunt Jemima brand name were rebranded to Pearl Milling Company after heightened awareness of Aunt Jemima being synonymous with Mammy and a nationwide protest for racial equality. In 1899, Aunt Jemima hired real-life chef Nancy Green to portray the character at various state and world fairs.

The Jezebel character is perpetuated by European colonists who shared stories that associated African polygamy and tribal dances with the uncontrolled sexual lust of the African people. Sarah Baartman, whose story is discussed in "Slavery and the 19th Century", is one example of this "Jezebel" portrayal of Black women. The Jezebel character reinforced this belief of uncontrolled sexual lust and concocted a narrative about how Black women were being treated by Black men and about the wants and desires of a Black woman. Colonists regarded Black men as *potential* rapists. And Black women, in the portrayal of a Jezebel, were believed to have a voracious desire for sex. The Jezebel character was used during slavery to rationalize forceful, sexual exchanges between enslaved, Black women and White men. This was what Black women wanted. And since enslaved, Black women were property, legally, the forceful, sexual exchanges could not be rape.

Situation to Communication Tradition

The socio-cultural tradition assesses how our understandings, meanings, norms, and rules influence communication. How we communicate with each other is a manifestation of our own realities, created by what we have learned or been conditioned to think about ourselves and others as constructed through social interaction - mainly in our racial and gender subgroups and from media. Racism, the act of assigning characteristics to people of a race and using these characteristics as a social determinant, fueling a discriminative nature towards a particular race(s), stems from the days of slavery.

Racism has held Black people at inferior levels socially, economically, and politically before the migration of African people to the United States. As stated in Chapter 1, inequality is the communication issue that fuels persistent and disproportionate health disparities of Black women in the United States. Even at the start of the 21st century and after major legal rulings, a majority of African Americans remained demographically, economically, and socially segregated and isolated within our nation's inner cities (Byrd & Clayton, 2001). This is because America was not meant to be fair to Black people. Black people see little subtle breakthroughs that we are capable of achieving greater levels of success as a people but are then subsequently faced with an example of how anti-Black the system is. Existing research proves that health equity can not be achieved without addressing the social root of the unfair treatment of Black women in America.

Relevant to persistent issues of disproportionate health disparities of Black women in the United States, highlighting the historic portrayal of Black women in the United States and how this portrayal is currently communicated through misunderstanding of Black women's health issues, I hope to address discriminatory acts against Black women in health spaces. This will explain why Black women experience poor communication with healthcare providers which leads to medical mistrust and education of Black women based on discrimination from healthcare providers (Cuevas et al, 2016). Another finding is relative to the reinforcement of health inequities. Gomez and Wapman (2017) found that pressure from healthcare providers based on implicit biases creates mistrust as providers would impose medical preferences while providing incomplete information regarding side effects without having conversations with patients or truly understanding how race and gender oppression has already played a huge role in the health of Black women. The intersection of race and effective communication in health spaces can not flourish unless the perspectives and narratives shift to consideration of how normalized the maltreatment of Black women is.

Nurturing this line of communication between healthcare providers and Black women will improve access to care by reducing the role of social determinants in patient treatment and increasing the understanding of healthcare providers to the existence of racial roots and cultural ignorance in persistent inequitable treatment of this population (Nesbitt & Palomarez, 2016). Another point to explore is the flow of information from a healthcare provider to the patient and the biased motive behind effective information exchange between the healthcare provider and their patient. Generally, Black patients experience poorer quality communication which results in the lack of adequate information exchange between the patient and the healthcare provider. Research shows that White patients are also more welcomed as participants in decision-making regarding their health than their Black counterparts (Shen et al, 2018).

The gendered, racial identity of Black women has long communicated the role of the Black woman in society and has further implications of the mental and physical health effects of Black women as well (Lewis et al, 2017). There is an ideal and a standard held of Black women that thrive implicitly from slavery and is present across systems and in social structures. Black women are expected to adhere and Black women are expected to be angry and strong, and promiscuous. Communal support empowers Black women to feel heard and have additional advocate assistance in highlighting this issue and fighting against it. The more Black women show up for themselves and the more communities show up for Black women, the greater the chance to empower them. Here, the voices of Black women and the designation of Black women as the stakeholders for Black women's health are necessary to change the narrative, shift systems, and address health disparities of Black women in the United States.

The legacy of slavery is deeply rooted in societal functioning today. From blatant racial acts to White privilege to implicit bias, human beings will be human beings. As aforementioned, communication is a determinant of inequality. The most obvious engagement when discussing communication in healthcare, is between healthcare providers and their patients. Healthcare providers are humans and although are trusted to do their work, can not be left out of the conversation of implicit biases (Fitzgerald & Hurst, 2017). There has long been an urge for more on-site research to measure the levels of implicit bias exhibited by a healthcare provider. However, implicit bias is subjective to the situation at hand and can be altered based on observation of healthcare provider and patient interaction. However, cultural competence, the ultimate goal for positive relationship building between healthcare providers and their patients, is a more effective approach to alleviating implicit bias in human interaction (DeAngelis, 2015). By Linking the racial foundation to the setbacks of Black women's livelihood and health, I hope to change the narrative of the misconceptions that have been communicated about Black women's health.

Health Disparities Faced by Black Women in the United States

Inequality is viewed as a communication issue that influences responses to Black women. But it is also important to consider equality as a communication issue that influences trauma response from actual disparate health concerns of Black women as well. Trauma responses refer to emotional, mental, and physical reactions to a traumatic event. Black women are vulnerable to the impacts of race-related stress. Stress is the feeling of being overwhelmed or unable to cope with mental or emotional pressure. Slavery, racism, sexual abuse, segregation, void of rights, medical maltreatment, and discrimination based on the intersection of gender and race are a few traumatic events explored in this paper that Black women are facing. Exploring contemporary times is deliberate because although the needle has moved for systems that upheld slavery, segregation, and the human rights of women and Black women, these constructs are still supported, often legally and often activated in social structure as well.

Disparate health concerns of Black women refer to the contrast of health concerns of Black women when compared to racial counterparts. First, let us highlight the top, disparate health concerns faced by Black women in the United States. According to the Office of Research on Women's Health of the National Institute of Health, Black women experience 6 diseases at disparate rates: heart disease and stroke, cancer, type 2 diabetes, HIV, overweight and obesity, and maternal health. Other named health disparities from additional sources are hypertension, linked to stroke, and lupus, which is linked to cancer.

Heart disease is the umbrella term for a group of diseases that can affect the heart. Stroke is a disease that affects the arteries leading to and within the brain disrupting blood flow to the brain. Heart disease and stroke are the first and third causes of death of Black women respectively. An article by the American Heart Association reported that Black people may be much more sensitive to the effects of salt than any other race and links salt to increased risk of stroke or heart disease, and diabetes. The article also reported that more than 50,000 Black women die from cardiovascular, or heart, disease each year, 39% of Black women are unaware that chest pain can be a sign of heart attack, and about 59% of Black women aged 20 or older have cardiovascular disease. Black women are two times more likely to have a stroke than White women. Cancer is the uncontrollable growth and spread of cells to other parts of the body, disrupting body functioning. Cancer, specifically breast and cervical cancer, is the second leading cause of death for Black women. The American Cancer Society (2022) reported that Black women are 41% more likely to die from breast cancer than White women, despite being less likely to be diagnosed with it.

Type 2 Diabetes regards the body’s disability to regulate and use blood sugar. Type 2 Diabetes can be treated by leading healthier lifestyles and receiving insulin therapy, which helps blood sugar enter body cells. If left untreated, diabetes can be fatal. According to the National Institute of Health, 1 in 4 Black women 55 years and older have diabetes. That is nearly twice the rate of White women.

Human Immunodeficiency Virus (HIV) is a virus transmitted through bodily fluids that attacks the body's immune system. Although there is no cure for HIV, it can be treated with medication. One article in the National Library of Medicine reported that Black women are no more likely to have unprotected sex, have multiple sexual partners, or use drugs than women of other racial/ethnic groups (Tillerson, 2008). According to the CDC, in 2021, Black/African American individuals aged 13 and older represented approximately 12% of the U.S. population but accounted for 40% of people with HIV. Even more, Black women account for nearly 60% of new HIV infections in the U.S. Research shows that exclusionary marketing, fewer treatment options, and provider wariness are contributors to disparate rates. (Whitehead, 2023).

It is reported that over 80% of midlife Black women are overweight or obese. An individual is considered overweight when their weight exceeds what is considered normal weight depending on the body mass index, and weight-to-height ratio. Obesity is the condition of being extremely overweight. Being overweight or obese increases the risk of heart disease, heart attack, diabetes, high cholesterol, and high blood pressure. As previously mentioned, unfair exposure to hazardous living conditions and inequitable access to healthy foods and adequate healthcare and resources contribute to unhealthy lifestyles and, subsequently, contribute to disparities in health status across marginalized communities at disparate rates for Black people - especially Black women.

Lastly, maternal health considers the health of women while pregnant, during birth, and in postnatal stages as well. Black women are reportedly 3 to 4 times more likely to die of pregnancy-related complications than women of other ethnic groups. The Centers for Disease Control reported that contributors are quality of healthcare, underlying chronic conditions, structural racism, and implicit bias.

Current Context

In 2020, the world shut down in response to the Coronavirus Disease 2019 (COVID-19) which claimed millions of lives. For Black women, this global health pandemic was a supplement to the existing racial and gender pandemic as it affects the lives of Black women and Black people as a whole. Black women and allies used social media to bring attention to disproportionate health issues and communicate ways for Black women to advocate for themselves during interactions with healthcare providers. Research shows that although Black women are disproportionately represented as essential workers, they often lack job security and are more susceptible to transmission of disease and, during the pandemic, subsequently risked having their symptoms minimized or dismissed by healthcare providers even when they showed visible symptoms of COVID-19 (Goody et al, 2023).

At the center was Black women's maternal health. Black women's maternal health is rooted in systemic racism, still relevant during the global COVID-19 pandemic (Chandler, 2021). For example, concerning the global COVID-19 pandemic, the need to explore where and how Black women are obtaining information that pertains to COVID-19, along with the impacts that COVID-19 may be having on their daily lives, stemmed from data concluding that Black women who become infected with COVID-19 have higher risks of complications and mortality than women from other racial groups.

The stories of Amber Isaac and Sha-Asia Washington are two examples of the health disparities Black women face, specifically in New York City which is the city with health disparities faced by Black women at levels alarming higher than that of the national average. In 2018, March of Dimes called on governmental bodies, the health care insurance industry, healthcare providers, and women's groups to help reverse the alarming rise in babies born by c-section around the world. Some have speculated that the rise may be due to heightened concerns during COVID-19, whereas others focus their attention on the financial and legal implications for the providers delivering babies.

On April 21, 2020, 26-year-old Amber Isaac died while giving birth to her son, Elias, during an emergency c-section at Montefiore Medical Center. Per family, Amber had done a lot of research regarding Black women's health and was knowledgeable of the maternity death rates. She expressed not believing she would survive childbirth and, a few days before delivery, tweeted "Can't wait to write a tell all about my experience during my last two trimesters dealing with incompetent doctors at Montefiore" (Christian, 2020). Amber's last in-person prenatal visit was in February of 2020. The remaining check-ups were virtual as the work experienced a lockdown during the pandemic. Virtual check-ups included only a series of health screening questions although Amber's medical records showed concerning numbers of her platelet count. Amber considered a doula for at-home birth after feeling neglected by the system but was advised that she was high risk and would require a surgeon. After continuous follow-up about updated bloodwork, she was finally able to have her bloodwork done and discovered that her platelets were still failing. Amber was admitted and was found to have HELLP syndrome, a complication of high blood pressure during pregnancy. Neither her mother nor boyfriend were allowed to join her initially. Amber was a month away from her due date. Doctors decided to induce Amber. She was then rushed to an emergency c-section. Amber's boyfriend was not allowed into the operating room. Doctors informed the family that Amber's blood wouldn't clot and removed her uterus in an attempt to stop the bleeding. Ultimately, doctors massaged her heart until she succumbed to the bodily damage.

On July 2, 2020, 26-year-old Sha-Asia Washington died while giving birth at Woodhull Hospital hospital in Brooklyn, NY (Goldstein, 2023). She was a paraprofessional at a Brooklyn charter school who, as reported by her family, had just moved into her own apartment and was anticipating motherhood. Sha-Asia arrived at Woodhull for a routine stress test but was admitted for observation as she was a few days past her due date and her blood pressure was abnormally high. Dr. Dmitry Anatolevich Shelchkov gave Sha-Asia pitocin to induce labor and administered an epidural at Sha-Asia's consent. Soon thereafter, the baby's heart rate began to drop and Sha-Asia went into cardiac arrest which led to an emergency c-section. The baby, Khole, entered the world healthy. After 45 minutes of CPR, Sha-Asia was pronounced dead. Dr. Dmitry Anatolevich Shelchkov's license was suspended in March of 2021.

Contemporary Approaches and Examinations

Over the years, the push for inclusive structures has made space for Black women and girls' health-related issues to be brought to the forefront. Today, medical students continue to recite a range of oaths of ethics, educational materials promoting healthy lifestyles continue to be distributed, and social, economic, and environmental factors contributing to health behaviors continue to be considered in health advocacy. Specifically for Black women, perspectives from Black women in health spaces regarding the health of Black women provide an ideal framework for services that would efficiently respond to the health needs of Black women (Jones & Guy-Sheftall, 2015). However, normalized social structures that disregarded how race has played an instrumental role in interpersonal communication persist. At the center of the foundation of social and political structures of the United States is racism and gendered oppression, both of which Black women identify with the inferior group. The level of care in consideration of Black women's health is a direct response to social determinants of who matters (Crear-Perry et al, 2021). I came across a Women's, Gender, and Sexuality Studies course taught at the University at Albany, State University of New York, my alma mater. The course is titled “The Global Perspectives on Women”. The course content mentions that enslaved women should not be completely regarded as victims because some enslaved women leveraged sex for better treatment. This inclusion is an example of the disconnect in health communication specifically regarding disparities of Black women's health in America beyond the confinement of a hospital or clinic and its employees. The narrative here reads that leveraging the only thing that mattered to their capturers to be able to obtain better treatment, outweighs the fact that they were victims of inhumanity. The goal of this study is to develop evidence-based strategies to address the racial and gendered roots of health disparities of Black women in the United States. Below, I will discuss two current approaches to addressing health disparities of Black women most closely aligned with this body of work.

Vice President Kamala Harris launched Maternal Health Day of Action on Tuesday, December 7, 2021. Earlier that year, President Joseph Biden expressed commitment to specifically addressing and reducing Black maternal mortality and morbidity rates in the United States. In the Proclamation on Black Maternal Health Week, 2021 he wrote: “pursuing systemic policies that provide comprehensive, holistic maternal health care free from bias and discrimination.” and deemed April 11 through April 17 as Black Maternal Health Week. The approach calls for addressing systemic racism existing across systems and disparate conditions to improve outcomes for Black mothers. The approach also calls for diversifying the perinatal workforce and collaborative action to increase quality care for Black women before, during, and after birth and reduce implicit bias towards Black women.

Learning about this initiative from the Biden Administration and views explored in previous sections (Slavery and the 19th Century and The Civil Rights Movement and the 20th Century), made me think about the body of a Black woman and the restriction of Black women's right to choice over her body. Such conditions due to law, and despite law, have thrived in social structures until less than 100 years ago and continue to exist today. I also thought about the sexualization of Black women, characteristics negatively associated with Black women, and the “eloquent rage” of the Black woman that is often regarded as unsubstantiated. and generally how Black women’s health disparities continue to be addressed in siloes rather than in a cohesive manner - leaving room for other health disparities of Black women to thrive in a system that contributes to them. I thought about the personal and professional social role of Black women as caretakers, maternal in nature and how that has implications for the health disparity most often brought to the forefront. Maternal health, because of how measurable and prevalent it is, is more often used as a precursor for addressing health disparities of Black women. However, health disparities of Black women, as outlined in this study, are not only inclusive of maternal health. Maternal health is not important to the United States because of disparities among marginalized groups. Maternal health is important to the United States because of its populated future and the analysis of Black women's health disparities is a byproduct of that bigger scope. And it is the few publicized stories of Black women's maternal health-related complications or death and the voices of advocates for Black women’s health that have called attention to this matter as well. This study aims to cast a wider net on health disparities of Black women in the U.S. by focusing on systemic catalysts of this issue from a communications lens which, as mentioned in an earlier section, is used to understand, explain, and predict health beliefs, attitudes, intentions, and behaviors of both patients and healthcare providers. However, because there are research gaps, there is a lack of availability of disaggregated data to show why there is a need for attention across the board. For example, the Journal of the American Medical Association reported statistics about misdiagnosis (Harris, 2023). The report showed that women and minorities are 30% more likely to be misdiagnosed than White men, 1 in 4 hospital patients who died or were transferred to intensive care had experienced a diagnostic error, and 18% of misdiagnosed patients were harmed or died. Another article reported that an estimated 795,000 patients a year die or are permanently disabled because of misdiagnosis (Newman-Toker et al., 2024). Additionally, a study by Miller-Kleinhenz et al (2021), although specific to racial disparities in diagnostic delay among women with breast cancer, says that Black women are increasingly at odds, almost twice as likely, of delay of diagnosis than women of other races. Considering health disparities faced by Black women in the United States, I have a hypothesis that disaggregated data will show that Black women experience misdiagnosis at disparate rates compared to any other group. For Black women, health is more than maternal health and I hope to address the “why” and “how” of Black women's health disparities in the United States.

Vijaya Hogan and Diane L. Rowley (2018) developed the dimensionality and R4P framework of action which stems from work on maternal and infant health. While dimensionality considers the causes of health inequities, R4P outlines the actions needed to address and eliminate health inequities experienced by African Americans. R4P stands for remove, repair, remediate, restructure, and provide. Remove calls for interventionists and practitioners to identify and remove structures, attitudes, beliefs, practices, or experiences specific to race/ethnicity, socioeconomic status, and gender that confer disadvantage. Repair calls for consideration of history that strongly impacts current health inequities. The idea here is that most health theories and interventions are ahistorical. Remediate calls for redressing the negative effects of institutions on people by reducing risk and focusing on changing individuals. This step occurs alongside restructure. Restructure calls for researchers and practitioners to assess the structures in their organizations that maintain the systematic exclusion of disparity populations while simultaneously providing advantage or privilege to others. Lastly, provide calls for thoughtful execution of policies, programs, and actions that target the various, interconnected axes of disadvantage that the disparity population faces, taking into account the settings in which individuals live, work, and play in the impacted communities as well as the institutions they turn to for assistance..

Hogan and Rowley (2018) argue that existing health disparity frameworks do not *adequately* include factors, such as historical implications and systemic, environmental, and social structures, that make African Americans susceptible to health issues and lead to health inequities - which then creates a barrier for the frameworks to be translated into practice. This framework specifically addresses health inequity of African American populations with acknowledgment of the past, present, and future as it relates to those aforementioned factors. This framework also places accountability and responsibility for strategizing for health equity in institutions and urges institutions to include marginalized communities in assessing and planning for racial equity in health institutions.

There are aspects of the dimensionality and R4P framework that are relative to this study such as the historical, systemic, environmental, and social considerations for the role race plays in health inequity. However, in this study there are not only historical, systemic, environmental, and social considerations for the role race plays in health inequity but also a mapping of what that actually looks like through historic timeframes. Another difference between the dimensionality and R4P framework and the approach in this study is the individual-level racism that the communication lens addresses. While dimensionality and R4P framework aims to address the institution as a root cause of health equity, this study aims to address health inequity and change the narrative at both the institutional- and individual level. Addressing the individual level simultaneously avoids a cycle of socialized maltreatment within a changed or eliminated system while placing accountability and responsibility on institutions that ignore, normalize, and socialize historic, racial narratives about the body, rights, and health of the Black woman. Furthermore, the dimensionality and R4P is tailored for African American people while this study is tailored specifically for Black women due to the health disparities. This study also aims to use the voices of Black women to substantiate the existence of this issue in historical and present contexts and unveil the situations and interactions for the changed narrative of the health of Black women.

The United States is historically known to fail Black people but even more so historically known to fail Black women. The legacy of slavery manifests in Black women's health through the de-personification of enslaved Black women as laborers and as medical patients (Owens and Fett, 2019). Black women did not have the right to choose concerning their bodies and forcibly experienced being trials for future research. Space has always been created to utilize Black women for the improvement of others. What is required now is space for listening to Black women and considering the historical experiences of Black women as a means for better understanding disparities and changing the narrative.

Theoretical Communication Theory and Black Women's Health

In chapter 1, theory of planned behavior, social learning theory, and the health belief model were explored as basis for recognition of social determinants of behavior. They are specifically related to health behavior from both the perspectives of the healthcare provider and patients who identify as Black women. In redefining these theories, I hope to highlight systemic and racially rooted foundations of communication between healthcare providers and Black women as a means of addressing health disparities of Black women in the United States. Interpersonal adaptation theory will also be explored to explain patterns in behavior. I will also explore Structuration, Theory of social action, and Afrocentricity.

Theory of Planned Behavior

Theory of planned behavior links a person's belief to their behavior to predict and understand change in and intention of that behavior. This theory focuses on three factors that influence behavior; attitude toward the behavior, subjective norms, and perceived behavioral control. Attitude toward the behavior refers to the positive and negative self evaluation of how an individual believes they may execute that behavior and accounts for behavior influenced by social determinants. This belief may be fueled by how the individual believes others will respond to them and considers normative societal responses to behavior. Subjective norms refer to behavior based on whether or not society approves or disapproves the behavior. With segregated thinking dependent on who is affected by the behavior, approval and disapproval remains a subjective measure that can be linked to historic communications of race, gender, and health. Lastly, perceived behavioral control refers to the expectation that a person will choose a behavior of interest in lieu of a behavior of disinterest that may align with the best interest of others.

The Health Communication Capacity Collaborative (2014) applied the Theory of Planned Behavior to health and offers that implementation crafts interventions aimed at promoting health-improving individual actions that might be deemed socially undesirable, as well as other behaviors that necessitate individual choices but differ in their degrees of social acceptance. Overall, it can either concentrate on removing obstacles to individual behavior modification or fostering societal attitudes conducive to change. The problem here is that since the Theory of Planned Behavior places the responsibility of behavior change on the patient, the change in behavior is measured by and expected in lieu of existing social determinants of a narrative that already have a negative impact on the patient. For the purpose of this study, the theory of planned behavior regards the pattern of poor health treatment of Black women as a communication issue relevant to understanding the history of Black women's health as a precursor for belief in how Black women should be regarded in health spaces as well as a precursor for belief in change of how Black women should be treated in health spaces [equally]. The keyword here is "belief". The approach here bears the question "How has the belief of what it means to be a Black woman in America affected the medical treatment of Black women in America?"

