

Addressing Racism and Advancing
Equity in Midwifery Education:

A PROGRAM CONTENT TOOLKIT FOR ACTION



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Introduction

The racial justice movement which coalesced and swept across the United States following the murder of George Floyd, Jr on May 25, 2020, has forced many organizations to begin to confront racism within their own structures and history. Among those organizations, the American College of Nurse-Midwives (ACNM) began to heed the decades-long call for a thorough examination of racism within midwifery education, practice, and the organization itself. As part of that process, ACNM formed the Racism in Midwifery Education Task Force. This Task Force was divided into subgroups designed to focus on elements of midwifery education. The authors of this toolkit volunteered to become the Program Content Subgroup (PCS), which was tasked to explore how racism is manifested in and rooted within midwifery education program content and to recommend ways to eradicate it and build antiracist curricula.

Efforts to address racism within ACNM and midwifery in the United States are not new. There is a powerful lineage of midwives of color who individually and collectively have worked to create space within ACNM, prompt essential change within the organization, and build a just and equitable organization and greater midwifery culture. *Into the Light of Day: Reflections on the History of Midwives of Color Within the American College of Nurse-Midwives*¹ by Linda Janet Holmes is the authoritative text on this work, and the PCS recommends that all faculty read it and add it to their curriculum.

Introduction to Racism in the Program Content of Midwifery Education

Racism is pervasive within midwifery education at the individual, institutional, and structural levels. The PCS' work as a subgroup was to focus on places where racism is evident in midwifery education program content. Racist ideology is present in the texts we read and recommend, the presentations we give, and the way we conceptualize and talk about midwifery in the United States.

One of the most egregious manifestations of racism in midwifery education is the way midwifery history is taught. In addition, the PCS sees biological racism perpetuated through our texts, such as when genetic ancestry is equated to race and an individual's race is considered a risk factor for pathology. White bodies are treated as the norm in the images we choose. White supremacy culture is evident in how we design programs and measure success. This Toolkit is intended to help midwifery educators reflect on their own racism, recognize how racism is present in midwifery education, and offer tools to address racism and build antiracist programs.

Statement on Racism in the Teaching of Midwifery History

The PCS of the Racism in Midwifery Education Task Force stands with the Midwives of Color Committee and student members of ACNM in strongly encouraging all midwifery education programs to include in their content a robust history of midwifery practice in the United States, which should include the histories of midwives of color and Indigenous midwives. The systemic erasure of these histories has contributed to the disenfranchisement of midwives of color and has perpetuated the racial disparities seen in maternal and infant health and care today. Prioritizing the history of white midwives, while ignoring the stories of midwives of color, is racist and should be stopped. Midwifery education programs have a duty to ensure that students understand the many ways midwifery has been practiced throughout the United States, and how the professionalization of the vocation has harmed communities of color, including the people we serve. These understandings are vital to students' conception of themselves as midwives and to their aptitude as future health care providers.

Racist ideology in midwifery can be passed down through educational institutions, but so, too, can an orientation of antiracism. Midwifery education programs have an opportunity to empower their students to be antiracist leaders through a robust and reflective examination of our collective history as midwives.

About the Toolkit

Purpose of the Toolkit

The purpose of the Toolkit is to provide faculty with resources for ensuring that their programs are addressing the historical racism in American midwifery and preparing future midwives to be aware of racism and bias in themselves, in institutions, and in the health care system. The Toolkit offers some insight into the impact of racism within midwifery education on midwifery students of color. It provides self-assessment resources for faculty to learn and grow regarding their own implicit biases and racist ideas. This foundational work is essential and ongoing. It provides a tool to evaluate the content of midwifery courses through a lens of antiracism and bias reduction. The last 2 components are a sample assignment for students and a tool for evaluating textbooks, respectively. Both are presented along with examples as to how these could be used in education.

Limitations of the Toolkit

There are many limitations to the Toolkit, but the members of the PCS view it as a starting point.

First, the Toolkit is not the panacea for all manifestations of racism within midwifery education. Simply using the Toolkit to improve program content will not eradicate racism within midwifery education. Use of the Toolkit is not an alternative to increasing diversity and representation among midwifery faculty and program directors. This document should be viewed as one tool in the work of addressing racism within midwifery education.