Applying historical context to the theory of planned behavior, Black women were enslaved, forced out of their homelands, trafficked on large ships, and sold as property. For a long time, Black women did not have any control over their own bodies and were sexually, mentally, and medically violated through social structures historically embedded in the foundation of the United States. This historical legacy of health inequality of Black women began during the days of slavery and Black people continue to experience discrimination because the color of their skin and social status remains disparate to that of their White counterparts (Prather et al, 2018). I have discussed the disregard of Black women's rights as a product of inferior thinking and beliefs. This same disregard is fueled by this line of thinking over 400 years later. In alignment with the theory of planned behavior, I predict that inequality of Black women in health spaces as a result of the belief of Black inferiority and the nuance of historical appropriation stemming from slavery and throughout the 20th and 21st centuries. Furthermore, quantitative and qualitative data continue to show us why behaviors of Black women, towards the healthcare system and/or healthcare providers, are reflective of feelings of mistrust and fear. I understand that behavior of healthcare providers towards this population has not changed enough to alleviate disparate health issues affecting Black women. I can also link the intention of behavior of healthcare providers to present day health outcomes of Black women due to historical treatment of Black women and the current disproportionate rates in which Black women experience health disparities.

Social Learning Theory

Social learning theory considers environmental factors like observation and imitation in behavioral change. There are five stages of social learning theory; observation, attention, retention, reproduction, motivation (Rumjaun, 2020). Observation is exposure to a certain behavior. Here, I considered what observations influence health related behaviors of Black women as well as what observations influence the response of healthcare providers to health behaviors of Black women. Attention is the focus in response to the behavior causing regard and consciousness for a particular behavior. Retention is the recollection of behavior. Reproduction is one's acting out of behavior. Although subjective, the trend of intended communication versus the actual reproduction can be explored. Lastly, motivation refers to the reinforcers that continue to feed the behavior and lead to imitation.

Horsburgh & Ippolito (2018) used Bandura's social learning theory as a framework to understand and improve learning from role modeling in clinical settings. They explored how medical students learn from role models, focusing on observational learning as an active, dynamic process. Using qualitative methodology, interviews with final year medical students and clinical teachers were conducted to understand their perspectives on role modeling. Findings reveal that students recognize learning from role models as complex and selective, involving attention, retention, reproduction, and motivation. Teachers report using strategies to support learning, but these are not consistently applied or informed by understanding of students' cognitive processing. The cognitive processing is the piece that I am addressing in this study: the dependent variable to the learning of the healthcare provider which influences treatment of Black women.

Attention considers the determinants of the behavior being observed that are unique to health related behavioral responses by both healthcare providers and patients who identify as Black women. Retention considers the relationship between the response and the observed behavior and establishes trends or errors in recollection of behavior as these factors relate to health behaviors of healthcare providers and Black women. Reproduction considers if behavior aligns with what was observed, focused on, and retained. Motivation explores what fuels the behaviors and communication between healthcare providers and patients who identify as Black women that ultimately lead to persistent issues of health disparities of Black women in the United States.

Inferior treatment, sexualization, and educational inequality of Black women all contribute to imitated behavior because racism and discrimination are not innate, they are learned. For the purpose of this study, environmental factors will regard ancestral transfer of thinking that Black people are inferior and how this influences the communication of healthcare providers to Black-female patients. It is important to keep in mind that this ancestral transfer also includes acts of disregard in which perpetrators are historically not held accountable for. The approach here bears the question “What key preconceived notions of Black female patients influences communication between Black-female patients and healthcare providers?” Applying historical context to the social learning theory, educating healthcare providers of Black women experiences and making connections to the disparate health concerns faced by Black women today is a means for comprehensive approach to changing the narrative of and for medical treatment of Black women. Theory of Planned Behavior and Social Learning Theory generally discuss the nature of an individual as a result of what is directly or indirectly communicated to them. In the next section, I will discuss the Health Belief Model which is specific to health behaviors due to experience or preconception of a health outcome.

Health Belief Model

The Health Belief Model accounts for the cognitive processing of decision making regarding health behavior. There are six parts to the health belief model; perceived severity, perceived susceptibility, perceived benefits, perceived barriers, cues to action, and self-efficacy. Perceived severity is the idea that the outcome of a health behavior will be negative. Perceived susceptibility refers to an individual's subjective perception of their risk of acquiring an illness or disease. Perceived benefits is the idea that the outcome of a healthy behavior will be positive. Perceived barriers refers to the challenges that create barriers in completing health behavior. This also speaks to general understanding of these barriers as well. Cue to action refers to what triggers an individual to actually accept the need to complete the health behavior. Lastly, self-efficacy refers to the level of confidence a person has in their ability to complete healthy behavior.

It is important to consider what the health behavior is, or how achievable it is, depending on social and racial context. Although the Health Belief Model acknowledges the variation in behavior, relevant to perception of an outcome, this model places accountability and blame on the patient by focusing on the patient's decision making or behavior as a determinant of the health outcome. Application of the Health Belief Model falls short of evaluating disparities because it focuses on the immediate catalyst of the behavior rather than the barrier beyond the patient's control.

Otto et al (2021) employed the Health Belief Model to assess racial or ethnic disparities in cancer-related behaviors by exploring how preventative health behaviors can lead to improved health outcomes. There is no emphasis on historical barriers and interactions with the healthcare system and healthcare providers that drive racial or ethnic disparities and/or result in a cancer diagnosis. They found that disparities were evident in community attributes, everyday discrimination, anxiety symptoms, and health literacy among different racial/ethnic groups. However, perceptions of cancer risk, health literacy, self-efficacy, and engagement in preventive health behaviors varied significantly whereas, White non-Hispanics reported higher perceived cancer risk but worse health literacy compared to other groups. Yet, according to the CDC (2023), African Americans and Black people are more likely to be diagnosed with and die from various forms of cancer and have the greatest cancer-related death rate.

Theoretical Framework

Theory of planned behavior, social learning theory, and the health belief model describe the health behavior and subsequent health outcome contributing to health disparities of Black women in the United States. Before highlighting theoretical structures (Structuration Theory, Theory of Social Action, and Afrocentricity) inclusive of relevant, historic factors that influence health disparities of Black women in the United States, let us bridge the gap between the concepts of change in behavior and subsequent interaction.

Interpersonal Adaptation Theory. The interpersonal adaptation theory explores the change in behavior that influences new interaction between the healthcare provider and the patient. Interpersonal adaptation theory helps us understand change in behavior by establishing patterns in interaction and the standard for the interaction as well. Here, I consider perpetuation of inadequate levels of care leading to distrust and even tragedy - both of which influence health disparities of Black women in the United States.

Structuration Theory. Anthony Giddens's structuration theory argues that both structure and agency cannot fully explain social action (Hardcastle et al., 2005). It recognizes that these structures cannot survive without human action and can only be reinforced by the people who comply with them. Giddens suggests that individuals and societies create and reproduce social structures through their actions, while these structures, in turn, shape and constrain individual behavior. This theory emphasizes the duality of structure, highlighting the dynamic interplay between agency (the capacity for individuals to act) and structure (the norms, rules, and resources that shape behavior). Giddens argues that social life is characterized by ongoing processes of structuration, wherein individuals both maintain and transform social systems through their actions.

Theory of Social Action. Max Weber's theory of social action suggests that humans modify their actions based on the desirability of that action as measured by social context. Giving specific consideration of our chronological exploration of Black women's health, from the days of slavery through the Civil Rights era and until today, I can link racism from a historical, social, and systemic context, relative to the life of a Black woman, to how Black women have long been treated as "inferior". This also applies to the influence of communication of Black women's health, whether between a healthcare provider and a Black woman seeking treatment, how a Black woman responds to healthcare providers, or how a Black woman responds to her own health due to treatment by the health provider and the broader society.

Afrocentricity. To this point, the theories mentioned speak to general human interaction and how social and political structures and personal understandings or values influence such human interactions and cause certain divides in humanity. However, these theories require a focused lens on African American culture, history, and perspectives to fully grasp social context and directly address the issue of racism and its institutional embedding. Individual- and institutional racism and anti-blackness are often treated as taboo terms but are too unique to be broadly addressed. Afrocentricity, an African-centered communication theory established in the 1980s by Molefi Kete Asante, a professor of African-American studies at Temple University, emphasizes the centrality of African culture, history, and perspectives in communication processes. It seeks to reclaim and promote African identities, values, and experiences within communication studies, challenging Eurocentric perspectives that dominate mainstream discourse. Afrocentricity encourages the recognition and validation of African voices, narratives, and contributions to communication practices and media representations. Conceptually, this theory looks at how African ethnicity has been defined, understood and constructed in different ways throughout history and implications for racial formation as well. Racism is an individual choice but also embedded in social and governing institutions. The Jim Crow Laws and the new Jim Crow are relevant examples of why afrocentricity, or more generally African American communication theories, are important. Jim Crow represented the legitimization of anti-Black racism and segregation while the new Jim Crow addresses the existence of racism through integration. Jim Crow Laws supported racism through legalization of inequitable access and normalizing the inferiority of Black people while sustaining White privilege. The new Jim Crow unveils and helps us understand how individual racism and racial social constructs exist in the foundation of existing law where we see the persistence of social and systemic inferiority of

Black people and the persistence of White privilege. White privilege is receiving advantages, benefits, and rights that are unearned but given to White people solely because of the color of their skin. The conversation of White privilege is complex as social class also plays a role in societal ascription of positive attributes of White people and it is inaccurate to claim all White people are racist because of their White privilege. However, complexity does not eliminate the existence of individualized racism nor treatment of Black people due to individualized and social understanding of Blackness in America.

Conclusion

Consider generations of White privilege and learned behavior through observation and direct or indirect teaching of the inferiority of Black people to White children as perpetuated by Jim Crow Laws. There is a cycle of human compliance with what has been normalized and sometimes with lack of true historical understanding of why as racial thinking and acts experienced by Black people are *gaslit* in exchange for sustenance of this same law and order that is rooted in racism. This is important because human action is a response to and a sustaining factor for how racism shows up in social structures and persists across systems. By changing the narrative this study will ultimately redefine health communication by deconstructing theoretical structures of health communication to align with relevant, historic factors that influence the disproportionate health disparities of Black women in the U.S and highlighting theoretical structures inclusive of these factors as well.

Chapter 3: Methodology

Introduction

Changing the narrative is a means for shedding light on the “what” and “why” of Black women's health disparities with hopes of providing strategies for addressing them (D’Agostino, 2017). As previously stated, the purpose of this study is to develop evidence-based, communication strategies to address health disparities of Black women in the United States. I told the chronological story of Black women’s health in the United States to clearly identify and define paradigms and outcomes of these health disparities. I highlighted trends of resolutions that have failed to adequately address root, inequitable experiences of Black women that continue to fuel health disparities. I also explored relevant communication theories that fell short of adequately addressing the health disparities of Black women with the goal of redefining and deconstructing health communication so that it aligns with relevant and historic underpinnings of Black women’s health disparities. The last of three phases of the development of evidence-based, communication strategies is use of the voices and stories of Black women’s healthcare experiences to create a new narrative of Black womanhood and Black women experience with the U.S healthcare system.

Research Design

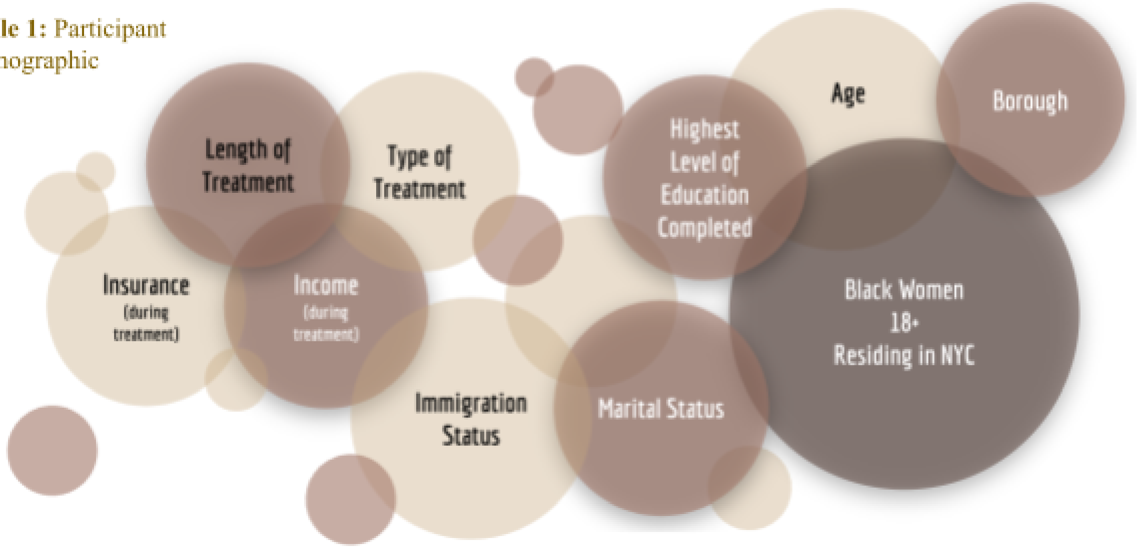
Changing the Narrative is a qualitative study aiming to use the stories of Black women to develop evidence-based, communication strategies to address health disparities of Black women in the United States. The qualitative research design refers to a more subjective lens of research and is concerned with establishing answers to the phenomenon in question (Creswell & Poth, 2018). The data collection method is interview, a method often used in qualitative studies. Interviews can be structured, with a set of prepared questions, or unstructured, without a set of prepared questions (Creswell, 2014). Interviewing is a strategy of collecting important information needed for analysis of the phenomenon under study (Creswell, 2014; Maxwell, 2013; Miles et al., 2014).

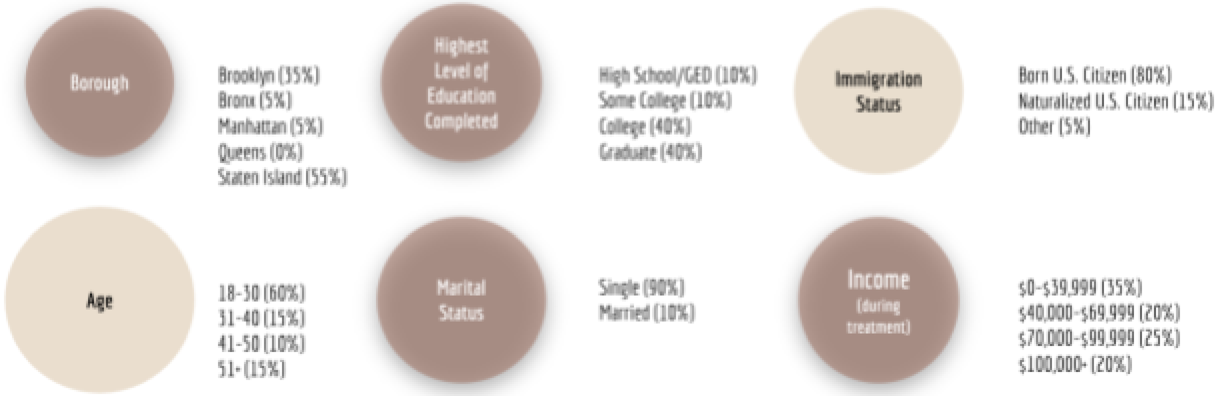
Ethnographic research design is the qualitative method for collecting data. Here, data is collected from interaction with the participant. The ethnographic design is essential to capturing intersubjectivity of participants and understanding trends of cultural influence on interactions with healthcare providers, trends of beliefs and assumptions of treatment that allow health disparities of Black women in the United States to persist, and trends in language and stories that influence shared values of the healthcare provider (Waring et al., 2014). The ethnographic approach allows social and cultural understanding of this issue from the perspective of the women being interviewed, how organizational cultures may socialize certain practices that result in inequitable treatment of patients that are Black women and how distinct values may exacerbate results. Conclusions made thereafter will allow for the determination of the functioning of the society (healthcare providers) and the individual (Black women in NYC). The facilitation of qualitative interviews will occur in each individual participant's own environment for better understanding of their experiences, perspectives and everyday practices.

Population and Geographic Location

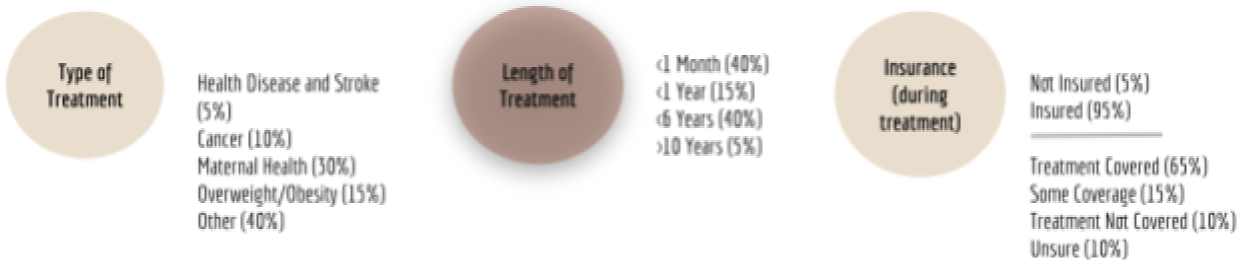
Participants were at least 18 years of age, self identified as a Black woman, and a current resident of 1 of 5 boroughs of New York City. New York City is known as the most diverse city in the world including the largest population of immigrants than any other city in the world. According to the United States Census Bureau (2023), New York City's population, as of 2022, is over 8 billion people. As this study focused on a sample size of 20 women, it was important to pull the sample from a geographic location as diverse as New York City. These women also represent a diverse group with different age, level of education completion, immigration status, marital status, ethnicity, annual income, insurance type, medical treatment, length of medical treatment and specific New York City borough of residence. Participants volunteered to share their story or stories of an experience with the healthcare system.

Table 1: Participant Demographic





Borough	Brooklyn (35%) Bronx (5%) Manhattan (5%) Queens (0%) Staten Island (55%)
Highest Level of Education Completed	High School/GED (10%) Some College (10%) College (40%) Graduate (40%)
Immigration Status	Born U.S. Citizen (80%) Naturalized U.S. Citizen (15%) Other (5%)
Age	18-30 (60%) 31-40 (15%) 41-50 (10%) 51+ (15%)
Marital Status	Single (90%) Married (10%)
Income (during treatment)	\$0-\$39,999 (35%) \$40,000-\$69,999 (20%) \$70,000-\$99,999 (25%) \$100,000+ (20%)



Type of Treatment

Health Disease and Stroke (5%)
Cancer (10%)
Maternal Health (30%)
Overweight/Obesity (15%)
Other (40%)

Length of Treatment

<1 Month (40%)
<1 Year (15%)
<6 Years (40%)
>10 Years (5%)

Insurance (during treatment)

Not Insured (5%)
Insured (95%)

Treatment Covered (65%)
Some Coverage (15%)
Treatment Not Covered (10%)
Unsure (10%)

There are five boroughs in New York City; Brooklyn, the Bronx, Manhattan, Staten Island, and Queens. Staten Island was represented by 11 participants. Brooklyn was represented by 7 participants. The Bronx and Manhattan were both represented by 1 participant each. There were no participants from Queens.

Participants were categorized into four age ranges. There were 12 participants ranging from ages 18-30. There were 3 participants ranging from ages 31-40 and 51+ each. There were 2 participants ranging from ages 41-50. There were 16 women who reported being born U.S. citizens, 3 reported being naturalized citizens, and 1 reported being on an education visa. A total of 18 participants reported a marital status of “single” and 2 reported being married. For the highest level of education completed, 8 women reported earning a masters degree, 8 women reported earning a bachelor degree, 2 women reported completing some college credits, and 2 women reported earning a high school or GED diploma.

Out of the 20 women interviewed, 19 women reported being employed at the time of medical treatment. The remaining woman was a stay at home mom. Out of 20 women interviewed, 19 reported being insured at the time of medical treatment and 1 reported not having insurance. Of the 19 women who were insured, 7 were insured through employment, 7 had a form of government insurance, and 2 were insured under their parents. Finally, of the 19 insured, 13 reported that insurance covered their treatment in full, 3 reported that insurance covered “some” of their treatment, 2 reported that they were unsure, and 1 reported that her insurance did not cover her treatment.

Women were also asked for their income at the time of treatment. A total of 7 participants reported that their income was between $0 and $39,999 at the time of treatment. A total of 4 participants reported that their income was between $40,000 and $69,999 or $100,000 or more at the time of treatment. Finally, there were a total of 5 participants who reported that their income was between $70,000 and $99,999 at the time of treatment.

Methods of Data Collection

Among the qualitative research methods, qualitative interviews were used in this study to investigate communication between healthcare providers and patients, patient level of care, and adequate access to resources from the experiences of research participants. According to Creswell (2013), qualitative research is a means for exploring and understanding the meaning individuals or groups ascribe to a social human problem. The social human problem being addressed here is health disparities of Black women in the United States. A flier with research information was posted to social media channels and emailed to social groups and educational institutions. Interested women visited a shared link and completed an online pre-screening. The pre-screening was presented as a Google Form and provided more information about the goal of the study, participant role in the study, and included criteria for participation as well. Once the pre-screening was completed, submissions were reviewed and prospective participants were contacted to schedule an interview through Calendly. Interviews were scheduled in 30-minute intervals and facilitated by video on Google Meet.

Qualitative Interview Conditions

Participants controlled their environment by selecting the physical location of the interview and deciding between a phone call or video conference with video being enabled or disabled depending on their level of comfortability. This method provided space for vulnerability when openly discussing their experience with the healthcare system. Also, for the purpose of anonymity, participants were assigned a 7-digit identification number once interviewed and a pseudonym. Anonymity in qualitative interviews refers to the practice of keeping the identity of participants confidential, ensuring that their names or any identifying information are not disclosed in the research findings or reports. Participant names with assigned identification numbers and pseudonyms are kept on a password protected spreadsheet with permissions that only allow access to the researcher. Pseudonyms used are shades of brown, reflecting melanin tones of Black women.

Furthermore, in addition to the manual recording of notes during interviews, all interviews were audio recorded to ensure accuracy of information included in this study. Through the consent form, all participants were informed that interviews would be recorded and they were also reminded of the recording just before recording commenced as well. The recordings also helped to draw out themes, explored in chapter 4, from the stories of the women interviewed and their shared experiences with and attitudes towards health disparities of Black women in the United States. Thematic and Interpretive Phenomenological Analysis are discussed in the next section of this chapter as methods for drawing out these themes. Themes in qualitative interviews refer to recurring patterns, topics, or concepts that emerge from the data collected during the interviews. These themes provide insights into the research questions and help to organize and interpret the qualitative data effectively. They represent the underlying meanings, experiences, or perspectives shared by participants and are identified through careful analysis of the interview transcripts. Names of institutions and healthcare providers have been blocked out for confidentiality purposes. In efforts to tell the true and authentic stories of women interviewed, expressions of profanity were not removed or blocked out.

Qualitative Interview Questions

There were five pre-screening questions used to filter through the pool of women interested in participating in this study. Women were asked to share their full name and email address so that they may be addressed properly in a response email. Women were asked to confirm that they were at least 18-years of age, which is in alignment with the federal threshold of adulthood and the age where people gain the legal status of an adult. Another question asked was whether the interested person identified as a Black woman. The correspondence explained that this study sought Black women to share their experiences. Lastly, women identified their borough of residence within New York City.

The interview questions were broken down into three categories- personal identifiers, insurance, and story/testimony. The personal identifiers were used to show diversity in the sample size. Insurance questions were essential to the type of treatment received and/or available to the participant as well as treatment costs and payment. The story/testimony category is the most important category because participants were provided space to speak their truths. Although there were prompting questions, most times women told their stories freely.

Methods of Data Analysis

Methods of data analysis refer to the process of utilizing statistical and/or logical techniques to analyze data. Content analysis, meta-analysis, thematic analysis, and interpretive phenomenological analysis methods are all best suited for this research and help to bring the quantitative and qualitative research together within the triangulated approach. Throughout this study, I have included quantitative data, qualitative data, and existing research to prove the systemic induced differences of the Black woman's health experiences in comparison to their racial counterparts. I have also considered such data in our analysis through the triangulated approach to data analysis.

Triangulation

Triangulation refers to the use of "multiple methods of data collection and analysis" to develop a comprehensive understanding of phenomena" (Patton, 1999, pg 1192). Triangulation is also a strategy in qualitative research that will test validity and reliability of information from different sources by cross-verifying information and reducing bias. This approach helps to strengthen the overall credibility of the research results by corroborating evidence from different sources or viewpoints. Those sources or viewpoints for this study are, as mentioned in chapter 2, the chronological story of Black women's health in the United States that has led to health disparities, existing research and trends of resolutions that have failed to adequately address root, inequitable experiences of Black women, and the responses of Black women interviewed for this story.

Content Analysis

Content analysis is linked to both qualitative and quantitative research methods. With content analysis, qualitative data can be quantified, which means data can receive a numerical assignment as a descriptor of themes or concepts discovered through data analysis. The main theme here is that Black women in the United States experience health issues at disparate rates. Content tells us why and how Black women in the United States experience health issues at disparate rates and provides numerical insight on the health issues and the rates at which the health issues are disparately experienced by Black women in the United States.

Meta Analysis

Meta analysis is linked to quantitative data and determines trends by examining multiple studies of the same subject. With meta analysis, I will establish clear patterns of Black women health disparities from a variety of contexts including historical, present, social, political, and economical measures of how these disparities came to be and the inefficient responses to these disparities as well. Additionally, evaluating responses can also shed light on new focus areas for problem solving solutions that were not previously regarded.

Thematic Analysis

Thematic analysis is linked to qualitative data and usually tied to transcripts of qualitative measures such as interviews. Common themes are identified through close examination of data. Repeated use of topics, ideas, and patterns are tracked within the dataset as identifying themes will assist with uncovering the various factors related to persistent and disproportionate health issues faced by Black women in the United States.

Interpretive Phenomenological Analysis

Lastly, interpretive phenomenological analysis will be used for this research. An article from the National Library of Medicine defines phenomenological analysis as a qualitative approach which “aims to provide detailed examinations of personal lived experience” (Smith and Osborn 2015). The twenty women interviewed shared their personal lived experiences with the healthcare system in the United States. Their stories were studied to show commonality in the research pool and the overall impact of treatment received by Black women from healthcare providers.

Data will be coded for easier digestion of findings. Coding of data refers to the process of transforming collected information into meaningful groups. Coding the data will invite reliability by providing operational definitions for key terms and concepts within the study. Coding will be developed once the researcher is able to extract themes from the data as coding will also need to include definitions of language used by research participants for the purpose of clarity. Coding will focus on capturing language, context, and influence and interaction - the key items relative to changing the narrative and addressing the issue of persistent health disparities of Black women in the United States.

Conclusion

As qualitative data will be analyzed to prepare the data story that will be the foundation for the new narrative, it is important that data is relevant, reliable, and timely in both the historical and present contexts. Historical contexts concern the root of the disparities while present contexts concern current patterns of these disparities as well as new influence of these disparities as well. Chapter 2 explores three centuries of influences of Black women health disparities. From slavery to the Civil Rights Movement to current concerns, I have established a timeline of the story of Black women's health in America but still require further analysis of data to develop communication strategies.

Chapter 4: Presentation of Research

Introduction

The methodology outlines the process for data collection and highlights the small, but diverse, sample population of which the data will be collected from. Given the triangulation approach of data collection throughout this body of work, content, thematic, and interpretive phenomenological analysis will be conducted on the data collected from the interviews. The content and thematic analysis will uncover key patterns from interviews to show prevalence and impact of the problem and the interpretive phenomenological analysis will allow for a deeper understanding of lived experiences of the women interviewed through my real-time interaction with them.

In this chapter, I will explore research findings and discuss relevant themes captured through interviewees. I will also link findings to the historical and present contexts of health disparities of Black women in the United States as outlined in Chapter 2. The women interviewed for this research study bravely recalled encounters at healthcare facilities and with healthcare providers in New York City. These women were asked a series of identifying questions to show diversity in the sample size. These identifying questions also attempted to delineate indicators of treatment by healthcare providers and as patients in the healthcare system based on identifiers. As mentioned in chapter 3, these identifiers are brough of residence in New York City, age, immigration status, marital status, employment status, insurance status, insurance type, insurance coverage, income, and highest level of education completed.

Recruitment

The purpose of this study is to develop evidence-based, communication strategies to address health disparities of Black women in the United States. This study prioritizes the voices of Black women as evidence of a Black woman's experience with the U.S. Healthcare System. In chapter 3, I discussed the study sample size of 20, Black women living in 1 of 5 boroughs in New York City. Recruitment efforts included posts to social media accounts such as LinkedIn, Facebook, Instagram, and Twitter. These posts included a brief description of the research study, a call to action for volunteers to share their experience with the U.S. Healthcare System, and a link to a Google Form that screened eligibility for participation in the research study. All women who were contacted by email regardless of eligibility. Women who met eligibility requirements were sent a calendar link with instructions for how to schedule their interview. Once the interview was scheduled, participants received an email from DocuSign prompting them to read and sign the consent form prior to the time of interview on the scheduled date. All signed consent forms were received prior to the scheduled interview.

A total of 25 women responded to the call to action by completing a pre-screening questionnaire. Of those 25 women, 21 completed interviews and 4 were no shows to scheduled interviews. 1 of the 21 women who completed interviews did not fully meet criteria as she resides in New York City but received treatment in another state. Our instructions were unclear with regards to location of treatment. To avoid possible conflicts with the sample size, I made the decision to not include data collected from this participant in findings. However, the issue I am addressing is not a New York City problem but rather a problem of the United States. The story of this participant will be included in the appendix.

Interviews

Interviews were scheduled in 30 minute intervals and were facilitated through Google Meet or, if participants experienced issues joining Google Meet, a telephone call. The researcher provided an overview of the study and reiterated that, per the consent form, participants were able to withdraw from the interview at any time. Participants were asked a series of questions categorized by personal identifiers, insurance information, and then provided space to freely tell their story/give their testimony. Personal identifiers provided data to show diversity in the sample size in addition to the New York City borough of residence. Questions requesting insurance information were intentionally seeking data that shows the difference in health treatment depending on insurance availability and type. Lastly, the story/testimony questions ensured uniformity in data collection about health treatment in lieu of the space for participants to freely speak their truths about their experiences. Interview questions are listed in Appendix A.5.

Findings

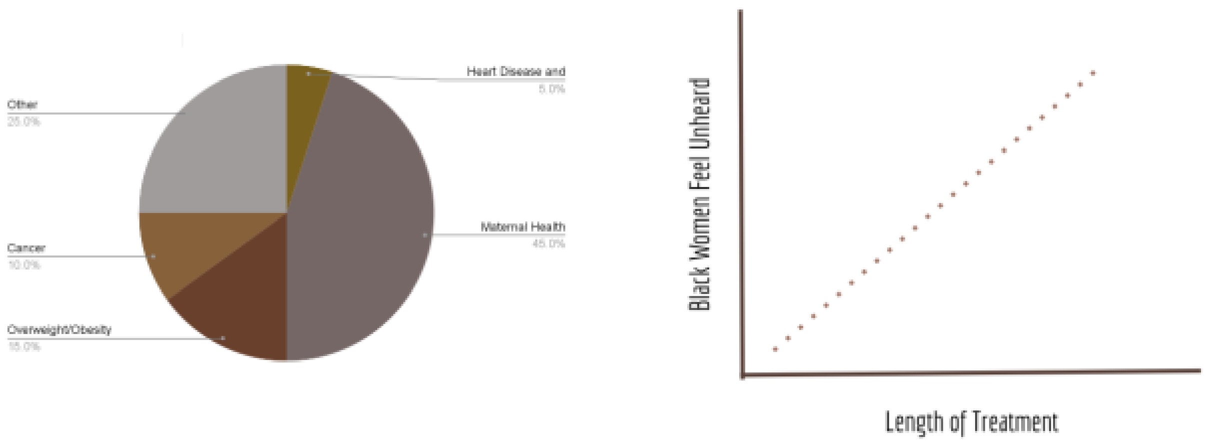
The research questions are addressed throughout this body of work. I have discussed the root and current exacerbators of health disparities faced by Black women and explored the lens of Communications as essential to addressing these disparities. Although findings are relative to the research questions addressed throughout this body of work, this section will prioritize RQ3: *How can existing data and shared experiences be leveraged to develop evidence-based, communication strategies to address health disparities of Black women in the United States?* Participant narratives spoke to their overall experience with the healthcare system and highlighted areas for improvement that have aligned with research and hypothesis thus far. To disclaim, although participant stories are not shared until after themes are discussed, I used their pseudonyms and experiences to describe the relevance of themes in this study.

I captured four themes across interviews relevant to the communication issue. Those themes are:

1. The health disparities of Black women in the United States are represented in this study
2. Black women feel unheard

3. Race, ethnicity, and gender of the healthcare provider does not always matter
4. Black women achieve better treatment outcomes when they advocate for themselves or are advocated for

Table 2: Research Findings

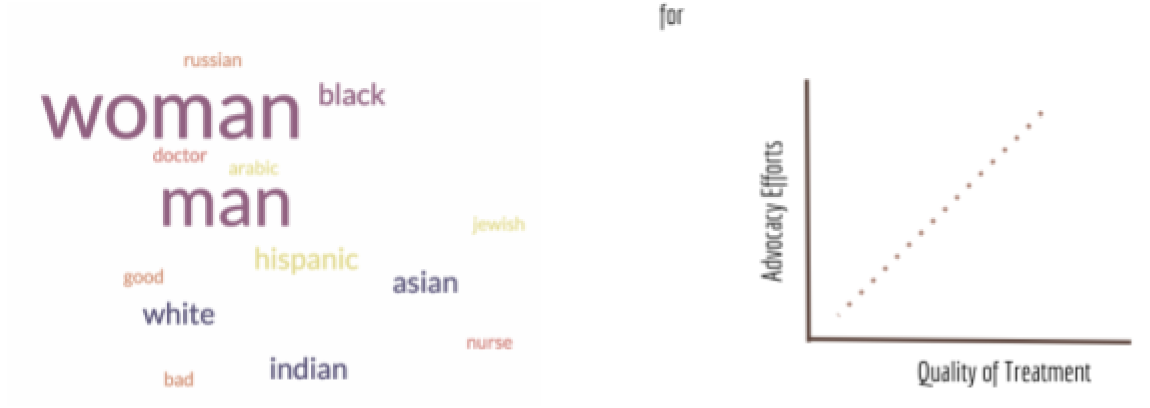


Emergent Theme #1

Emergent Theme #2

Emergent Theme #3: Race, ethnicity, and gender do not always matter

Emergent Theme #4: Black women achieve better treatment outcomes when they advocate for themselves or are advocated for



In chapter 2, I discussed the top six health disparities experienced by Black women in the U.S. These disparities are heart disease and stroke, cancer, type 2 diabetes, maternal health, HIV, and overweight and obesity. Even with a random sample size from one city in the United States of America, almost all of the top 6 health disparities of Black women in the United States were experienced by the women interviewed in this study. Now, it is important to keep in mind that this research is not attempting to affirm the health disparities but rather prove that the disparities are an issue of historic and present day narratives of Black women. All women answered the interview question, “What do/did you require treatment for?”. About 45% of women interviewed reported treatment for maternal health related concerns, 15% reported treatment of overweight or obesity, 10% reported treatment for cancer, and 5% reported treatment for heart disease and stroke. None of the women reported being directly treated for HIV; which may be due to socialized shame or embarrassment. Furthermore, 25% reported “other” types of treatment including COVID-19, gallstone removal, appendicitis, a ruptured cyst, and cervical psychosis- some of which can be linked to one of the health disparities. Coffee reported treatment for COVID-19 also shared how treatment for COVID-19 was impacted by her underlying health condition, Type II Diabetes; which is the final health disparity. Desert shared that her gallstones were removed. According to Fogel et al. (2023), gallstones can be caused by obesity or diabetes. Peanut shared that she was diagnosed with cervical psychosis. Cervical psychosis can be linked to cervical cancer (Tilbrook, 2010).

As for the second theme, *Black women do not feel heard*, all women who participated in this study reported not feeling heard, at some point, mainly regarding expressions of pain or bodily abnormality and inclusion in planning for treatment. Participants answered the interview question “What is/was the length of your treatment(s)?” Results from this study showed that when Black women go unheard, there is a higher chance of misdiagnosis and treatments last longer. Length of treatments ranged from a few days to over 14 years whereas some treatments lasted longer because initial expressions of pain were ignored and/or misdiagnosed. Umber reported a 14-year long journey for accurate medical diagnosis. Hickory reported a pattern of treatment by healthcare providers parallel to the race and/or ethnicity of the healthcare provider. Buff reported being called “dramatic” when she expressed pain. Chocolate reported that she was given medication that gave her an infection and caused her to have an immediate c-section. Brunette refused medication and visited the hospital three times within one week to ensure she was properly diagnosed and treated for severe pains that ultimately led to a ruptured cyst. Mahogany expressed receiving a treatment that she did not need and subsequently undergoing a procedure without anesthesia. Cinnamon reported being “tired” of seeing healthcare providers whose initial response to expressed pain is to prescribe medication. There are also implications of the influence insurance type and coverage may have on this theme as well. Chestnut reported that her health concerns were never resolved as she became, with no insurance, afraid of the cost for care.

The third theme, *race, ethnicity, and gender of the healthcare provider does not always matter*, references the race, ethnicity, and/or gender of the healthcare provider and not the patient. There was not enough distinction regarding interaction with healthcare providers of different race, ethnicity, or gender for a clear conclusion to be made about the type of interaction being determined by the race, gender, or ethnicity of the healthcare provider. However, racism and gender discrimination may still play a role because of the race and gender of the participants. In instances where Black women experienced inadequate medical treatment or lack of care from a Black woman or Black man, internalized racism, when members of marginalized racial or ethnic groups adopt negative societal perceptions and stereotypes about their own group, still applies. Hickory shared that White male healthcare providers feel insulted when a Black woman attempts to advocate for herself or asks to be included in health planning. Umber shared that she has been treated by many men but it took a woman to make her feel heard. Mocha shared that one bad experience with a female GYN, stopped her from receiving services from a female GYN for many years.

The last theme, *Black women achieve better treatment outcomes when they advocate for themselves or are advocated for*, speaks to stories the women shared about the power and necessity of advocacy to ensure improved health treatment and outcome. In most cases, the women who reported advocating for themselves, through research or direct communication with the healthcare provider and despite the length of time, were taken more seriously and received proper diagnosis which ultimately saved many of their lives. Umber reported that she changed her specialist 20 times before being properly diagnosed. Buff reported that she leveraged her employment with the hospital to ensure she and her baby, who was admitted into the neonatal intensive care unit (NICU), received quality care.Brunette shared that when surgery did not help to rid her body of cysts, researched holistic treatments and found that there were different triggers to the disorder which was not mentioned in any conversation with her doctor. Through change in diet and being intentional about stressing less, she has been able to reverse her disorder.

Relatives or friends in the health profession were able to ask the right questions, provide medical guidance, explain treatments, make referrals, and ensure equitable treatment and appropriate follow ups post treatment. Umber reported that it was actually a friend, who also happens to be a nurse, that advised her to detox her body after taking radioactive iodine pills for cancer treatment to rid her body of radioactivity. Chocolate shared that her cousin worked at the hospital where she gave birth. She was able to call her cousin to get things that she needed when she felt neglected by healthcare providers. Cedar reported that her mom, a nurse, “shut down” an invasive surgery option which doctor's claimed to be the only option. Her mom advised of a non-invasive method which doctors ultimately moved forward with.

As discussed, health disparities of Black women in the United States exist because of racial and social constructs but persist because it is a communication issue that addresses data of the health disparity without considering the historical context of Black women's health in the United States and the voices of Black women and their experience with the United States healthcare system and healthcare providers today. Because details from each story align across themes, the stories will be organized by the first theme, *the health disparities of Black women in the United States are represented in this study*. Each story will then be tagged with one or more of the other three themes: Black women go unheard; race, ethnicity, and gender of the healthcare provider does not always matter; and Black women achieve better treatment outcomes when they advocate for themselves or are advocated for. Also, as mentioned in chapter 3, the names included in these stories are pseudonyms. Pseudonyms used are shades of brown, reflecting melanin tones of Black women. By using a pseudonym, confidentiality remains present while humanizing the narratives and protecting expressed facts or opinions without revealing true identity.

Heart Disease and Stroke

Hickory. *Black women feel unheard*; *Black women achieve better treatment outcomes when they advocate for themselves or are advocated for.* Hickory suffered a mild stroke and was immediately admitted to the hospital for treatment. Hickory asked a lot of questions and used her phone to research everything communicated to her about the stroke she suffered. Hickory reported a pattern of treatment, parallel to the race and/or ethnicity of the healthcare provider, while hospitalized. Hickory reported that one resident doctor, possibly hispanic, was sent in to inform her that her brain activity needed to be checked but then went 12 hours without being seen by a doctor. The Personal Care Assistant (PCA) and nurse, both Black women, were the only two who checked on her and explained her care to her. Hickory noticed that her roommate, a White woman, was met with “nurses, PCAs, and everyone she asked for.” She did not feel that her health was in “good hands” and decided to sign herself out of the hospital: discharge against medical advice. She was informed that if she left, her insurance would not pay for treatments received. But Hickory planned to follow-up with her insurance and primary care doctor, a Black man. When she followed up with her primary care doctor, she explained everything about her hospital visit and was given guidance for how to get hospital treatments paid for and a referral to a cardiologist where she received the heart and stress tests that the hospital delayed to do.

Cancer

Umber. *Black women go unheard, Race Ethnicity, and Gender do not always matter*; *Black women achieve better treatment outcomes when they advocate for themselves or advocated for*. It took doctors, of specialization, over 10 years to diagnose Umber with cancer. The diagnosis came after years of doctors not being able to identify the issue and Umber expressing concerns of and presenting facts, through research, of the aligned symptoms. She was diagnosed with hyperthyroidism in her early 20s. Umber shared that she has changed her Endocrinologist at least 20 times. She said, “I knew I was sick for so long and they kept telling me they couldn’t find what was wrong.” For years she tried to get her doctors to “dig deeper” because of the accompanying symptoms she experienced and not wanting to continue to take medication or receive treatments that would not work. Through her own research, she found that her symptoms aligned with Thyroid Cancer and she requested surgery. More than 10-years later, she met a White woman, visiting the same hospital, who shared that she had elective surgery to remove the thyroid. Umber then asked her doctor for elective surgery and once pre-surgery tests were done there was a new sense of urgency to remove the cancer that they could now see. Post surgery to remove the cancer, she had to take radioactive iodine pills. This treatment was not chemo but Umber expressed that “it felt like it”. After treatment, a friend, who also happens to be a nurse, advised her to detox her body after the treatment to get rid of the symptoms and told her “you’re literally radioactive”. Umber had not been advised of this by her surgeon or physician.

Umber encountered many male doctors but the doctor that listened to her feelings and choices regarding her body was a woman. She expressed that White male doctors “look at you like *how dare you* when you question them” about what they are doing with your own body. Umber shared that her first doctor was an Indian doctor by “design”. He listened to her and explored many options for treatment. This doctor trusted her and did his research but he could only do so much before having to refer her to a specialist.

Type 2 Diabetes

Coffee. Black women feel unheard, Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for. Coffee disclosed being diagnosed with Type 2 Diabetes prior to treatment for COVID 19 and discussed the impact of that diagnosis to the hospitalization and treatment for COVID 19. Coffee felt ill at work and believed she may have had bronchitis. She opted to work from home and had a virtual doctor appointment. She was prescribed antibiotics for bronchitis. A few days later, Coffee began feeling worse. She decided to go take a Covid test. She visited a nearby testing site and waited in line with people who appeared to be sicker than others but nevertheless all in the same line waiting to be tested. Coffee began to feel faint and “almost passed out on that line”. She was rushed to the hospital by ambulance. There, it was confirmed that she had contracted COVID. Coffee was hospitalized for four days. She advised that “once you start getting better they transfer you to a medical facility used for patient overflow.”

She described treatment and conditions at the medical facility as “awful”. Coffee shared that the hospital was understaffed and staff were overworked but there was an abundance of medical staff at the medical facility. Additionally, there were military officials on each floor. No visitors were allowed and even though no phones were allowed at the facility, Coffee had her phone and was able to call her daughter. She was unable to shower because the shower was being used as a hospital storage. Bathrooms were not fully functioning. Staff seemed brand new out of nursing school. They didn’t know what they were doing. Patients did not receive meals at a set time and watched staff eat well before patients received meals. Coffee, a diabetic, was not given diabetic food options and received insulin injections even after consistently informing healthcare providers that she usually takes pills.

Coffee began breathing treatments that required her to walk up and down the hallway with an oxygen tank. She was slowly weaned off as her breathing improved. She was told that she would be sent home with an oxygen tank but wasn’t sent home with one nor given a prescription for one. Coffee had her blood drawn everyday but was unsure if a COVID test was done prior to her discharge. No one ever mentioned why they were taking her blood. She also talked about receiving a shot to her stomach while in the hospital to prevent blood clots because she was not moving around. She refused this treatment at the medical facility. She expressed that she “forced” herself to get better by getting up and walking around.

On the morning of the 7th day hospitalized, Coffee was told that she would be discharged. She was seen by two Black nurses, one of which told her that she couldn’t leave because her blood sugar was high. Coffee asked the nurse why she took her blood sugar after she ate because “of course it would be high”. Coffee was discharged at 9pm that night - still very weak but was not taken out with a wheelchair. The nurse just walked her out.

Overweight or Obesity

Taupe. *Black women feel unheard*; *Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Taupe experienced intense knee pain that prevented her from sleeping and completing normal day-to-day activity. Upon visiting two separate doctors, she was advised that her only option was a knee replacement. After surgery, she learned that a knee replacement was not the only option after all. The knee replacement did not help and the issue with her knee turned into a back issue. Over the course of two years, she sought other opinions for treatment. Some doctors advised that her weight was an issue while others advised that her weight had nothing to do with the pain. She was prescribed a concoction of medication for pain relief, anti-inflammation, and blood thinning to treat the long-term effects of her knee replacement surgery.

Almost 10 years later, she is still taking this concoction of medication with no resolve to her knee pain. Taupe reported that through the year, she felt the least heard when she expressed the pain she felt in her knees and still believes she needs “individualized care and concern”. Of those who had health insurance, Taupe reported that her health insurance did not cover her treatment in full and she never paid the balance. Taupe was intentional about obtaining opinions from two or more doctors and always informed her doctor of pain or discomfort. However, she wishes she would have done more research and knew about other options because she got a knee replacement that did not help but rather gave her a “different type of pain” and left her taking a concoction of drugs to cope with the pain.

Bistre. Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for. For about five years, Bistre was told that the source of swelling and pain in her legs was a result of her being overweight. She reported that doctors were dismissive to her expressions of pain and her weight was mentioned before a "how are you?" or before her vitals were even checked. She suspects that this is a common response for people who may be overweight. She considered losing weight before seeking medical attention so that her weight is not used against her.

Bistre reported four separate incidents where she felt uncomfortable during doctor visits. Her primary doctor is an Indian woman who she believes has an aversion to obesity because of how "everything is clouded by her view of weight". Dr. Dakkak was referred to two orthopedic doctors whom she had undesirable experiences with. One male orthopedic became frustrated with Bistre when she expressed that she thought it was more than just weight. She was also frustrated because he gave her 4 or 5 medicinal prescriptions before he heard her full story. During a separate encounter, she arrived at a doctor's appointment before being told the doctor was not available that day. She was sent in a room with Physician Assistants, two young White males. She remembers laughter, immaturity, and an overall negative experience.

Bistre then used a phone application to find an orthopedic doctor she could relate to. A former dancer, she scheduled an appointment with an orthopedic doctor who had experience with dancers. Out of the four doctors she hoped to get opinions from, this doctor listened to her expressions of pain before diagnosing her and considered her history as a dancer is a cause of the pain. Other doctors placed blame on her weight before asking her about her feelings. She reported that she felt comfortable enough to start off their conversation with what she experienced from other doctors and she thinks that caused the doctor to have a different approach. He suggested joint vitamins and supplements for the pain.

Penny. *Black women feel unheard, Race, ethnicity, and gender of the healthcare provider does not always matter, Black women achieve better treatment outcomes when they advocate for themselves or advocated for*. Over the course of three years, through research and seeking a second opinion, Penny was diagnosed with sleep apnea. Penny informed her doctor that she was having issues breathing. She was told the breathing issues were a result of her not sleeping properly. Penny's symptoms were often ignored and she recalls experiencing "a lot of bias" regarding her weight. She said, "I was told to try losing weight but I just do not have a fast metabolism… no one in my bloodline does. Other options should've been ruled out first."

Penny shared that she was "brushed off" by three doctors. Penny believes that her primary care doctor, a woman for southeast Asian, brushed off sleep apnea because the doctor believed that Penny's symptoms aligned with her diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) and obesity. When Penny expressed continued concern, she was referred to a psychiatrist as some psychiatric symptoms may be explained by undiagnosed sleep apnea. The psychiatrist was a White woman, who also dismissed Penny's claims by saying that the breathing issue could be a response to Penny not adjusting to her ADHD medication. Penny then tried what she calls the "fake advocate trick" when she met with another psychiatrist, a Black man. Penny described the "fake advocate trick" as used to imply that someone else is concerned about her breathing issues. It is intended to urge doctors to consider other options for diagnosis because the symptom is noticeable by someone other than the patient. She told the psychiatrist that her "boss noticed the breathing issues." A deeper look into Penny's case led to the sleep apnea diagnosis. The psychiatrist referred her to a sleep study. Penny then learned that her insurance would not cover this level of treatment but her doctor adjusted the title of the procedure so that it would be covered by her insurance.

Maternal (or Reproductive) Health

Chestnut. *Black women feel unheard; Black women achieve better treatment outcomes when they advocate for themselves or advocated for. Chestnut experiences severe menstrual cramps* that cause her to miss days of work and school. She has been hospitalized on a few occasions due to the pain. Although treated immediately, she is given a concoction of medication which only provides temporary relief. It is also important to mention that although she received immediate attention for menstrual cramps, her journey for answers to her health concerns lasted for over two years and yielded no results. Chestnut also has insurance that partially covers health treatments. Although there was no follow-up or resolution by the hospital, this participant was stuck with a hospital bill that took her a year to pay off. Another physician advised that this participant might have endometriosis, a condition whereas tissue grows outside the uterus and causes pelvic pain. This participant never sought the opinion of a specialist because she was afraid of the cost associated with the treatment. She was prescribed birth control for her severe menstrual cramps. She attempted to pick up the medication on multiple occasions but was told that the pharmacy had not received the prescription despite the prescribing doctor advising that a new prescription was sent to the pharmacy each time this participant inquired. This participant decided to just “forget about the birth control”. Chestnut also reported that her employer designated health insurance covered “some" of her treatment. Chestnut paid the balance out of pocket and continued to seek treatment for severe menstrual cramps despite several failed hospital visits but has since stopped.

Beige. *Black women feel unheard; Race, Ethnicity, and Gender do not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Beige was diagnosed with Polycystic Ovary Syndrome (PCOS) and told that she was unable to have children. However, she has been able to reverse the PCOS with a proper diet. She found out she was pregnant in August of 2022 when she was almost in her 2nd trimester. When she aged out of her parent's insurance, she decided that paying out of pocket for services would be cheaper than paying monthly for insurance as she is now a "sickly person" and is "big on holistic health". Beige received prenatal treatments at a medical center and described check-ins as "helpful" and "easy". One month after finding out she was pregnant, she suffered a miscarriage. Her water broke at about 4 AM and she visited the emergency room at a nearby hospital with her partner. For about 5 minutes, she was forced to answer questions despite being in apparent pain. She was taken to the maternity ward but not given a room right away although doctors announced that she was dilated and in labor. About 10 minutes after being situated into a room, she delivered a still born son. Shewas advised to remain at the hospital until the placenta naturally fell out. One doctor checked placement of placenta and pushed placenta out by pressing down on Beige's stomach because he did not want her to put her body through more trauma with surgery. Beige was discharged with period panties and plenty of literature to read. There were no instructions or referrals for follow up with an OBGYN. She was unable to receive treatment at the medical center because she was no longer pregnant. Beige tried to find an OBGYN that was Black but had a bad experience so she did not follow through. The hospital that treated her for the miscarriage never followed up and never asked if she had an OBGYN. Beige did not notice any bodily changes after the miscarriage and decided to continue holistic health practices. Beige was the one participant who did not have health insurance at the time of treatment. She aged out of her parent’s insurance and decided that paying out of pocket for treatment would be cheaper than paying monthly for insurance.

Buff. *Black women feel unheard; Black women achieve better treatment outcomes when they advocate for themselves or advocated for*. Buff went into labor and was given epidural. The anesthesiologist was aggressive when administering the epidural but ignored her when she expressed pain. The epidural made her entire body go numb, from her neck down. When she alerted the nurse, she was told that she was “being dramatic”. During labor, the baby’s heart rate dropped. A number of healthcare providers rushed the room but no one notified Buff of the issues. They then asked for consent for emergency surgery, and not until she pushed them for more information did they disclose that the emergency surgery was needed because of the drop in heart rate. The baby spent a few days in the Neonatal Intensive Care Unit (NICU) and was fed through a feeding tube. The NICU was staffed by mostly floating nurses due to COVID. Buff then felt inclined to leverage her employment with the hospital to ensure she and her baby received quality care.

Buff often heard nurses talking about “how much money they were making” for being there while she and “other families were dealing with sick children”. The baby vomited often because he was being overfed by the nurses. When weaning the baby off of the feeding tube, Buff noticed that the baby was having a hard time feeding without the tube. The responding nurse advised that “it will take a while for him to get used to eating” but did not provide any information or tips. However, another nurse physically helped Buff position herself and the baby for better milk flow. Although the baby was discharged because he was deemed “fit to eat on his own”. he still vomited after eating once discharged and struggled with feeding at home. Buff’s primary care doctor referred her to a Gastroenterologist to determine how best to feed the baby and ultimately the instructions helped.

Sandy. *Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Sandy reported "transactional" treatment through the 9-month timeframe of pregnancy and during birth for her first child in comparison to that of her second child. Sandy fell down the subway stairs while pregnant with her second child. She visited her Obstetrician (OB) and was cared for immediately. Her OB gave her a belly band and sent home with resources and followed up with her as well. It helped that her OB was also pregnant at the time. Sandy identified type of insurance as a possible indicator for type of treatment from a healthcare provider. Sandy had medicaid during her first pregnancy and received no personalized care. As previously mentioned, she reported that treatment was transactional. However, years later she had a different experience with employer insurance and access to a doctor who provided a different level of care. Sandy and her OBGYN were both pregnant at the same time. She reported feeling like they were going through pregnancy together. She is a White Jewish woman, described as "thorough" with care. Sandy reported that her sister was employed at the hospital where she gave birth. She was a nurse in the maternity unit. Sandy believes that her sister's presence was the reason she received community support and resources like pampers, formula, and a car seat before she left.

Chocolate. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Chocolate experienced rashes on her belly two weeks to her due date. The rashes were "itchy" and spread to her arms overnight. She sent pictures of the rashes to her doctor and he said it could either be a Pruritic Urticarial Papules and Plaques of

Pregnancy (PUPPPS) rash or an issue with liver or kidney. Chocolate's OBGYN is a hispanic male. She reported having a "great experience" with OBGYN. He expressed that all of his patients are important to him but his African American pregnant patients are most important because of the death rate during pregnancy and labor due to lack of care. Chocolate's OBGYN had COVID so he was unable to treat her. He contacted labor and delivery on her behalf. When Chocolate was admitted into the hospital, she was treated by a White male attending and White female resident. She reported that she showed the rashes to healthcare providers at the hospital but they did not immediately address the rashes.The resident was "short" with words and exposed the gender of the baby by referring to the baby as "she" twice before asking Chocolate if she knew the gender of the baby. Chocolate planned to wait until birth to find out the gender of her baby.

Unfortunately, the medication administered caused an infection and Chocolate had to have an immediate c-section. They were giving her paperwork to fill out while she was experiencing contractions but had not yet explained the reason for a procedure. Chocolate needed to stay in the labor and delivery ward for care after giving birth and her baby was taken to the NICU because the medicine got into her bloodstream. She was unable to see her baby for over 24 hours. Chocolate reported that there was only one instance that a doctor informed her about her child's well-being. When she was moved to the maternity ward, Chocolate learned that her child was given formula.

When Chocolate was moved to the maternity ward, she was paired with a Filipino nurse. She describes this nurse as ”nice" and explained that she helped her change her pads, and got her a wheelchair because she was unable to walk. Chocolate reported that her cousin worked at the hospital of which she gave birth. She was able to call her cousin to get things that she needed when she felt neglected by healthcare providers. She was finally treated for the rashes on her stomach and arms. Chocolate remained at the hospital for 4 days and even though the doctors wanted to keep her through the weekend. she signed herself out. At a follow up appointment, her doctor confirmed that she had PUPPPS two weeks later during an appointment.

Chocolate reported being unsure if her health insurance covered “some" or all of her treatment nor is she aware of her balance. Before Chocolate left the hospital, she was informed of a copayment of over $1000. However, she later received a bill in the mail for $32,000 that she never saw on her insurance claims.

Cinnamon. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Cinnamon described a three year journey of finding a GYN who provided thorough examination and inclusive conversations about patient health planning. She shared that when she expressed pain or concern, “the initial response is medication rather than addressing the issue and asking questions.” She was ready to have children but was aware of the high mortality rates of Black women and their infants due to “lack of good healthcare” and she said “I don’t want that to be me.” Cinnamon visited a White woman GYN for three years. She reported that this GYN was “nice” but “exams did not feel thorough”. This GYN also did not notice existing fibroids, which Cinnamon was later informed about with her new GYN, a Black woman. However, Cinnamon encourages women to seek doctors that are relatable. Not necessarily one of the same race or ethnicity, but finding a community that works. She said “we control our health and can not take the backseat to that.” Cinnamon, through research, identified key considerations as she searched for a new OBGYN. She was intentional about finding someone relatable, knowledgeable about Black women’s health, and trustworthy and inclusive when planning for next steps. Her new OBGYN also celebrates little milestones and corrects misinformation about maternity and motherhood.

Mahogany. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter*. At 19-years-old, Mahogany went to get a check-up after having sex for the first time. The doctor performed a Pap smear and results showed that she contracted the Human Papillomavirus Infection (HPV). Mahogany grew up in Jamaica and had not taken the vaccine. Mahogany described her Russian male doctor as "rude as f–k" because his response to the diagnosis was "you should not have had sex". She also described her Arabic nurse as "judgemental".

Mahogany took the three rounds of the vaccine and followed up with a Gastroenterologist two months later for a colposcopy, a procedure to closely examine the cervix and vagina for signs of disease. The Gastroenterologist informed Mahogany that the doctor should not have performed a Pap smear because of her age. The doctor advised that "it is a money making thing" and that the doctor "should have done it at 21". The Pap smear can help prevent cervical cancer or find it early. The likelihood of someone under the age of 21 getting cervical cancer is very low (CDC, 2023).

Mahogany shared that she experienced a high level of pain and discomfort during the 2-hour colposcopy procedure. She was advised to take two tylenols prior to the procedure but is unsure why she was not offered local anesthesia to numb the area. Mahogany still has post traumatic stress disorder (PTSD) due to the pain. She was told "if you're still experiencing pain after, take tylenol". Mahogany thought "there's no way ya'll don't know that this sh–t hurts". She bled for 3 days, heavy enough for her to need to wear a pad. Six months later, she had another colposcopy. A year later, the HPV had cleared from her body on its own.

Brunette. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Brunette described an almost two year journey to save her ovaries. Brunette suffered from a ruptured ovarian cyst days after being diagnosed with a Urinary Tract Infection (UTI). She was prescribed antibiotics but felt no change in symptoms after about four days. She experienced pain to the point of not being able to move. Brunette was taken to the ER by a friend. A computed tomography (CT) scan was completed and results showed that Brunette had a cyst in her ovary that was pressing on her bladder. She was then sent home with a referral to a Gynecologist (GYN), whom Brunette was adamant should be Black. She visited the GYN and an intravaginal ultrasound was completed and the GYN prescribed vicodin for the pain. Brunette did not like how the medication made her feel so she did not take it and managed the pain by sleeping on her opposite side. The GYN scheduled the pre-surgery appointment for the following Monday, which was 3 days later. This was a *red flag* for Brunette because the GYN had her wait a few days to remove the cyst when it was "already so big".

That Monday morning, at around 4:30 AM, Brunette's cyst erupted. She returned to the ER. Brunette was given morphine for the pain and waited 11-hours for surgical removal of the ruptured cyst. She was told that a unilateral hysterectomy had to be done. She completely lost her left ovary because it could not be saved. The cyst was cleaned out of the ovary through a Caesarean (C) section incision but Brunette was unaware of which organs she had left. The next day, she complained to nurses about an intense pain in her stomach. When offered pain relief, she refused them because she "knew the pain needed a different type of attention". The resident doctor advised that the pain she was feeling was *gas* from the incision. She was discharged a day later with pain relief, antibiotics, and reassurance that the pain she was feeling was "just gas".

Brunette returned two days later as the pain had worsened once again. After a 4-hour wait, a CT scan was performed and an abscess was found in her stomach. It was found that while Brunette waited 11-hours for her surgery, the cyst fluid spread into her abdomen and they did not clean her out properly.

While hospitalized after surgery, Brunette overheard her nurse, a White woman, say "At 28 years old you should know how to wipe your a–." On her day of discharge, the doctor advised "If you can keep your food down, you can go home". The same nurse neglected to check on Brunette during her entire shift but rather apologized to Brunette during the shift change, saying "I'm so sorry. I had a lot to do today". Brunette responded, "It's okay. I know you're doing the best that you can do" and expressed seeing an expression of embarrassment on the nurse's face. Although Brunette was unable to keep her food down, she did not share this information with the doctor or her nurse because she no longer wanted to be in a place of miscare. She was discharged with antibiotics that made her feel sick. Yet, if she didn't take them her stomach would make her sick. Thankful, the antibiotics ended up working.

Brunette's primary doctor, after reciting hospital records, notified Brunette that one of her fallopian tubes had been removed- which she was unaware of. Her primary gave her 6 weeks from her original admit date to stay home from work other than from her discharge date. However, her employer allowed her to work from home. A few months later, Brunette's GYN noticed a small cyst on her ovary and advised that lack of ovulation would not allow the cyst to grow. They GYN prescribed birth control as her "only option" and Brunette settled on the nuvaring. Brunette's insurance would only pay for the generic version.

About 2 years laters, Brunette decided to remove the birth control because of apparent side effects, such as depression and anxiety. She searched for a new GYN and found an Arabic woman. Brunette explained everything to her and the GYN performed an ultrasound before confirming all reproductive organs that Brunette still had. She also found no cysts in the surviving ovary. The GYN also advised that birth control was not her only option and it "would not have made a difference so you do not need to be on it if you do not want it." Brunette reported a "different experience" with this GYN because she "asked for my opinion and explained everything."

Mocha. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Mocha has long had "issues with going to local doctors within a confined area who do not show the right level of concerns". She tries to find doctors who are "attentive and communicative". Mocha shared that she has seen so many things which is why she is much more assertive with doctors. She dealt with the death of someone she knew due to a cancer misdiagnosis. Her cousin had surgery for carpal tunnel, compression of nerves near one's wrist, when she actually had amyotrophic lateral sclerosis (ALS), a disease that affects the brain and spinal cord. Her cousin was bed ridden before her death. Mocha's sister died of emphysema, a type of lung disease that causes breathlessness, caused by an allergic reaction to medication. This medication triggered Stevens-Johnson's syndrome, a rare, serious disorder of the skin and mucous membranes. Mocha shared that "doctor's are just people who studied something different than we did and still need something to refer back to."

In her early 20s, Mocha was referred to a new GYN when her primary GYN no longer took her insurance. Mocha thought she had a yeast infection. This was before over the counter treatment for yeast infections became available. The new GYN was an Asian woman. Mocha reported that when the new GYN noticed that her discharge was a little heavy she said, "That's the problem with you, American women. You don't know how to clean yourself properly." Mocha responded "What you stated was rude and incorrect. I know what my vagina smells like and I know what my discharge looks like." She made a big deal about not being charged for the visit because she did not receive treatment and walked out of that doctor's office. Mocha called her former GYN and asked for a referral somewhere else. She was referred to a man of West Indian descent who performed a full exam, confirmed the yeast infection, and provided a prescription for necessary medication. After this incident in 1991, Mocha refused to go to a female GYN until referred to her current GYN by her former primary care physician, a Black woman, in 2013. Her current GYN is a Jewish woman that she feels comfortable with.

Mocha also shared that in 2018, when her former primary care left her practice, all patients defaulted to her partner, an Indian man, whom Mocha expressed knee pain to. She felt pain when walking up and down steps and when stretching. Sometimes her knees would "flare up". The primary care doctor advised "the pain you feel in your knee is because of your weight. I'll send you to our nutritionist." Mocha located her own orthopedic doctor for a second opinion. There, she learned that her "knee cap was tilted and the cartilage was starting to wear out." She was initially misdiagnosed and actually needed surgery. Mocha's primary care doctor needed to clear her for surgery. Although he was apologetic for the misdiagnosis, Mocha reported her primary physician to her insurance company because she did not believe she should be billed for this treatment. Surgery went well and recovery, through therapy, went well also.

Carab. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Carab experienced three attempts of implanted birth control removal over the course of 2 months although she was advised that the implant would be "easy to remove” when this form of birth control was suggested to her. Carab was just 16-years-old when her high school clinic introduced Nexplanon, a birth control implant, in response to her painful menstrual cramps. Although she was informed of side effects, such as weight gain and irregular periods, she decided to get the Nexplanon because nothing else helped to relieve the pain of her menstrual cramps and she was reassured that the implant is easy to remove. The Nexaplon was implanted in her arm. By age 18, Carab began to experience the side effects and by age 19 she was ready to take it out. Not only was she gaining weight and experiencing very irregular periods, Carab got bad acne and “experienced nerve pain”.

First, Carab visited her primary care doctor for removal. She received anesthesia and the doctor opened a tiny hole for access to the Nexplanon. The removal was unsuccessful because the Nexaplon was deep in her arm and stuck in tissue. “It hurt really bad and the final tug made my arm go numb.” Carab was not offered pain relief but given a referral to see the Radiologist. She sought a second opinion from her GYN who advised that she get an x-ray and then go to the hospital to get it taken out. With the x-ray, Carab was shown exactly where the implant landed in her arm. She expressed being nervous when she returned for removal. She thought of the unsuccessful first experience and the pain she felt. She was given anesthesia and her arm was once again cut open. Carab recalls two healthcare providers who were present for the removal. The Hispanic woman did not listen to her and seemed cocky. When Carab expressed pain, she ignored her and continued removing the implant. She described the other healthcare provider, an Asian woman, as calm and gentle. She distracted Carab and reassured her that she was there for her. Removal proved to be difficult because tissue grew around it over the years. However, removal was successful this time around. Carab continues to experience nerve pain in her arm but has decreased over the years.

Other Types of Treatment

Desert. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Desert described the childbirth experiences at her local hospital as “amazing”. However, she experienced the opposite when seeking help for abdominal pain. She compared the pain to labor pain. When she went to the hospital, she was given a pregnancy test and ultrasound. The pregnancy test came back negative and nothing was found on the ultrasound. Desert said that healthcare providers were dismissive. She was discharged that same day.

Later that evening, the doctor called to let her know that she had gallstones. She was admitted as an out-patient because the pain was not “consistent over a long period of time.” She was told that she would be scheduled for surgery if the pain persists. “You’ll be okay”. A week later, Desert started feeling “a different type of pain”, worse than before and she was now vomiting. When she returned to the hospital, doctors said “You’re back”. Another ultrasound was taken and results showed that there were two very large gallstones. She was then set to be discharged from the hospital. However, desert refused to leave and demanded treatment. She stayed and underwent surgery.

Cedar. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for*. Cedar suffered from appendicitis and was hospitalized for 7 days. She was in her school library when she felt a sharp pain in her side. She called her mom, a nurse, and her mom took her to her primary care doctor. The primary found that the pain was possibly being caused by appendicitis and sent her to the hospital for confirmation. When appendicitis was confirmed, the doctor advised that there was only an invasive option to check the appendix before surgery. Her mom "shut down" this option and advised that she was aware that the appendix could be checked by way of ultrasound. Cedar had not been sexually active and did not prefer the invasive option.

Nurses attempted to withdraw blood for testing but were unable to locate her vein. The first nurse, a White Italian woman, tried to find the vein but then rushed off to surgery. During the attempts, there was no acknowledgement of the pain Cedar was feeling while nurses were trying to find her vein. They finally found a vein in her neck.

She reported feeling a "different demeanor" from healthcare providers when her mom was in the room. The procedure was explained and went well. Cedar's mom was kept informed during the procedure. After the surgery, she stayed hospitalized for about a week, waiting to pass gas. Her mom was by her side the whole time. Cedar expressed the importance of having her mom there. "When you're in pain, you're not thinking about asking certain questions." She followed with, "as much as it is unfortunate that we have to advocate for ourselves as Black women, from the point of entering a health facility, and as much as it may feel like you're overstepping, you have to prioritize your health in order for them to prioritize your health."

Peanut. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for.* Peanut visited a physician, an "old" White man, after locating a lump on her neck. She described the physician as "dismissive". He said that the lump was "very small" and that her visit to his office might not be the "best use" of her time. Only after Peanut "told him off", did the physician screen her lump and refer her to a specialist. However, due to recent unemployment, she experienced a lapse in insurance and was unable to see the specialist. It was not until about 10 months after her initial visit with the primary physician that Peanut secured insurance and saw the specialist.

She decided to go to a doctor's office predominantly staffed with all women of color. She was treated by a woman of color, an Indian woman who let Peanut talk and was attentive and took a lot of notes. She sent her to see a specialist and “nothing major was wrong but it could have been something serious”. Peanut was told that the lump was stress-related and caused by the bed she was sleeping on, this is called cervical psychosis. The specialist recommended physical therapy.

Pecan. *Black women feel unheard; Race, ethnicity, and gender of the healthcare provider does not always matter; Black women achieve better treatment outcomes when they advocate for themselves or advocated for*. Pecan experienced symptoms of Hidradenitis Suppurativa (HS) from age 16 but was not diagnosed until she was 25 years old. HS is a painful, long-term skin condition that can be linked to cancer and causes abscesses and scarring on the skin. She gets huge cysts, under her arms, breasts, and pubic areas. Cysts lasted from about a few days to a week and could be as small as a penny or as big as a tennis ball. Pecan’s primary physician referred her to a dermatologist but the dermatologist was not as knowledgeable about HS. Her diagnosis was the start of a 2 year journey of a series of surgeries as well as self-research which eventually served as the primary tool for effectively addressing her health concerns.

Pecan started seeing an HS specialist and was put on an antibiotic remedy of about 7-8 pills for eight months to a year. She did not experience any cysts for the first 3-4 months but then they started coming back. Pecan became frustrated because she was “taking all of these pills and the cysts keep coming back”. She began to believe that her body became immune to the pills. Pecan’s mom, a nurse, worked with a plastic surgeon, a Black man, who specializes in HS so she went to see him. Her boyfriend, also a nurse, “asked appropriate questions that were not on her radar.” He was also helpful in providing clarity on treatments and outcomes. Pecan was given two surgical options and decided on a Tdap-flap because the doctor told her she would experience less pain after the surgery. She had 2-3 preoperative appointments with the surgeon before surgery. Pecan felt welcomed when she arrived at the hospital for surgery. The first surgery was set to remove cysts from under her arm. Pecan reported that she felt “woozy” after surgery. She was anemic and believed that her feelings were a result of anemia. Her boyfriend alerted the “immediate” nurse, a White woman, and she advised that Pecan was “okay”. She then alerted another nurse, Black woman, who found that she “didn't have enough iron and increased my drip.”

Pecan stayed overnight and left the next day with follow up appointments. After surgery, she explained that it seemed like disease was looking for somewhere else to go on her body. In fact, they grew back in other places, more painful than before. After she showed the doctor the growth under her breasts, she returned for a second surgery to get the cysts removed. After this surgery, she developed a blood clot that needed to be drained out.

Pecan researched holistic treatments for Hidradenitis suppurativa diagnosis (HS). She found that there were different triggers to the disorder which was not mentioned in any conversation with her doctor. These triggers are diet, hormones, and stress.Has managed to control her diet with a paleo diet. Work is no longer a stress factor for her anymore. Lives mindfully and does yoga and meditation. Doesn’t get them in surgical spots anymore. Around Pecan’s menstrual cycle she gets cysts because she is unable to control hormones yet.

Conclusion

Chapter 4 provided insight into the qualitative interview process for this study and shared themes gathered from participant responses. Although the lived experiences of participants are previewed in this chapter, full stories can be found in the appendix. The first two research questions - *What are root and current exacerbators of health disparities faced by Black women in the United States? What are these health disparities?* and *Why is the communication lens essential to unveiling historic and existing methods of addressing exacerbators of health disparities faced by Black women in the United States?* - were addressed in previous chapters. The final research question, *How can existing data and shared experiences be leveraged to develop evidence-based, communication strategies to address health disparities of Black women in the United States?*, is partially addressed in the literature review with existing information and stories relevant to historical context of health disparities faced by Black women in the United States, and in this chapter through shared lived experiences of the women interviewed. In chapter 5, I will delve deeper into findings and present evidence-based, communication strategies to address health disparities of Black women in the United States.

Chapter 5: Summary, Implications, and Outcomes

Introduction

At root, the communication issue here is racism. That is, the race of Black women and not necessarily the race of the healthcare provider. As mentioned in the operational definitions section, Dr. David R. Williams, a Harvard Scholar, provided a definition of racism that aligns with this study. He defines racism as “an organized social system in which the dominant racial group, based on an ideology of inferiority, categorizes and ranks people into social groups called “races” and uses its power to devalue, disempower, and differentially allocate valued societal resources and opportunities to groups defined as inferior” (Williams et al., pg 106). Our experiences govern the way we interact and communicate with each other. In health communication, there is a need for communication theories to embed historical and societal contexts within theoretical frameworks and stop focusing on patient attitude and behavior as the problem but rather at institutional and individual levels of racism that influence patient attitude and behavior.

This study expands the scope of health communication to consider the role that the racial systems, root contributors to health inequity, play in health communication strategies. As previously stated, the key to developing evidence-based strategies to address health disparities of Black women in the United States is the identification of trends and contributors of health disparities of Black women in the United States. The merging of three separate moments in history, 19th, 20th, and 21st centuries, and the voices of Black women allowed for a deeper, data informed approach to developing these strategies. In chapter 5, I will discuss study findings and synthesize existing data and shared experiences and develop evidence-based, communication strategies to address health disparities of Black women in the United States.

Summary of Findings

Before delving into research findings from qualitative interviews, I will revisit the research questions. There are 3 research questions: (1) RQ1. What are root and current exacerbators of health disparities faced by Black women in the United States? What are these health disparities? (2) RQ2. Why is the communication lens essential to unveiling historic and existing methods of addressing exacerbators of health disparities faced by Black women in the United States? (3) RQ3. How can existing data and shared experiences be leveraged to develop evidence-based, communication strategies to address health disparities of Black women in the United States? The first question guides exploration of health disparities faced by Black women in the United States and provides perspective into why these health disparities continue to persist. The second question introduces the role of communication, specifically health communication, in the historic and persistent existing health disparities faced by Black women in the United States. The third question aims to identify patterns between historical and present contexts and establish a connection between root and current issues of health disparities faced by Black women in the United States through the voices of Black women. This includes an analysis of themes existing in research and through themes collected from interviews focusing on the lived experiences of Black women.

RQ1. What are root and current exacerbators of health disparities faced by Black women in the United States? What are these health disparities?

In this study I explored historical root exacerbators of health disparities faced by Black women in the United States as well as top disparate health concerns faced by Black women today. Such exacerbators of health disparities faced by Black women in the United States were slavery, racial institutions, socialized narrative of Black women, and the intersection of race and gender. It is all historical context that continues to exist today. Black women, with no right or bearing of choice over their own bodies, were sexually assaulted, unwillingly impregnated, and sexualized by White male slave masters. Black women were used as medical experiments, seldomly without their consent, and excluded from health planning. Black women did not have access to adequate health facilities or treatment. Black women did not have the basic human right to vote for ideas and policies that aligned with their health or liberation. Black women continue to be characterized as “strong”, “angry”, sexual, aggressive, and loyal to servitude. All narratives developed by White men, embedded in the systemic foundation of this country, and subsequently embedded in social structures.

According to the Office of Research on Women’s Health of the National Institute of Health, Black women experience 6 diseases at disproportionate rates: heart disease and stroke, cancer, type 2 diabetes, maternal health, HIV, overweight and obesity, and maternal health. These health disparities are linked to structural racism - such as environmental racism through food intake, disparities in misdiagnosis of Black people, lack of attention to or disregard to awareness of symptoms, lack of quality of care, implicit bias, and underlying chronic conditions.

RQ2. Why is the communication lens essential to unveiling historic and existing methods of addressing exacerbators of health disparities faced by Black women in the United States?

In this study, health communication is explored as more than just about health information, literacy, and choices, but also how researchers can compute and view the bigger picture of the more comprehensive acknowledgements of the racial and unequal foundation for Black women that narrates the life cycle of a Black woman and then contributes to health disparities. Health communication has long blamed Black women for health choices and behaviors and offers opportunities, through promotional health materials, that force Black women to possibly experience equitable care while navigating racial foundations of this country.

The communication lens is essential to unveiling historic and existing methods for addressing exacerbators of health disparities faced by Black women in the United States. In this study, I explored how detrimental systemic racism, embedded in social structure, is to communication between patient and healthcare provider. It is not enough to solely understand or address the systemic implications of the disparities because a changed system does not change people. Addressing the exchange of information leading to inadequate interactions is our attempt to change people.

Poor communication in healthcare is rooted in systemic racism and marginalism, and gender oppression and discrimination. Poor communication, for the case of this study, is not only inclusive of the immediate interaction between patient and healthcare provider, but also includes pre-existing and socialized understanding or regard for the life or rights of a Black woman and a Black woman's response to continued micro- and macro aggressions that result from the pre-existing and socialized understanding or regard for the life or rights of a Black woman. The behavior of poor communication is caused by bias from healthcare providers based on their views of the Black population. These views and subsequent treatment cause feelings of defeat or mistrust in healthcare providers and in the healthcare system. Despite historical context, the Black community is seldomly blamed, shamed, or ignored for current health circumstances that can be directly linked to a system founded on racism.

Generally, the narrative of the Black woman in the United States is not a narrative that was constructed by nor is a true or authentic narrative of the Black woman. The true narrative is one that includes years of abuse and misuse of Black women. The narrative is one that highlights the systemic and socialized barriers that allow abuse and inadequate treatment of Black women to persist. The narrative is one that highlights perceptions, bias, attitudes, and behaviors of healthcare providers when interacting with Black women and links it to health disparities experienced by Black women. The narrative is one that equally focuses on institution and individual and how the narrative plays a defining role in treatment outcomes.

RQ3. How can existing data and shared experiences be leveraged to develop evidence-based, communication strategies to address health disparities of Black women in the United States?

Research questions one and two address findings from existing data, quantitative and qualitative, relevant to health disparities of Black women in the United States. Here, I will discuss how shared experiences, recorded from qualitative interviews, align with existing data and offer a pathway for developing evidence-based strategies. There were three themes gathered from the qualitative interviews. Each theme is relevant to the new scope of health communications as explored in this study and are relative to communication or interaction as essential indicators of better health outcomes for Black women.

I interviewed twenty Black women from 4 of the 5 boroughs of New York City (NYC). As mentioned, demographically, NYC is the most diverse city in the world. According to the United States Census Bureau, New York City's population, as of 2022, is over 8 billion people. Yet, results from interviewing twenty women from this population included all but one of the top health disparities of Black women in the United States - which is the first identified theme. These health disparities are heart disease and stroke, cancer, type 2 diabetes, maternal health, HIV, overweight and obesity, and maternal health. Women were asked "What do/did you require treatment for?" and, with the exception of HIV, were either directly treated for one of those health disparities or treated for an illness linked to one of those health disparities. I wondered if

HIV is a health concern that women intentionally concealed due to social implications. Hutchinson and Dhairyawan (2017) discuss the negative role shame plays in public health and with the diagnosis and treatment of HIV. The other health disparities could be directly linked to unhealthy lifestyles of the Black woman, which is a response to environmental racism and inadequate access to adequate health resources. The health disparities are linked to health related mistreatments and outcomes for Black women from the three timeframes explored in this study - 19th, 20th, and 21st centuries. Overall, representation of this sample size affirms how prevalent these health disparities are.

For evidence-based strategies, response to this research question provides an opportunity for changing the narrative about the root of the disparity from blame to consideration of systemic and social structures with the appropriate narrative influencing communication and interaction between patient and healthcare provider.

The second theme is Black women feel unheard. I found that when Black women feel unheard, there is a higher chance of misdiagnosis and treatments last longer. All women who participated in this study reported not feeling heard, at some point, by the healthcare provider administering treatment to them or monitoring their treatment. This is specifically regarding expressions of pain or bodily abnormality and inclusion in planning for treatment. I found that length of treatment correlated with two factors for all participants: (1) healthcare providers not listening to what Black women were saying about their health concerns and (2) misdiagnosis. When health providers are not attentive to what a patient is saying about their body, regardless of the color of the patient's skin color, there is room for misdiagnosis and exacerbated health concerns. Women reported that their voices were generally ignored. I also found that race, gender, and insurance played a role in length of time for treatment and attentiveness to the voices of Black women.

Length of time for treatment was short-term when the type of treatment was evident or if participants required immediate attention. I can conditionally define *short-term* as any treatment with a length of a month or less. This included treatments for two named disparities, stroke and maternal health. One participant reported a mild stroke and reported a pattern of treatment by healthcare providers parallel to the race and/or ethnicity of the healthcare provider. As for maternal health, Black women are reportedly 3 to 4 times more likely to die of pregnancy related complications than women of other ethnic groups. In this study, 3 of the participants who received maternal health treatment reported treatment lasting from a few days to one month. One woman reported being called “dramatic” when she expressed pain. Another woman reported that she was given medication that gave her an infection and caused her to have an immediate c-section. The fourth woman reported treatment for the entire length of her pregnancy which is of course a longer length of time. She shared a positive experience of being able to connect with her physician. Three women reported treatments for other health concerns. Two of them reported that lack of positive interaction with healthcare providers contributed to treatments lasting longer than they needed to be. Lastly, there were three exceptions to this short term time frame whereas participants were either misdiagnosed or misled, leading to longer time frames of treatment both consecutively or nonconsecutively.

The length of time for treatment was long-term when types of treatment were not evident and required more research. In such cases, it took about 2 years to more than 10 years for proper diagnosis and treatment. Of the eight women who reported long term treatments, six reported being misdiagnosed initially. These six women reported seeking several opinions and advocated for themselves on numerous occasions before a healthcare provider listened to their concerns and took them seriously. One of the six women never resolved her health concerns as she became, with no insurance, afraid of the cost for care that continued to not be resolved. For the last two women, one expressed receiving a treatment that she did not need and then subsequently underwent a procedure without anesthesia while the other reported being "tired" of seeing healthcare providers whose initial response to expressed pain is to prescribe medication.

Another implication is insurance. All but one participant had health insurance at the time of treatment. The exception aged out of her parent's insurance and decided that paying out of pocket for treatment would be cheaper than paying money for insurance. Women faced issues with insurance (i.e. lapsed due to employment gap) which caused a gap in treatment and reported that treatment was different depending on the type of insurance they were covered by. Women reported having to report healthcare providers to their insurance company due to inappropriate transactions. Women also reported that they were initially unaware of the gap between insurance coverage and out of pocket payment and are unsure if they have a balance to pay.

Although race, ethnicity, and gender are indicators of treatment, I found that they do not always matter. Participants were most treated by Black and White women. However, there was only one instance where participants reported a good experience when treated by a White woman - a Jewish woman. Participants reported treatments from over seven White male healthcare providers. However, there was only one instance where participants reported a good experience when treated by a White man - a Russian man. One participant reported that White male healthcare providers feel insulted when a Black woman attempts to advocate for herself or asks to be included in health planning. One participant noted that she has been treated by many men but it took a woman to make her feel heard. Participants reported a good experience when treated by Black and Hispanic women and Hispanic males. Participants reported good and bad healthcare experiences with Black men and women, Asian women, Arabic women, Indian men and women.

For the evidence-based strategy, response to this research question provides an opportunity for changing the narrative about patient and healthcare provider interaction that leaves Black women feeling heard, and not judged, and included in health planning.

The final theme is Black women achieve better outcomes when they advocate for themselves. I also found that Black women achieve better outcomes when relatives and friends in the health profession advocate for them. In most cases, the women who reported advocating for themselves, through research or direct communication with the healthcare provider and despite the length of time, were taken more seriously and received proper diagnosis which ultimately saved many of their lives. One woman shared that she reported treatment concerns with her insurance company after inappropriate treatment from a healthcare provider. A total of five women reported advocacy from a family member or friend in the health profession. These advocates were able to ask the right questions, provide medical guidance, explain treatments, make referrals, and ensure equitable treatment and appropriate follow ups post treatment.

For the evidence-based strategy, response to this research question offers a pathway of resiliency through advocacy for self or through a trusted and knowledgeable friend, family member, or a professional advocate.

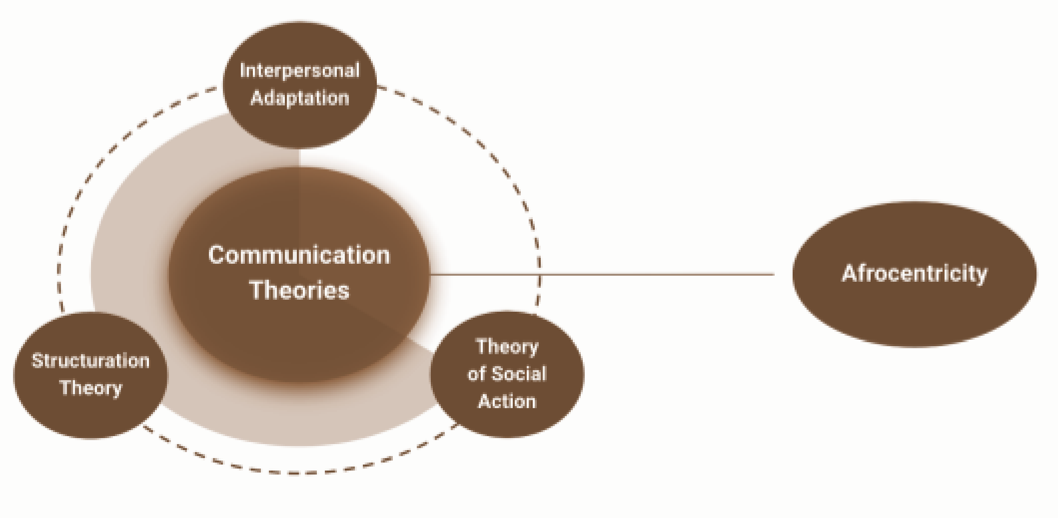
Evidence-Based, Communication Strategies to Address Health Disparities of Black Women in the United States

To restate the problem, health disparities of Black women in the United States exist because of racial and social constructs but persist because it is a communication issue that addresses data of the health disparity without considering the historical context of Black women's health in the United States and the voices of Black women and their experience with the United States healthcare system and healthcare providers today. I have linked relevant historical context and existing data to responses from qualitative interviews with the target population, Black women. This link shows the pattern of and root for health disparities of Black women despite shifts in systemic structures and current ethical training of healthcare providers. This study addresses the problem from both the institutional and individual level because, as previously stated, a shift in system, although essential to equity, does not equate to a change in the ideals of people. Malcolm X once said "The most disrespected person in America is the Black woman." Considering the narrative and status of Black women in the United States that has thrived in systemic and social structures which Black women have been and are required to navigate everyday, communication, specifically our notion of health communication, seeks to change the exchange of information, ideas, and emotions of healthcare providers regarding Black women in health spaces. Although Black women are the target population here, I believe that the strategies can be generally implemented as the ultimate goal is to reduce and eliminate disparities to make way for equitable outcomes.

Theoretical Framework

Table 3 shows the theoretical framework used in this study. It bridges the gap between the ideas of change in behavior and the subsequent interaction and outlines four theories. First, interpersonal adaptation theory explores the change in behavior that influences "new" interaction between the healthcare provider and the patient. It is used to uncover patterns of ineffective interaction and also understand how patterns influence health disparities of Black women in the United States. Second, structuration theory argues that social structures are produced by individual and societal actions and shape individual behavior. It is used to deliberately uncover social and systemic determinants of these behaviors and their influence on health disparities of Black women in the United States. Third, the theory of social action argues that people adjust their behavior depending on how desirable it is within their social environment. It explores what perpetuates thinking that health equity for Black women is undesirable and pinpoints what specifically needs to be addressed to change such mental models. Lastly, Afrocentricity, situated on the exterior of the framework, is a meta theory that can be overlaid on any framework. For the purpose of this study, it is used as a lens to ensure this study stays focused on Black women. Afrocentricity emphasizes the centrality of African culture, history, and perspectives in communication processes. It is used to center the stories and perspectives of Black women like Odakor, Harriet, Sarah, Fannie, Henrietta, Sha-Asia, and Amber in efforts to make a case for the current narrative of Black women's health disparities in the United States.

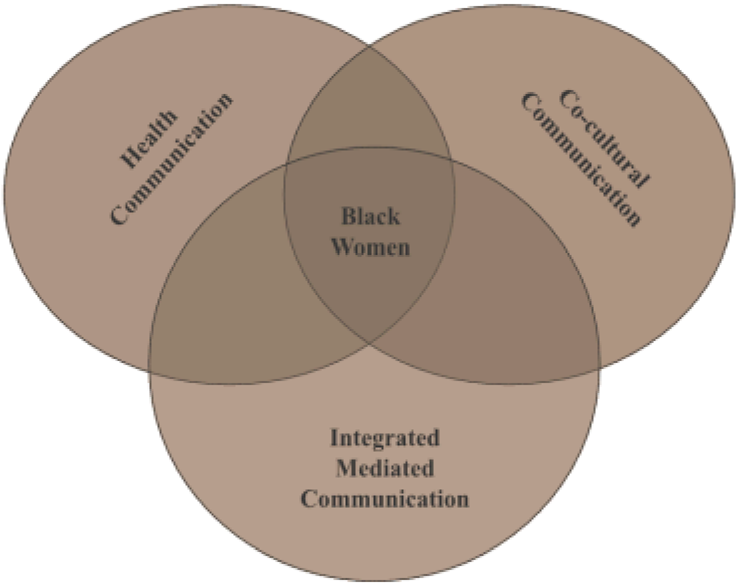
Table 3: Theoretical Framework



Three-Dimensional Health Equity Approach for Black Women

"Three-Dimensional Health Equity Approach for Black Women" is the evidence-based communication strategy this study aimed to develop and was informed by research, qualitative interview findings, and the Three Principles to Communicate About Health Equity Concepts (CHEC) released by the Centers for Disease Control and Prevention's Office of Health Equity.

Table 4: Three-Dimensional Health Equity Approach for Black Women (venn diagram)



The Office of Health Equity launched a survey in 2022 to understand what a variety of audiences believed, understood, and felt about the idea of health equity. These findings informed improved strategies for crafting communications that resonate with target audiences. These three principles are to meet the audience where they are, communicate health equity as a “we” issue, and frame health equity as achievable. These principles align with this study as they refine public communication about health equity to account for the underlying drivers of inequity and shift from stigma and blame (Harris, 2020) to accountability on individual and institutional levels.

Before digging deeper and making the connection, let us discuss the Three-Dimensional Health Equity Approach for Black Women.

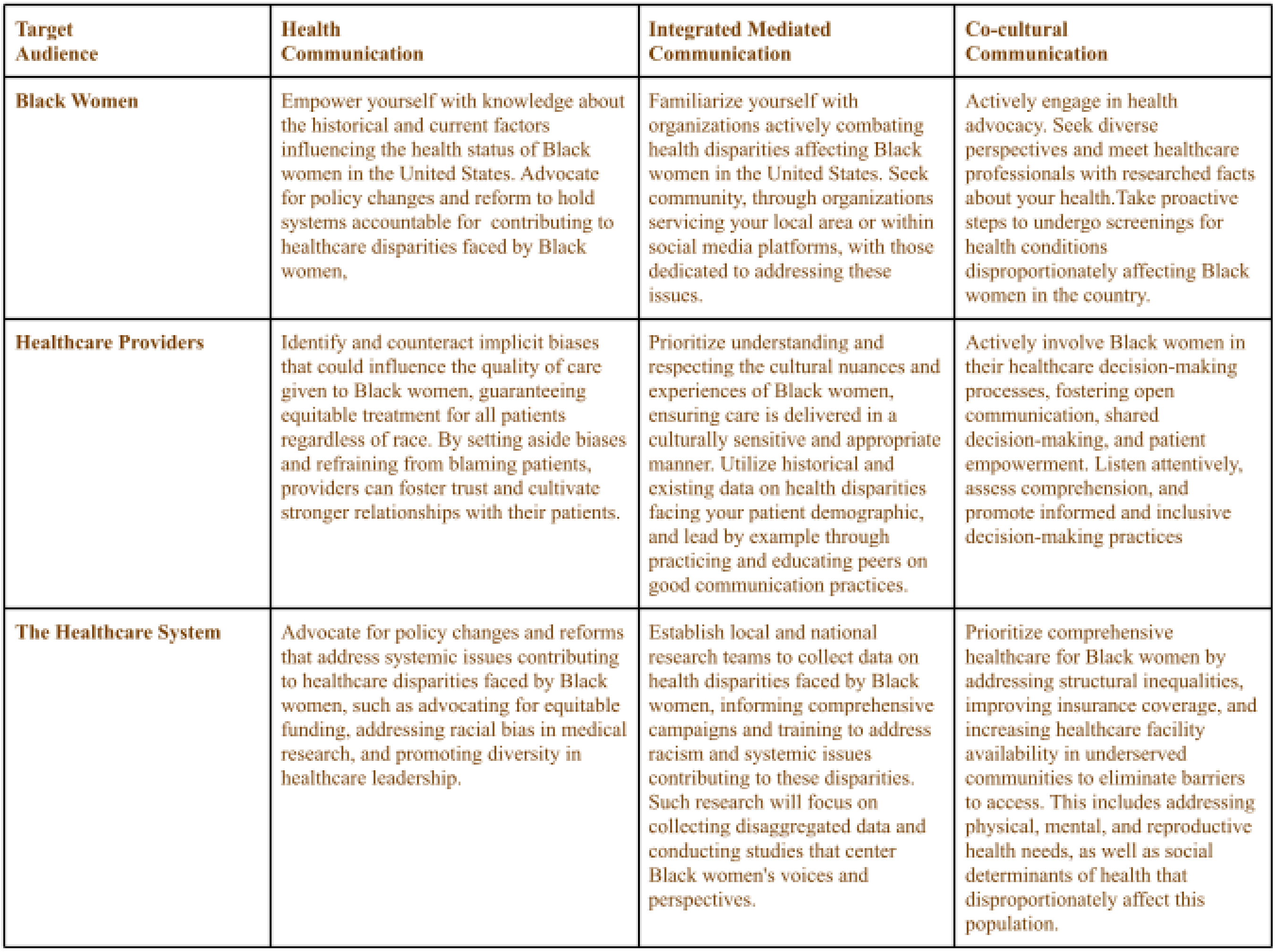
The Three-Dimensional Health Equity Approach for Black Women fosters a shared sense of accountability, at the individual and institutional level, for addressing health disparities faced by Black women in the United States. This approach puts Black women at the center of three African American communication theories, health communication, co-cultural communication, and integrated mediated communication, to cultivate cross sectional action and situate diverse perspectives and roles in strategizing for improved health outcomes of Black women in the United States. One important note here is that in implementing this approach, there is a required carefulness to not blame the health behaviors of Black women for disparities or stigmatize Black women due to existing health disparities but rather encourage Black women to take charge of our health because our health has long been led by a racial system that results in and continues to perpetuate disparities faced by Black women. Table 5 further describes accountability of healthcare providers and the healthcare system to this approach although not explicitly included in Table 4.

As mentioned in chapter 1, this study aimed to redefine health communication by reinforcing inclusion of relevant, historical factors that influence the persistence of health disparities of Black women in the United States. Health communication involves the strategic dissemination of information to promote health. In the context of Black women's health, it can be used to raise awareness about prevalent health issues and social, racial, and systemic exacerbators, encourage preventive behaviors from an equity lens that address individual and institutional level contributions to disparities, and facilitate access to healthcare services. This aligns with the first principle, meet the audience where they are, which emphasizes understanding the audience's beliefs and biases about health equity concepts to tailor effective messages. Communicators should use resonating language, provide context on health disparities, and encourage the audience to reconsider their perspectives about health equity and health disparities to include an understanding of social determinants and fairness of health. The goal is to influence action that will lead to reduction or elimination of disparate health concerns.

Next, Integrated mediated communication, combines various communication channels, such as traditional media, social media, and interpersonal communication, to reach and engage diverse audiences. This approach can be used to amplify health messages tailored to the needs and preferences of Black women, disseminate culturally relevant health information, and provide platforms for community dialogue and advocacy. By leveraging these communication approaches, Black women are empowered to advocate for self and healthcare providers and the healthcare system (institution) can address health disparities among Black women by promoting culturally sensitive healthcare practices, improving access to information and resources, and empowering individuals to take control of their health and well-being. Integrated mediated communication aligns with Principle 2: Communicate health equity as a “we” issue. This principle advises framing health equity as a collective issue rather than an "us versus them" scenario. By emphasizing shared values and interconnectedness, communicators can foster empathy and engagement among diverse audiences. Gain-framed messaging, focusing on positive outcomes and the benefits of equitable approaches for all, helps destigmatize health disparities and promote understanding of how health equity efforts can benefit everyone. Additionally, it's crucial to emphasize that achieving health equity is not a zero-sum game and that interventions aimed at helping one group do not come at the expense of others.

Last, co-cultural communication focuses on understanding and respecting the cultural norms, values, and communication styles of the African American community. It involves actively involving Black women in healthcare decision-making processes, fostering open dialogue between healthcare providers and patients, and promoting patient empowerment. This aligns with the third principle, frame health equity as achievable. This principle underscores the importance of presenting health equity as attainable through collective action at various levels. By offering concrete examples of how individuals, communities, and institutions can contribute to advancing health equity, communicators empower audiences to recognize their agency in effecting change. Using action-oriented language and avoiding fatalistic narratives, messages can inspire people to engage in efforts to address systemic factors contributing to health disparities and work towards achievable solutions.

Table 5: Three-Dimensional Health Equity Approach for Black Women Explained



Target Audience	**Health Communication**	**Integrated Mediated Communication**	**Co-cultural Communication**
Black Women	Empower yourself with knowledge about the historical and current factors influencing the health status of Black women in the United States. Advocate for policy changes and reform to hold systems accountable for contributing to healthcare disparities faced by Black women,	Familiarize yourself with organizations actively combating health disparities affecting Black women in the United States. Seek community, through organizations servicing your local area or within social media platforms, with those dedicated to addressing these issues.	Actively engage in health advocacy. Seek diverse perspectives and meet healthcare professionals with researched facts about your health.Take proactive steps to undergo screenings for health conditions disproportionately affecting Black women in the country.
Healthcare Providers	Identify and counteract implicit biases that could influence the quality of care given to Black women, guaranteeing equitable treatment for all patients regardless of race. By setting aside biases and refraining from blaming patients, providers can foster trust and cultivate stronger relationships with their patients.	Prioritize understanding and respecting the cultural nuances and experiences of Black women, ensuring care is delivered in a culturally sensitive and appropriate manner. Utilize historical and existing data on health disparities facing your patient demographic, and lead by example through practicing and educating peers on good communication practices.	Actively involve Black women in their healthcare decision-making processes, fostering open communication, shared decision-making, and patient empowerment. Listen attentively, assess comprehension, and promote informed and inclusive decision-making practices
The Healthcare System	Advocate for policy changes and reforms that address systemic issues contributing to healthcare disparities faced by Black women, such as advocating for equitable funding, addressing racial bias in medical research, and promoting diversity in healthcare leadership.	Establish local and national research teams to collect data on health disparities faced by Black women, informing comprehensive campaigns and training to address racism and systemic issues contributing to these disparities. Such research will focus on collecting disaggregated data and conducting studies that center Black women's voices and perspectives.	Prioritize comprehensive healthcare for Black women by addressing structural inequalities, improving insurance coverage, and increasing healthcare facility availability in underserved communities to eliminate barriers to access. This includes addressing physical, mental, and reproductive health needs, as well as social determinants of health that disproportionately affect this population.

The goal, in addition to improving health outcomes for Black women, is not to reinvent the wheel but rather broaden the scope of current strategies or theories, coupled with research about "what works", to account for the causes of health disparities facing Black women in the United States. I will use this section to provide more context for each strategy outlined per target audience.

Evidence based strategies for Black Women

Health Communication. Empower yourself with knowledge about the historical and current factors influencing the health status of Black women in the United States. In this study, women saw better outcomes when they did their own research for health complications which even reversed misdiagnosis. The state of Black women's health in the United states accounts for the current narrative about the health disparities and the one Black women will be involved in creating. Knowledge of those disparities and of how they may be a present reality of a Black woman are important to how Black women communicate about their health. Getting tested for those relevant health disparities puts Black women in front of the problem and begins to craft an empowered narrative of Black women.

Integrated Mediated Communication. Familiarize yourself with organizations actively combating health disparities affecting Black women in the United States. Seek community, through organizations servicing your local area or within social media platforms, with those dedicated to addressing these issues. In this study, women reported better health outcomes when they felt a sense of community and understanding. Seek community through local organization or on social media platforms. Considering disparate concerns, Black women should never feel alone in doing their part to address disparities. There are a number of organizations who are dedicated to addressing health disparities faced by Black women. Black women may even find community in their local area and/or with relevant groups and individuals.

Co-cultural Communication. Actively engage in health advocacy. Seek diverse perspectives and meet healthcare providers with researched facts about your health. Take proactive steps to undergo screenings for health conditions disproportionately affecting Black women in the country. Research shows that Black women are the least likely to advocate for themselves in a healthcare setting (Wiltshire, 2006). In this study, women who advocated for themselves, or were advocated for, reported better outcomes. Their voices were weapons against them not feeling heard, misdiagnosis, and preventable health outcomes. Advocacy is often associated with voice but also includes research, seeking opinions from more than one healthcare provider, and presenting facts during negative and positive interactions with healthcare providers.

Evidence-based strategies for healthcare providers

Health Communication. Identify and counteract implicit biases that could influence the quality of care given to Black women, guaranteeing equitable treatment for all patients regardless of race. By setting aside biases and refraining from blaming patients, providers can foster trust and cultivate stronger relationships with their patients. A study led by Lisa A. Cooper, MD, from Johns Hopkins University School of Medicine, revealed that doctors with elevated levels of implicit bias tended to exert more control over discussions with black patients compared to those with lower levels of implicit bias. Consequently, black patients expressed less trust, confidence, and rated the quality of care provided by these doctors as lower (Cooper, 2012). Throughout this study, I talked a lot about the bias of the healthcare provider and how a negative bias can influence poor communication. The goal here is, with the aforementioned sourcing of historical and existing data relevant to health disparities facing the patient, to remind healthcare providers to check their biases and focus on ethical treatment. I also believe that the aforementioned sourcing of data will also remove barriers that place blame on the patient for existing health concerns or outcomes.

Integrated Mediated Communication. Prioritize understanding and respecting the cultural nuances and experiences of Black women, ensuring care is delivered in a culturally sensitive and appropriate manner. Utilize historical and existing data on health disparities facing your patient demographic, and lead by example through practicing and educating peers on good communication practices. Research shows that by engaging in evidence-based care, connecting with patients effectively, and receiving and offering cross-cultural education, healthcare providers can have an impact on health inequalities (Cardarelli, 2007). healthcare providers should educate themselves on health concerns as related to their patient demographic and see trends of disparities. With this information, you can properly plan for successful interactions and improved outcomes for your patients and model good communication by practice and educating your peers.

Co-cultural Communication. Actively involve Black women in their healthcare decision-making processes, fostering open communication, shared decision-making, and patient empowerment. Listen attentively, assess comprehension, and promote informed and inclusive decision-making practices. Active listening empowers healthcare providers to genuinely comprehend patients' symptoms, feelings, and concerns. In this study, women reported not feeling heard by healthcare providers which in some cases led to misdiagnosis. Connecting this back to the strategies listed in this section, healthcare providers can do their part in changing the narrative by listening attentively to Black woman claims about her body, test for comprehension of diagnosis or treatments, and include Black women in health planning.

Evidence-based strategies for the healthcare system

Health Communication. Advocate for policy changes and reforms that address systemic issues contributing to healthcare disparities among Black women, such as advocating for equitable funding, addressing racial bias in medical research, and promoting diversity in healthcare leadership. Black women and other minority groups experience racism in medical interactions and treatments that stem from racial systems which cause mistrust and, ultimately, disparities in healthcare. Everyone can play a role in informing of the issue and changing the narrative. The goal here is for institutions to conduct research from a communication lens to reimagine the problem, uncover gaps, and create inclusive, data informed reports that drive results with this changed narrative.

Integrated Mediated Communication. Establish local and national research teams to collect data on health disparities faced by Black women, informing comprehensive campaigns and training to address racism and systemic issues contributing to these disparities. Such research will focus on collecting disaggregated data and conducting studies that center Black women's voices and perspectives. One component of a successful health campaign is the identification of competing behavior. With information retrieved from research, launching health campaigns may cast a wider net of importance addressing health disparities facing Black women and improve communication between patient and healthcare provider which will then lead to change in behavior.

Co-cultural Communication. Prioritize comprehensive healthcare for Black women by addressing structural inequalities, improving insurance coverage, and increasing healthcare facility availability in underserved communities to eliminate barriers to access. This includes addressing physical, mental, and reproductive health needs, as well as social determinants of health that disproportionately affect this population. Upfront treatment costs will help to eliminate the fear of cost which deters Black women from seeking medical treatment by putting the decision back in the hand of the Black woman to seek other healthcare facility options. A number of women interviewed reported issues with insurance as well as unpaid balances from health treatments.

Making the Connection

In chapter 1, I introduced you to my cousin Odakor Gloria Lamptey, affectionately referred to as “Korkor” by family and “Coco” by friends. In remission from non-Hodgkin's

Lymphoma, she developed an even stronger affinity for life, traveling the world and seeking and embracing worldly experiences. In December of 2020, Korkor's life was cut short. Amidst a global health crisis, her cause of death was not COVID-19 related but rather the result of misdiagnosis. Black women feel unheard. Kokor was unheard. Unfortunately, although Kokor was advocated for by herself and her sisters when she was being treated, they also adhered to the medical advice rendered by the physician. That advice ultimately caused her, her life.

Health disparities of Black women in the United States exist because of racial and social constructs but persist because it is a communication issue that addresses data of the health disparity without considering the historical context of Black women's health in the United States and the voices of Black women and their experience with the United States healthcare system and healthcare providers today (Nesbitt & Palomarez, 2016). Throughout this study, I have shared and linked historical and present information that substantiates early claims that health disparities faced by Black women in the United States is a communication issue.

Applying the Three-Dimension Health Equity Approach to Korkor's story, I will walk you through how Korkor's story may have been different with different responses from the healthcare provider and healthcare system. However, it is important to regard earlier claims about the communication issue including both conditions that perpetuate disparities and the interaction with healthcare providers and/or the healthcare system as well. For instance, in earlier chapters I discussed components of health communication that place *blame* on Black women, and generally Black women for health conditions (Harris, 2020). Blame for being Black, enslaved, poor, uneducated, and rebellious - all of which are a result of or response to the oppressive systems and social structures built on racism.

Korkor reported body pains which were immediately conflated with COVID symptoms even after she tested negative for COVID. Korkor's medical history was also fully available to the healthcare provider as this was the same clinic where Korkor received previous treatments for her cancer diagnosis (non-Hodgkins-Lymphoma). Korkor was prescribed medication that exacerbated the existing condition for which she was misdiagnosed and the medication killed her. The first column of Table 5 lists Black women, healthcare providers, and the healthcare system as the target audiences. As a Black woman being accountable to her health, Korkor was intentional about taking charge of her health and diagnosis, adhering to check-ins and treatments and doing her own research to better understand her bodily changes. Korkor also joined fundraising efforts for the Leukemia & Lymphoma Society (LLS) and volunteered at the Memorial Sloan Kettering Cancer Center to give back to the organization that supported her and raise awareness about this cancer. She even continued volunteerism and service while in remission. When Korkor sought medical attention for body pain, she did her part to position herself for identifying what she needed to be treated for and subsequently receiving that treatment.

As the healthcare provider, implicit bias amidst the COVID-19 pandemic caused keen focus on a COVID diagnosis. There is no substantial proof that the provider's nonchalant attitude towards Korkor and her sisters was due to racial bias, however there can be an inference made here that her attitude may have been influenced by the pandemic and not be Korkor's expressed feelings or test results. In chapter 2, I discussed how Black women experienced existing health disparities amidst the COVID-19 pandemic (Chandler, 2021) and often risked having their symptoms minimized or dismissed by healthcare providers even when they showed visible symptoms of COVID-19 (Goody et al, 2023). In this case, the healthcare provider did not ask for or consider Korkor's pre-existing health condition even after she tested negative for COVID and even with full access to Korkor's medical records. As mentioned, Korkor was in remission from non-Hodgkin's-Lymphoma and received her previous treatments from this same clinic. Had the healthcare provider asked more questions about Korkor's symptoms and medical history, she may have properly diagnosed Korkor. This leads to the importance of healthcare providers fostering channels for open communication between them and their patients and also actively involving Black women in their healthcare decision-making process.

As for the healthcare system, reforms that address systemic issues contributing to healthcare disparities faced by Black women may influence perspectives of healthcare providers by informing on how interactions with Black women perpetuate health disparities as well as historical conditions that led to health disparities. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that mandates the development of national guidelines to guard against the disclosure of private patient health information without the informed consent or awareness of the affected parties (Center for Disease Control and Prevention). However, per research, I was unable to locate any federal laws that required healthcare providers to inquire about medical history to inform treatment. If the healthcare provider inquired about Korkor's medical history there may have been additional avenues explored for proper diagnosis. Furthermore, according to the Standard of Care practice for healthcare providers, if a physician fails to refer a patient to a specialist for further care, diagnostic testing, or treatment that can only be administered by another medical professional, the physician *may* be held accountable for any unfavorable outcomes the patient experiences (Vanderpool, 2021). This is instituted if damages caused by the failure to refer were found to be unavoidable and the practice is determined by protocol of individual practices and states as well (Stein, 2015). Korkor was walked out of the clinic without a referral and without a diagnosis.

Suggestions for Future Research

This study does not cover policy, current health campaigns, or specific ethical training required of healthcare providers. Future research should consider exploring relevant policies or power structures that not only influence the health disparity but also the flow of information about disparities faced by Black women. This includes the current attacks on Diversity, Equity, and Inclusion in the United States, specifically pertaining acceptance and enrollment in medical schools and, generally, in medicine, and the implications it may have on Black women health disparities and racism as a communication issue. Also, exploring required training for healthcare providers will assist in understanding how the training contributes to or alleviates the communication issue. Other topics to explore are cost associations of insurance and medication that, more often than not, lead to immediate prescription of medication or invasive procedures before exploration of alternative options as well as avoidance to seek medical attention due to inability to afford treatment.

Conclusion

This study used a communication lens to examine historical and existing quantitative data relevant to health disparities faced by Black women in the United States. I then used data collected from qualitative interviews to substantiate quantitative claims and show a pattern of disparities rooted in racism and embedded in social structures. Thematic analysis of data resulted in the formation of three themes. Even with a random sample size from one city in the United States of America, almost all of the top 6 health disparities of Black women in the United States were experienced by the women interviewed in this study. When Black women go unheard, there is a higher chance of misdiagnosis and treatments last longer. With that, Type of insurance impacts level and cost of care and race, ethnicity, and gender of the healthcare provider does not always matter. And last, Black women achieve better outcomes when they advocate for themselves or when they are advocated for.

References

Adler, R. B., Rodman, G., & du Pré, A. (2020). Understanding Human Communication. Oxford University Press.

Agency for Healthcare Research and Quality. (2016). Defining Health Systems. https://www.ahrq.gov/chsp/defining-health-systems/index.html

Altmanac, M.R., Oseguera, T., McLemore, M.R., Kantrowitz-Gordon, I., Franck, L.S., & Lyndon, A. (2019). Information and power: Women of color's experiences interacting With healthcare providers in pregnancy and birth. *Social Science & Medicine*, *238*. https://doi.org/10.1016/j.socscimed.2019.112491

American Heart Association (n.d.). Heart Disease and Stroke in Black Women. https://www.goredforwomen.org/en/about-heart-disease-in-women/facts/heart-disease-in-african-american-women

Anderson, J.G., Baer, R.J, Partridge, J.C., Kuppermann, M., Franck, L.S., Rand, L., Jelliffe-Pawlowski, L.L., Rogers, E.E. (2016). Survival and Major Morbidity of Extremely Preterm Infants: A Population-Based Study. https://doi.org/10.1542/peds.2015-4434

Arnault, D.S. & Sinko, L. (2021). Comparative Ethnographic Narrative Analysis Method: Comparing Culture in Narratives. Global Qualitative Nursing Research. https://doi.org/10.1177/23333936211020722

Ashing-Giwa, K. (1999). Health behavior change models and their socio-cultural relevance for breast cancer screening in Black women. Women Health. *28*(4), 53-71.

Ashley, R.R. (2021). How Sarah Baartman's hips went from a symbol of exploitation to a source of empowerment for Black women. *Florida International University*. https://news.fiu.edu/2021/how-sarah-baartmans-hips-went-from-a-symbol-of-exploitation-to-a-source-of-empowerment-for-blackwomen

Ashton, C. M., Haidet, P., Paterniti, D. A., Collins, T. C., Gordon, H. S., O'Malley, K., Petersen, L. A., Sharf, B. F., Suarez-Almazor, M. E., Wray, N. P., & Street, R. L., Jr. (2003). Racial and ethnic disparities in the use of health services: bias, preferences, or poor communication?. *Journal of General Internal Medicine*, *18*(2), 146–152. https://doi.org/10.1046/j.1525-1497.2003.20532

Auerbach A.D., Lee T.M., Hubbard C.C., Ranji, S.R., Raffel, K., Valdes, G., Boscardin, J., Dalal, A.K., Harris, A., Flynn, E., & Schnipper, J.L. (2024). Diagnostic Errors in Hospitalized Adults Who Died or Were Transferred to Intensive Care. *Journal of the American Medical Association. 184*(2): 164–173. https://doi.org/10.1001/jamainternmed.2023.7347

Balkansky, A. (2020). Library of Congress. Harriet Tubman: Conductor on the Underground Railroad. https://blogs.loc.gov/headlinesandheroes/2020/06/harriet-tubman-conductor-on-the-underground-railroad/

Bangham, J. (2015). What Is Race? UNESCO, mass communication and human genetics in the Early 1950s. *History of the Human Sciences*. *28*(5), 80–107. https://doi.org/10.1177/0952695115600581

Bay, M.E., Griffin, F.J., Jones, M.S., & Savage, B.D. (2015). Toward an Intellectual History of Black Women.

Bekalu, M. A. (2014). Communication inequalities and health disparities. Information Development, *30*(2), 189-191. https://doi.org/10.1177/0266666914527412

Belgrave, F. Z., & Abrams, J.A. (2016). Reducing disparities and achieving equity in African American women's health. *American Psychologist*, *71*(8), 723–733. https://doi.org/10.1037/amp0000081

Bhui, K.S. et al. (2018). Interventions to improve therapeutic communications between Black and minority ethnic patients and professionals in psychiatric services: Systematic review. *Cambridge University Press*.

Bonilla-Silva, E. (1997). Rethinking Racism: Toward a Structural Interpretation. *American Sociological Review*, *62*(3), 465–480. https://doi.org/10.2307/2657316

Bowleg, L. (2017). Towards a Critical Health Equity Research Stance: Why Epistemology and Methodology Matters More Than Qualitative Methods. *Health Education & Behavior*, *44*(5), 677–684. https://doi.org/10.1177/1090198117728760

Bradbury-Jones, C. et al. (2017). The state of qualitative research in health and social science literature: a focused mapping review and synthesis. *International Journal of Social Research Methodology*, *20*(6), 627-645. https://doi.org/10.1080/13645579.2016.1270583

Braveman, P.A, Heck, K., Egerter, S., Marchi, K.S., Dominguez, T.P., Cubbin, C., Fingar, K., Pearson, J.A., & Curtis, M. (2015). The role of socioeconomic factors in Black-White disparities in preterm birth. *American Journal of Public Health*, *105*(4):694-702. https://doi.org/10.2105/AJPH.2014.302008

Bryan, E. E. K., & Austin, L. L. (2018). Racism in health communication: A synthesis of the literature and directions for future research. *Health Communication, 33*(8), 1065-1072. https://doi.org/10.1080/10410236.2017.1339699

Butler, S.M. & Sheriff, N. (2021). How poor communication exacerbates health inequities – and what to do about it.

https://www.brookings.edu/research/how-poor-communication-exacerbates-health-inequities-and-what-to-do-about-it/

Byrd, M.A. & Clayton, L.A. (2001). Race, Medicine, and Healthcare in the United states: a historical survey. *Journal of the National Medical Association*, *93*(3 Suppl), 11S-34S. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2593958/

Capodilupo, C. M., & Kim, S. (2014). Gender and race matter: The importance of considering intersections in Black women's body image. *Journal of Counseling Psychology*, *61*(1), 37–49. https://doi.org/10.1037/a0034597

Cardarelli, R. & Chiapa, A.L. (2007). Educating primary care clinicians about health disparities. Osteopathic Medicine and Primary Care. 1;*1*(5). https://doi.org/10.1186/1750-4732-1-5

Carter, N. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, *41*(5), 545-547. https://doi.org/0.1188/14.ONF.545-547

Centers for Disease Control and Prevention. (2017). Health Disparities. https://www.cdc.gov/aging/disparities/index.htm#:~:text=Health%20disparities%20ar20preventable%20differences,age%20groups%2C%20including%20older%20adults

Centers for Disease Control and Prevention. (2022). *What is Sepsis?* https://www.cdc.gov/sepsis/what-is-sepsis.html

Centers for Disease Control and Prevention. (2023). What Should I Know About Screening? https://www.cdc.gov/cancer/cervical/basic_info/screening.html

Centers for Disease Control and Prevention. (2023). Working Together to Reduce Black Maternal Mortality. https://www.cdc.gov/healthequity/features/maternal-mortality/index.html

Chandler, R. et al. (2021). The impact of COVID-19 among Black women: evaluating perspectives and sources of information, *Ethnicity & Health*, *26*(1), pp 80-93. https://doi.org/10.1080/13557858.2020.1841120

Chenc, X., Fu, S., & Vreede, G.J. (2017). Understanding trust influencing factors in social media communication: A qualitative study. *International Journal of Information Management*, *37*(2), pp 25-35. https://doi.org/10.1016/j.ijinfomgt.2016.11.009

Chinn, J. J., Martin, I. K., & Redmond, N. (2021). Health Equity Among Black Women in the United States. *Journal of women's health (2002)*, *30*(2), 212–219. https://doi.org/10.1089/jwh.2020.8868

Christian, T.A. (2020). New York Woman Dies During Childbirth Days After Tweeting Concerns About Hospital Care. *Essence Magazine*. https://www.essence.com/news/amber-isaac-dies-childbirth-bronx-hospital-tweet/

Clay, S.L., Griffin, M., Averhart, W. (2018). Black/White disparities in pregnant women in the United States: An examination of risk factors associated with Black/White racial identity. *Health & Social Care in the Community*, *26*(5). https://doi.org/10.1111/hsc.12565

Comrie et al. (n.a.). Anti-Blackness/Colorism. *Boston University*. https://www.bu.edu/antiracism-center/files/2022/06/Anti-Black.pdf.

Cooksey-Stowers, K., Schwartz, M. B., & Brownell, K. D. (2017). Food Swamps Predict Obesity Rates Better Than Food Deserts in the United States. *International journal of environmental research and public health*, *14*(11), 1366. https://doi.org/10.3390/ijerph14111366

Cooper, B. (2018). Eloquent Rage: A Black Feminist Discovers Her Superpower.

Cooper, L.A. Roster, D.L., Carson, K.A., Beach, M.C., Sabin, J.A., Greenwald, A.G., & Inui, T.S. (2012). The Associations of Clinicians' Implicit Attitudes About Race With

Medical Visit Communication and Patient Ratings of Interpersonal Care. *American Journal of Public Health 102*, 979-987. https://doi.org/10.2105/AJPH.2011.300558

Crear-Perry, J., Correa-de-Araujo, R.,Johnson, T.L., McLemore, M.R., Neilson, E. & Wallace, M. (2021). Social and Structural Determinants of Health Inequities in Maternal Health. *Journal of Women's Health*. *30*(2), pp 230-235. http://doi.org/10.1089/jwh.2020.8882

Creswell J.W. (2003). *Research design. Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks: SAGE.

Creswell, J. W. (2013). Qualitative inquiry & research design: Choosing among five approaches (3rd ed.). Thousand Oaks, California: Sage Publications.

Creswell, J. W. & Poth, C. N. (2018). Qualitative inquiry & research design: Choosing among five approaches (4th ed.). Thousand Oaks, CA: Sage Publications. ISBN: 9781506330204

Cuevas, A. G., O'Brien, K., & Saha, S. (2016). African American experiences in healthcare: “I always feel like I’m getting skipped over”. *Health Psychology*, *35*(9), pp 987–995. https://doi.org/10.1037/hea0000368

D’Agostino, M.J. (2017). Changing the Narrative: The Difference Women Make in Public Administration. https://doi.org/10.1177/0095399716641986.

Davis, R., Campbell, R., Hildon, Z., Hobbs, L., & Michie, S. (2015). Theories of behaviour and behaviour change across the social and behavioural sciences: a scoping review. *Health Psychol Rev, 9*(3):323-44. https://doi.org/10.1080/17437199.2014.941722

DeAngelis, T. (2015). In search of cultural competence. *Monitor on Psychology*, *46*(3). http://www.apa.org/monitor/2015/03/cultural-competence

DeAngelis, T. (2019). How does implicit bias by physicians affect patients' health care?

Research is exploring how specific factors affect patients' perception of treatment. *50*(3), 22. https://www.apa.org/monitor/2019/03/ce-corner

Drewnowski, A., & Specter, S.E. (2006). The importance of social and economic factors in understanding health behaviours. *Annals of Medicine, 38*(7), 479-481. https://doi.org/10.1080/07853890600993946.

Eltoukhi, H.M, Modi, M.N., Weston, M., Armstrong, A.Y., & Stewart, E.A. (2014). The health disparities of uterine fibroid tumors for African American women: a public health issue. *American Journal Obstetrics and Gynecology, 210*(3):194-9. https://doi.org/10.1016/j.ajog.2013.08.008

FitzGerald, C., Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics*, *18*(19). https://doi.org/10.1186/s12910-017-0179-8

Fogel, E.L. & Sherman S. (2020). Diseases of the gallbladder and bile ducts.*Goldman-Cecil Medicine*. 26th ed. chap 146.

Forsythe, K. (2022). Food Apartheid Explained. *Global Center for Climate Justice*. https://www.climatejusticecenter.org/newsletter/food-apartheid-explained

Frost, D. M., Hammack, P. L., Wilson, B. D. M., Russell, S. T., Lightfoot, M., & Meyer, I. H. (2020). The qualitative interview in psychology and the study of social change: Sexual identity development, minority stress, and health in the generations study. *Qualitative Psychology, 7*(3), 245–266. https://doi.org/10.1037/qup0000148

Gelberg, L., Browner, C.H., Lejano, E., & Arangua, L. (2004). Access to Women's Health Care: A Qualitative Study of Barriers Perceived by Homeless Women. *Women and Health*, *40*(2), 87-100. https://doi.org/10.1300/J013v40n02_06

Ghiyasvandian, S., Zakerimoghadam, M., & Peyravi, H. (2014). Nurse as a facilitator to professional communication: a qualitative study. *Global Journal of Health Science*, *7*(2), 294–303. https://doi.org/10.5539/gjhs.v7n2p294

Griffin, F. (1996). Textual Healing: Claiming Black Women's Bodies, the Erotic and Resistance in Contemporary Novels of Slavery. *Callaloo, 19*(2), 519-536. http://www.jstor.org/stable/3299218

Godoy, S.M., Dukes, L., Chapman, M., Day, S., Goode, R.W. (2023). “You have to continue doing the work”: Black women essential workers coping amidst the dual pandemics of COVID-19 and racism. Qual Soc Work. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10083710/

Goldstein, J. (2023). A Deadly Epidural, Delivered by a Doctor With a History of Mistakes. *The New York Times*. https://www.nytimes.com/2023/01/23/nyregion/anesthesiologist-brooklyn-deaths.html

Gomez, A.M. & Wapman, M. (2017). Under (implicit) pressure: young Black and Latina women's perceptions of contraceptive care. *Contraception*, *96*(4), pp 221-226. https://doi.org/10.1016/j.contraception.2017.07.007

Gordon-Chipembere, N.M.(2006). ‘Even with the best intentions’: The misreading of Sarah Baartman's life by African American writers, Agenda, 20:68, 54-62.

Gough, B., & Deatrick, J. A. (2015). Qualitative health psychology research: Diversity, power, and impact. Health Psychology, 34(4), 289–292. https://doi.org/10.1037/hea0000206

Graham, H. (2004). Social determinants and their unequal distribution: clarifying policy understandings. Milbank Quarterly, *82*(1):101-24. https://doi.org/10.1111/j.0887-378x.2004.00303.x

Haas, A. M. (2012). Race, Rhetoric, and Technology: A Case Study of Decolonial Technical Communication Theory, Methodology, and Pedagogy. *Journal of Business and Technical Communication*, *26*(3), pp 277–310. https://doi.org/10.1177/105065191243953.

Hajar, R. (2017). The Physician's Oath: Historical Perspectives. *Heart Views, 18*(4), 154-159. https://doi.org/10.4103/HEARTVIEWS.HEARTVIEWS_131_17.

Haley, S. (2016). No Mercy Here: Gender, Punishment, and the Making of Jim Crow Modernity.

Hall, S. (1992). Race, Culture, and Communications: Looking Backward and Forward at Cultural Studies. *Rethinking Marxism*, *5*(1), 10-18. https://doi.org/10.1080/08935699208657998

Hardcastle, M.A., Usher, K.J., & Holmes, C.A. (2005). An overview of structuration theory and its usefulness for nursing research. Nurs Philos. *6*(4):223-34. https://doi.org/10.1111/j.1466-769X.2005.00230.x

Harrigan-Farrelly, J. (2022). For Black Women, Implicit Racial Bias in Medicine May Have Far-Reaching Effects. *United States Department of Labor Blog*. https://blog.dol.gov/2022/02/07/for-Black-women-implicit-racial-bias-in-medicine-may-have-far-reaching-effects

Harris, E. (2023). Misdiagnosis Might Harm up to 800 000 US Patients Annually. *Journal of the American Medical Association. 330*(7):586. https://doi.org/10.1001/jama.2023.13135

Harris, O.O., Leblanc, N., McGee, K., Randolph, S., Wharton, M.J., & Relf, M. (2020) Alarm at the Gate-Health and Social Inequalities are Comorbid Conditions of HIV and COVID-19. Journal of the Association of Nurses AIDS Care, (4):367-375. https://doi.org/10.1097/JNC.0000000000000190

Harvey Wingfield, A. (2019). “Reclaiming Our Time”: Black Women, Resistance, and Rising

Inequality: SWS Presidential Lecture. *Gender & Society*, *33*(3), 345–362. https://doi.org/10.1177/089124321983545

Health Communication Capacity Collaborative. (2014). Theory of Planned Behavior An HC3 Research Primer. https://www.healthcommcapacity.org/wp-content/uploads/2014/03/theory_of_planned_behavior.pdf

Hogan, V., Rowley, D.L., White, S.B., Faustin, Y. (2018). Dimensionality and R4P: A Health Equity Framework for Research Planning and Evaluation in African American Populations. *Matern Child Health Journal,*. 22:147–153. https://doi.org/10.1007/s10995-017-2411-z

Horsburgh, J. and Ippolito, K. (2018). A skill to be worked at: using social learning theory to explore the process of learning from role models in clinical settings. *BMC Med Educ*, 18, 156. https://doi.org/10.1186/s12909-018-1251-x

Hutchinson, P. and Dhairyawan, R. (2017). Shame and HIV: Strategies for addressing the negative impact shame has on public health and diagnosis and treatment of HIV. Bioethics. *32*(1):68-76. https://doi.org/10.1111/bioe.12378

Indla, V., & Radhika, M. S. (2019). Hippocratic oath: Losing relevance in today's world?. *Indian Journal of Psychiatry*, *61*(Suppl 4), 773–775. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_140_19

Ishikawa, H., & Kiuchi, T. (2010). Health literacy and health communication. *BioPsychoSocial medicine*, *4*, 18. https://doi.org/10.1186/1751-0759-4-18

Jones, L.V. & Guy-Sheftall, B. (2015). Conquering the Black Girl Blues. *Oxford Academic: Social Work*, *60*(4), pp 343–350. https://doi.org/10.1093/sw/swv032

Jones, L.V. & Harris, M.A. (2019). Developing a Black Feminist Analysis for Mental Health Practice: From Theory to Praxis. *Women & Therapy*, *42*(3-4), 251-264. https://doi.org/10.1080/02703149.2019.1622908

Lewey, J. et al. (2020). *Importance of Early Diagnosis in Peripartum Cardiomyopathy*. Hypertension, *75*(1):91–97. https://doi.org/10.1161/HYPERTENSIONAHA.119.13291

Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among Black women. *Journal of Counseling Psychology*. *64*(5), pp 475–486. https://doi.org/10.1037/cou0000231

Little, B. (2021). What Prehistoric Cave Paintings Reveal About Early Human Life. https://www.history.com/news/prehistoric-cave-paintings-early-humans

Louis, J.M., Menard, K.M., & Gee, R.E. (2015). Racial and Ethnic Disparities in Maternal Morbidity and Mortality. *Obstetrics & Gynecology*, *125*(3), 690-694. https://doi.org/10.1097/AOG.0000000000000704

Malikhao, P. (2020). Health Communication: Approaches, Strategies, and Ways to Sustainability on Health or Health for All. Handbook of Communication for Development and Social Change. 1015–37. https://doi.org/10.1007/978-981-15-2014-3_137

Malik, K. (1996). The Meaning of Race: Race, History and Culture in Western Society.

Merriam, S. B, & Grenier R.S. (2018). Qualitative Research in Practice: Examples for Discussion and Analysis.

Mikkonen, K., Koskinen, M., Koskinen, C., Koivula, M. Koskimäki, M., Lähteenmäki, M., Mäki-Hakol, H., Wallin, O., Sjögren, T. Salminen, L., Sormunen, M., Saaranen, T., Kuivila, H., & Kääriäinen, M. (2019). Qualitative study of social and healthcare educators' perceptions of their competence in education. *Health & Social Care in the Community*, *27*(6), 1555-1563. https://doi.org/10.1111/hsc.12827

Miles, S.H. (2004). The Hippocratic Oath and the Ethics of Medicine.

Miller-Kleinhenz J.M. Collin, L.J., Seidel, R. Reddy, Arthi, Nash, R., Switchenko, J.M., & McCullough, L.E. (2021). Racial Disparities in Diagnostic Delay Among Women With Breast Cancer. J Am Coll Radiol. https://doi.org/10.1016/j.jacr.2021.06.019

Moon, D.G. & Holling, M.A. (2015). A Politic of Disruption: Race(ing) Intercultural Communication. *Journal of International and Intercultural Communication*, *8*(1), 1-6. https://doi.org/10.1080/17513057.2015.991073

National Cancer Institute (n.d.). Addressing Communication Inequalities to Advance Health Equity. https://cancercontrol.cancer.gov/brp/hcirb/addressing-communication-inequalities-advane-health-equity

National Institute of Health (2021). 7 Diseases that Affect Your Health, and What You Can Do. *Office of Research on Women's Health*.

National Museum of African American History and Culture (n.d.). *Smithsonian*. https://nmaahc.si.edu/explore/stories/popular-and-pervasive-stereotypes-african-americas.

National Park Service. (2021). The Middle Passage. *Boston African American National Historic Site, United States Department of the Interior*.

Nesbitt, S., & Palomarez, R. E. (2016). Review: Increasing Awareness and Education on Health Disparities for healthcare professionals. Ethnicity & disease, *26*(2), 181–190. https://doi.org/10.18865/ed.26.2.181

Newman-Toker, D.E., Nassery, N., Schaffer, A.C., Yu-Moe, C.W., Clemens, G.D., Wang, Z., Zhu, Y., Tehrani, A.S.S., Fanai, M., Hassoon, A, & Siegal, D. (2024). Burden of serious harms from diagnostic error in the USA. *BMJ Quality & Safety.* 33:109-120. https://qualitysafety.bmj.com/content/33/2/109

News from Columbia. (2017). Kimberlé Crenshaw on Intersectionality, More than Two Decades Later. https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-wo-decades-later

North, M. (2002). Greek Medicine “I swear by Apollo Physician”... Greek Medicine from the Gods to Galen. *National Library of Medicine*. https://www.nlm.nih.gov/hmd/greek/greek_oath.html

Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, *15*(3), 259–267. https://doi.org/10.1093/heapro/15.3.259

Nyanchoka, L., Tudur-Smith, C., Porcher, R., & Hren, D. (2020). Key stakeholders' perspectives and experiences with defining, identifying and displaying gaps in health research: a qualitative study. BMJ Open. 10;*10*(11):e039932. https://doi.org10.1136/bmjopen-2020-039932

Office of Health Equity. (2024). Three Principles to Communicate About Health Equity Concepts (CHEC). *Centers for Disease Control and Prevention*. https://www.cdc.gov/healthequity/whatis/comm-principles/index.html

Office of the Assistant Secretary for Administration & Management. *Legal Highlight: The Civil Rights Act of 1964, United States Department of Labor*. https://www.dol.gov/agencies/oasam/civil-rights-center/statutes/civil-rights-act-of-1964

Ong, W. (2012). *Orality and literacy: The technologizing of the world*. (3rd ed.). New York, NY: Routeledge. ISBN: 9780415538381

Otto, A.K. et al. (2021). Using the health belief model to assess racial/ethnic disparities in cancer-related behaviors in an NCI-designated comprehensive cancer center catchment area. Cancer Causes Control. *32*(10):1085-1094. https://doi.org/10.1007/s10552-021-01457-7

Owens, D.C. & Fett, S.M. (2019). Home American Journal of Public Health (AJPH). Black Maternal and Infant Health: Historical Legacies of Slavery. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2019.305243

Parkinson, J. (2016). The significance of Sarah Baartman. *BBC News Magazine*. https://www.bbc.com/news/magazine-35240987

Patton M.Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Serv Res*, *34*(5 Pt 2):1189-208. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089059/

Prather, C., Fuller, T.R., Jeffries, W.L., Marshall, K.J, Howell, A.V., Belyue-Umole, A, & King, W. (2018). Racism, Black women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health equity*, *2*(1), 249–259. https://doi.org/10.1089/heq.2017.0045

Pulido, L. (2017). Environmental Racism. *International Encyclopedia of Geography: People, the Earth, Environment and Technology.* https://doi.org/10.1002/9781118786352.wbieg0453

Roopali Mukherjee (2016) Antiracism Limited, Cultural Studies. 30:1, 47-77. https://doi.org/10.1080/09502386.2014.935455

Rosenthal, L. & Lobel, M. (2016). Stereotypes of Black American Women Related to Sexuality and Motherhood. *Psychol Women Q*. *40*(3):414-427. 10.1177/0361684315627459

Rumjaun, A., Narod, F. (2020). Social Learning Theory—Albert Bandura. In: Akpan, B., Kennedy, T.J. (eds) Science Education in Theory and Practice. Springer Texts in Education. Springer, Cham. https://doi.org/10.1007/978-3-030-43620-9_7

Schmandt-Besserat, D. (2014). The Evolution of Writing. James Wright, ed., International Encyclopedia of Social and Behavioral Sciences, Elsevier.

Shen, M.J., Peterson, E.B., & Costas-Muñiz, R., Hernandez, M.G., Jewell, S.T., Matsoukas, K., & Bylund, C. (2018) The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *Journal of Racial and Ethnic Health Disparities*. 5, 117–140. https://doi.org/10.1007/s40615-017-0350-4.=

Simon, L.V., Hashmi, M.F., & Bragg, B.N. (2023). APGAR Score. https://www.ncbi.nlm.nih.gov/books/NBK470569/

Skloot, R. (2017). The Immortal Life of Henrietta Lacks.

Smith, C.E., Fullerton, S.M., Dookeran, K.A., Hampel, H., Tin, A. Maruthur, N.M., Schisler, J.C., Henderson, J.A., Tucker, K.L., Ordovás, J.M. (2016). Using Genetic Technologies To Reduce, Rather Than Widen, Health Disparities. *Health Affairs, 35*(8), https://doi.org/10.1377/hlthaff.2015.1476

Smith J.A. and Osborn M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. Br J Pain. *9*(1):41-2. https://doi.org/10.1177/2049463714541642

Society for Health communication. (2017). About Health Communication. Retrieved from https://www.societyforhealthcommunication.org/health-communication.

Sodeke, S. O., & Powell, L. R. (2019). Paying Tribute to Henrietta Lacks at Tuskegee University and at The Virginia Henrietta Lacks Commission, Richmond, Virginia. *Journal of health care for the poor and underserved*, *30*(4S), 1–11. https://doi.org/10.1353/hpu.2019.0109

Spates, K., Evans, N.M., Watts, B.C., Abubaker, N., & James, T.. (2020). Keeping Ourselves Sane: A Qualitative Exploration of Black Women's Coping Strategies for Gendered Racism. *Sex Roles*, *82*, 513–524. https://doi.org/10.1007/s11199-019-01077-1

Stein, A. (2015). Of Competence and Referrals: When a Doctor's Failure to Refer a Patient to another Physician Constitutes Malpractice? https://blog.petrieflom.law.harvard.edu/2015/06/07/of-competence-and-referrals-when-a doctors-failure-to-refer-a-patient-to-another-physician-constitutes-malpractice/

Stretesky, P. B., & Lynch, M. J. (2002). Environmental Hazards and School Segregation in Hillsborough County, Florida, 1987-1999. *The Sociological Quarterly*, *43*(4), 553–573. http://www.jstor.org/stable/4120939

Stubbe D.E. (2020). Practicing Cultural Competence and Cultural Humility in the Care of Diverse Patients. *Focus, 18(1):49-51*. https://doi.org/10.1176/appi.focus.20190041

Taylor, J. (2019). Racism, Inequality, and Health Care for African Americans. *The Century Foundation.*

Thompson, B., Molina, Y., Viswanath, K., Warnecke, R., & Prelip, M.L. (2016). Strategies To Empower Communities To Reduce Health Disparities: Disparities, Hospital Financing, and More. *Health Affairs, 35*(8). https://doi.org/10.1377/hlthaff.2015.1364

Tilbrook, D., Polsky, J., & Lofters, A. (2010). Are women with psychosis receiving adequate cervical cancer screening? Can Fam Physician. *56*(4):358-63. https://pubmed.ncbi.nlm.nih.gov/20393098/

Tillerson, K. (2008). Explaining racial disparities in HIV/AIDS incidence among women in the

U.S.: a systematic review. 10;*27*(20):4132-43. https://doi.org/10.1002/sim.3224

Ting-Toomey, S. (1999) Communicating across Cultures. The Guilford Press, New York, 261.

U.S. Environmental Protection Agency. (2024). Environmental Justice. https://www.epa.gov/environmentaljustice

U.S. Food and Drug Administration. (2023). Uterine Fibroids. https://www.fda.gov/consumers/womens-health-topics/uterine-fibroids

U.S. Government Accountability Office. (2020). Racial Disparities in Education and the Role of Government. https://www.gao.gov/blog/racial-disparities-education-and-role-government

Vanderpool, D. (2021). The Standard of Care. *Innovations in Clinical Neuroscience*, *18*(7-9):50-51. https://pubmed.ncbi.nlm.nih.gov/34980995/

Versey, H.S., Cogburn, C.C., Wilkins, C.L., & Joseph, N. (2019). Appropriated racial oppression: Implications for mental health in Whites and Blacks. *Social Science & Medicine*, *230*, 295-302.

Wade, J.H. (2022). Embracing the Sapphire: Black Women's Rage in Speculative Fiction. *CLA Journal 65*(1), 106-121. https://doi.org/10.1353/caj.2022.0010

Wall, L.L. (2006). The medical ethics of Dr J Marion Sims: a fresh look at the historical record. J Med Ethics. 2006 Jun;32(6):346-50. https://doi.org/10.1136/jme.2005.012559

Waring J, M.F., Bishop, S., Sahota, O., Walker, M., Currie, G., Fisher, R., & Avery, T. (2014). An ethnographic study of knowledge sharing across the boundaries between care processes, services and organizations: the contributions to 'safe' hospital discharge. NIHR Journals Library; *Health Services and Delivery Research, 2*(29), Chapter 3, Study design and methods. https://www.ncbi.nlm.nih.gov/books/NBK259989/pdf/Bookshelf_NBK259989.pdf

Washington, H.A. (2008). Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present.

Weber, L. and Parra-Medina, D. (2003), "INTERSECTIONALITY AND WOMEN'S HEALTH: CHARTING A PATH TO ELIMINATING HEALTH DISPARITIES", *Gender Perspectives on Health and Medicine Advances in Gender Research*, 7, 181-230. https://doi.org/10.1016/S1529-2126(03)07006-1

Weiner, S. (2018). The solemn truth about medical oaths. Association of American Medical Colleges. https://www.aamc.org/news/solemn-truth-about-medical-oaths

Wessel, M., Wynant, T., Peña, C., Cabrera, M., Alteri, R., Zhang, Q., Libejko, B.,Petri, D., Merrick, L., Eidsmoe, K., Lovely, B., Thomas, C., Henkle, T., Rogers, C. Greene, B. Delfin-Davis, R., Garcia Olea, E… (2022). More Black Women Die from Breast Cancer Than Any Other Cancer. *American Cancer Society*. https://www.cancer.org/research/acs-research-news/facts-and-figures-african-american-back-people-2022-2024.html#:~:text=Black%20women%20are%20TWICE%20AS,rate%20compared%20with%20White%20women

West, E. (2021). Enslaved Women in the Civil War. *Hidden Voices: Enslaved Women in the Lowcountry and US South.* Lowcountry Digital Library. https://ldhi.library.cofc.edu/exhibits/show/hidden-voices

Whitehead, S. (2023). Why Black women face barriers to accessing PrEP, an HIV-preventing drug. *PBS News Hour.* https://www.pbs.org/newshour/health/why-Black-women-face-barriers-to-accessing-prep an-hiv-preventing-drug

White House. (2021). FACT SHEET: Vice President Kamala Harris Announces Call to Action to Reduce Maternal Mortality and Morbidity. https://www.whitehouse.gov/briefing-room/statements-releases/2021/12/07/fact-sheet-vice-president-kamala-harris-announces-call-to-action-to-reduce-maternal-mortality-and-morbidity/

Williams, D.R. Lawrence, JA., & Davis, B.A. (2019). Racism and Health: Evidence and Needed Research. Annual Review of Public Health. *40*:1, 105-125. https://www.annualreviews.org/doi/10.1146/annurev-publhealth-040218-043750?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed#_i3

Williams D.R. & Rucker, T.D. (2000). Understanding and addressing racial disparities in health care. *Health Care Financ Rev. 21*(4):75-90. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/.

Williams, J. & Wilson, V. (2019). Black workers endure persistent racial disparities in employment outcomes. *Economic Policy Institute.* https://www.epi.org/publication/labor-day-2019-racial-disparities-in-employment/.

Wiltshire, J., Cronin, K., Sarto, G. E., & Brown, R. (2006). Self-Advocacy during the Medical Encounter: Use of Health Information and Racial/Ethnic Differences. *Medical Care*, *44*(2), 100–109. http://www.jstor.org/stable/3768379

World Economic Forum. (2020). How has technology changed - and changed us - in the past 20 years? https://www.weforum.org/agenda/2020/11/heres-how-technology-has-changed-and-changed-us-over-the-past-20-years/

Appendix

A.1 Research Screening Questions

1. What is your email address?
2. What is your full name?
3. I will be 18 years of age or older by January 1, 2023.
    - Yes
    - No
4. I identify as a Black woman.
    - Yes
    - No
5. Please select the NYC borough of which you reside.
    - Brooklyn
    - Bronx
    - Manhattan
    - Queens
    - Staten Island

A.2 Recruitment (Social Media)

Instagram

ATTENTION INSTAGRAMMERS: I am conducting research as part of the requirements for a doctorate degree at Liberty University. The purpose of my research is to develop evidence-based, communication strategies to address health disparities of Black women in the United States To participate, you must identify as a Black woman, be 18 years of age or older at the time of interview and reside in one of 5 boroughs in New York City. Participants will be asked to respond to a series of questions relative to experiences at healthcare facilities/with healthcare providers and to be authentic and honest in their truths. The interview will be virtual and audio-recorded. This process should take about 20-30 minutes to complete. If you would like to participate and meet the study criteria, please click here and complete this survey. More information will be sent to you following completion.

Facebook

ATTENTION FACEBOOK FRIENDS: I am conducting research as part of the requirements for a doctorate degree at Liberty University. The purpose of my research is to develop evidence-based, communication strategies to address health disparities of Black women in the United States To participate, you must identify as a Black woman, be 18 years of age or older at the time of interview and reside in one of 5 boroughs in New York City. Participants will be asked to respond to a series of questions relative to experiences at healthcare facilities/with healthcare providers and to be authentic and honest in their truths. The interview will be virtual and audio-recorded. This process should take about 20-30 minutes to complete. If you would like to participate and meet the study criteria, please click here and complete this survey. More information will be sent to you following completion.

Twitter

Do you identify as a Black woman, at least 18-years-old, living in one of 5 boroughs in New York City, and interested in telling your story about a healthcare experience? If interested, click here for more information about a research study on addressing health disparities of Black women and to complete pre-screening.

A.3 Recruitment (Verbal)

Hello [Potential Participant],

As a graduate student in the School of Communication and the Arts at Liberty University, I am conducting research as part of the requirements for a doctorate degree. The purpose of my research is to develop evidence-based, communication strategies to address health disparities of Black women in the United States, and if you meet my participant criteria and are interested, I would like to invite you to join my study.

Participants self-identify as a Black woman,18 years of age or older, and reside in one of 5 boroughs in New York City. Participants, if willing, will be asked to respond to a series of questions relative to experiences at healthcare facilities/with healthcare providers and to be authentic and honest in their truths. It should take approximately 20-30 minutes to complete the interview. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

Would you like to participate?

[*No Response*]
I understand. Thank you for your time.

[*Yes Response*]

Great! If you provide me your email address I can follow up with next steps.

A consent document will be given to you one week before the interview. The consent document contains additional information about my research. In order to participate, you will need to sign the consent document electronically and return it to me before the start of the interview. Signing the consent form indicates that you have read the consent information and would like to take part in the study.

Thank you for your time. Do you have any questions?

[Yes]
Investigator to answer questions.
[No]
Awesome! Lookout for an email from me. I am looking forward to working with you!

A.4 Recruitment (Follow-Up)

Dear [Recipient]:

Thank you for expressing your interest in participating in research I am conducting as a part of the requirements for a doctorate degree. I am looking to better understand health disparities faced by Black women in the United States. Please respond to the screening here if you would like to participate.

Participants, if willing, will be asked to take part in a virtual, audio-recorded interview, where they will respond to a series of questions relative to experiences at healthcare facilities/with healthcare providers and to be authentic and honest in their truths. It should take approximately 20-30 minutes to complete the interview. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

A consent document will be given to you one week before the interview. The consent document contains additional information about my research. In order to participate, you will need to sign the consent document electronically and return it to me before the start of the interview. Signing the consent form indicates that you have read the consent information and would like to take part in the study.

Sincerely,

Emmerline Nelson-Rogers

PhD Candidate, Liberty University

A.5 Consent Form

Consent

Title of the Project: Changing the Narrative: Developing Evidence-Based, Communication Strategies to Address Health Disparities of Black Women in the United States

Principal Investigator: Emmerline Nelson-Rogers, PhD Candidate, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18+, identify as a Black woman, and reside in one of the 5 boroughs in New York City. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to develop evidence-based, communication strategies to address health disparities of Black women in the United States The goal of this study is to offer an action plan for addressing persistent and disproportionate issues of health disparities of Black women in the United States from a systemic level and reimagining this issue as a communication issue based on how inequality has long influenced the communication of Black women's health in America.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

- Participate in a 20-30 minute virtual interview, where they will be asked to respond to a series of questions relative to experiences at healthcare facilities/with healthcare providers and to be authentic and honest in their truths. This interview will be audio-recorded.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include contribution to research intended to address health disparities of Black women in the United States and strengthen the argument that these health disparities are a communication issue based on how inequality has long influenced the communication of Black women's health in America.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study may include, but are not limited to, anxiety, depression, stress, nostalgia, and fear of recurrence. These risks may be triggered as the participant relives the traumatic experience during the interview. The likelihood of these risks is dependent on the unique journey of healing for each participant. To minimize psychological or emotional risks, participants will be provided with a comforting space for conversation.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of codes. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored in Google Cloud. Data may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Emmerline Nelson-Rogers. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] [redacted]. You may also contact the researcher's faculty sponsor, Dr. Kami Anderson, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record our conversation as a part of my participation in this study.

____

Printed Subject Name

____

Signature & Date

A.6 Qualitative Interview Questions

Interview Questions

Personal Identifiers

How old are you?

A. 18-30
B. 31-40
C. 41-50
D. 51+

What is your immigration status?

A. Born United States Citizen
B. Naturalized United States Citizen
C. Permanent Resident
D. Undocumented Immigrant
E. Other

What is your marital status?

A. Single
B. Married
C. Widowed

What is your highest level of education completed?

A. Middle School
B. High School Diploma/GED
C. College/University
D. Doctorate
E. Other

Are you currently employed?

A. Yes
B. No

What is your current annual income?

A. $0 to $39,999
B. $40,000 to $69,999
C. $70,000 to $99,999
D. $100,000+

Insurance

1. Did you have insurance at the time of treatment?
    1. If no, why not?
2. Was this insurance provided through government or employment?

3. Did your insurance cover your treatment?
4. Do you currently have insurance?
    1. If no, why not?
    2. If you have a different insurance, is it provided through government or employment?

Story/Testimony

1. Which health facility did you visit for treatment? Was this your first visit at this health facility?
2. What do/did you require treatment for?
3. What is/was the length of your treatment(s)?
4. If past treatment, what was your annual income at the time of treatment(s)?
5. How do/did you pay for your treatment(s)
6. Tell me about your full experience?
    1. Tell me about your check-in experience. Were healthcare providers welcoming?
    2. How long did you wait to be treated?
    3. Was treatment explained to you? Did the healthcare provider confirm your understanding of treatment?
    4. Were you admitted for extended stay?
    5. Were you discharged? Did you receive clear reasoning for discharge? Did you understand discharge instructions?
    6. What other conversation did you have with the healthcare provider?

7. What was the outcome of your visit? Did the service provided resolve the issue?
8. Was there any need for follow-up? Did you return for follow-up?

Follow-up questions will be based on facts provided during the interview relevant to the story/testimony and research

A.7 Recent First-hand Experience with the U.S. Healthcare System

Early November 2023, my mother was placed on life support and spent fifteen days in the hospital. She was diagnosed with pneumonia which caused accumulation of liquid in her lungs and an inability to breathe without a breathing tube. Concerned with the state of Black women's health in America, through my learnings from mainstream media, my cousin’s death, and especially with my current research on this topic, I knew that I needed to be present and attentive at all times while my mother was hospitalized. Initially, nurses were extremely helpful and willing to go above and beyond to care for my mom. My aunt, who has decades of experience as a practicing nurse, and I shared stories and pictures with nurses so that they could see and hear about the vivacious and beautiful soul that laid there unable to breathe on her own. I recorded notes with timestamps, names of medication and increased or decreased doses, names of nurses, residents, nutritionists, and respiratory specialists. I was as amicable as I could possibly be because my mother’s life was in their hands and I appreciated the positivity they gave in return. However, somewhere along the lines, interactions changed.

Nurses, especially, became annoyed with family and friends who came to visit my mom. The visitation policy was not violated and we were unsure of what brought about the annoyance. In our culture and community, we are present in times of celebration, present in times of sickness, and present in times of mourning. My mom is a pillar in our community, the president of a local peacebuilding network and a mother and sister to many - all of whom visited at some point while my mom was hospitalized. The more my mom received visitors, the less forthcoming the nurses became with information about my mother’s progress and the less they interacted with me, my aunt, and my mother. We often needed to remind nurses to reposition my mother in her bed, wipe down her body, and drain the saliva buildup in her tube - all things they completed without reminder when my mother was first admitted. But then, one day, a nurse said “We know what we’re doing.” and I realized that the issue was actually the advocacy and support that my mom had. It made nurses feel like they were being micromanaged and not trusted to do their job. However, I wondered how the need for communication and clarity about my mother’s health could be an annoyance to the very people that would be able to provide answers. And I also wondered if they were also weary of the presence of my aunt given her experience as a nurse.

A few days after my mom was admitted, my father was able to get a flight back to the United States from Liberia, West Africa. When he arrived, my father, my aunt, and I took shifts to monitor the care of my mom in the hospital, throughout the day and overnight. My father is not as assertive as my aunt and myself so I often advised him of Black women's health disparities and treatment when they are unable to advocate for themselves or when they are not advocated for. My mom was awake and alert but only communicating with us by writing her thoughts in a notebook. There were two unsuccessful attempts to extubate (remove the breathing tube) for the doctor to conduct breathing tests. On the first attempt, my mother was unable to breathe on her own. On the second attempt, she breathed on her own for over an hour but had to be re-intubated after nurses changed her positioning. We were asked to leave the room and when we returned, my mom, frustrated, wrote “they were being rough with me and I struggled to breathe because the nasal cannula fell from my nose”.

Before my dad arrived, I, being my mother’s health proxy, advised nurses and the doctors that I did not want for my mom to undergo a tracheostomy, a procedure that requires an external opening into the windpipe (trachea) through her neck to allow the flow of air and oxygen to her lungs. One morning, my father texted me saying “They were about to do a procedure but mommy spoke.” I rushed to the hospital. While there I learned that the doctor was getting ready to perform a tracheostomy. My father was told that it was a mandatory procedure so he did not meet the doctor with any objection. The doctor prepped the room for the procedure and just before the procedure was to commence, my mother, still intubated, said “It’s hot”. Generally speaking, The tube traverses the vocal cords, rendering the patient unable to speak until the tube is taken out. The doctor was shocked and asked her to say her name. She said her name. The doctor said “she’s verbalizing” and demanded that my mom be extubated immediately. We thank God everyday because we know that it is by His grace and protection that my mother experienced a miracle and avoided an unnecessary procedure that may have delayed her recovery.

A.8 Caramel

Although Caramel did not meet participant criteria, I decided to move forward with the interview because her story needs to be heard. Caramel recently moved to New York and shared an experience with a hospital from her hometown, which I will not disclose. In October of 2021, Caramel learned that she was six weeks pregnant. Diagnosed with Polycystic ovary syndrome (PCOS), Caramel never tried to get pregnant. Although aware that not all women with PCOS have infertility issues, Caramel knew that such issues were a possibility. The pregnancy was not planned but she decided to keep the pregnancy and requested continuous follow up with an Endocrinologist to ensure her health and that of her baby were monitored.

At 26-weeks, Caramel's blood pressure was abnormally high. Her GYN advised that she required a procedure because her baby was *growth restricted*. Her GYN also advised that some women "carry smaller babies and take aspirin for nutrient flow." Caramel said her GYN did not sound confident. Two weeks later, at 26 weeks, Caramel went for a scan and was notified of restriction with blood flow. Physicians told her that she and the baby would be monitored in the case a Cesarean section, or C-section, would need to be performed. Caramel received doses of steroids and magnesium to help with blood flow. Eventually, the physician informed Caramel that they were going to "hold the pregnancy as much as we can. Usually, we do the c-section right away." She subsequently spent over two weeks in the hospital.

On the 13th day, Caramel complained about discomfort and subsequently was taken for a c-section. Caramel's son was born with an Apgar score of 9/10 meaning that her newborn was in good health. The acronym APGAR stands for Appearance, Pulse, Grimace, Activity, and Respiration and is used to assess baby health one minute and five minutes after they are born. Caramel expected to be discharged from the hospital two days after delivery. Anderson (2016) reported that babies born at 26 weeks have an 86% survival rate. Yet, she was told that her son "would not make it." Her son was placed in an incubator and taken to the neonatal intensive care unit, NICU, after delivery. Caramel was never given the option to hold her son nor was he ever given the breast milk she provided. Even after his prognosis, she was not given the option to have him naturally *go* in her arms.

When discharged, Caramel did not receive any resources relevant to bereavement services or support after losing her baby. And she was never given an opportunity for a discharge conference. Caramel did some research after her discharge and found that with blood flow restriction, pregnancies are monitored up to 32 weeks. Caramel was 28 weeks and 5 days when she was forced to undergo a c-section. She expressed that her discharge paperwork read that she "opted" to have a c-section. Caramel also found that families were able to hold their babies even when incubated. Further research helped her learn more about how to take care of herself after discharge. Nothing of such was included in her discharge paperwork. The next time she heard from the hospital, the billing department called to congratulate her for becoming a mother.