Second, the Toolkit is a product of its time. It is not a tool that will forever retain its relevance in its current form. The PCS hopes that in engaging in the important endeavor of confronting racism, the most pressing challenges of today will improve. They envision iterative editions of the Toolkit or the creation of a new one wholesale at some juncture for it to be essential and relevant.

Third, the Toolkit is a product of those who created it. The members of the PCS largely reflect the current membership of ACNM and the demographics of practicing midwives. Most of the subgroup members are racialized as white in a white supremacist world. The Toolkit would not be possible without the invaluable contributions, wisdom, and visionary leadership of the PCS members of color.

Fourth, this Toolkit is directed toward midwifery faculty—a majority-white group—many of whom may just be beginning their antiracism work. Although the PCS members believe in the need for racial healing and desire to focus on resilience, they feel that the essential first step is to stop harm that is occurring. Members of the PCS believe that an important next step will be to focus on the importance of healing and resilience.

Fifth, the PCS recognizes that many midwifery education programs are housed within colleges of nursing. Some of the most egregious examples of racism in program content are seen in pre-RN licensure courses. In addition, midwifery programs likely have constraints placed on them by the larger college to which they belong. To this, the PCS cannot speak in detail, given that each situation is unique. The subgroup hopes that faculty and program directors in such institutions see themselves as possible catalysts for broader change.

Sixth, most members of the subgroup are nurse-midwives. The PCS believes that the principles and tools referenced herein are broadly applicable to all midwifery educational programs.

Finally, the creation of a toolkit does not ensure its use. The Racism in Midwifery Education Task Force was created to make recommendations to the ACNM Board of Directors (BOD). Some recommendations, though, fall outside ACNM's jurisdiction. True change will require the Accreditation Commission for Midwifery Education (ACME) and American Midwifery Certification Board (AMCB) to modify what is expected of programs and those prepared to begin practice. To that end, the PCS has collaborated with other subgroups in the Task Force to create a list of recommendations to the ACNM BOD, who may have leverage to prompt change (see below).

Recommendations to the ACNM Board of Directors

In addition to creating the Toolkit, the PCS created the following list of recommendations for the ACNM BOD:

- A. ACNM should advocate for ACME credentialing/recredentialing criteria for programs that they incorporate a more complete, accurate, antiracist, non-white supremacist history of midwifery into their curricula;
- B. ACNM should acknowledge that current and past core midwifery textbooks contain racist content, and ACNM should advocate for antiracist textbook revisions;
- C. ACNM should advocate that antiracist deliverables developed by the Task Force be part of the educational program credentialing/recredentialing process of ACME;
- D. Consistent with ACNM's Strategic Plan, the BOD should continue the important work of this Task Force with a long-term focus on not only addressing harm but also on fostering racial healing and a positive racial climate, as well as acknowledging and bolstering resilience;
- E. ACNM should create a permanent office and full-time position for a Diversity, Equity, Inclusion, and Belonging (DEIB) professional to coordinate antiracism initiatives within the College; and
- F. ACNM should develop a plan to distribute and implement this Toolkit. This plan should include a study of the impact of Toolkit use within midwifery programs before its use is made mandatory.

Characteristics of White Supremacy Culture

One of the greatest challenges to confronting white supremacy is the way in which it has historically masked its own existence to white people. Those who grow up with the privilege of being white live in a world where everything reflects their own culture back at them. Whiteness is treated as the default, which leads to the thinking that other racial/ethnic identities are inferior. Racism is present in our curricula and programs not solely in the images we use, but also in what is included in the history of midwifery, and in equating race with genetic ancestry. It is present in how we structure our programs, what is expected of both students and faculty, and in what has been left out.

In 2001, Kenneth Jones and Tema Okun wrote the essential *Dismantling Racism: A Workbook for Social Change Groups*,¹ which clearly outlined characteristics of white supremacy culture. This work was based on a similar article written by Okun alone in 1999. Okun also wrote an article in 2021 titled, “White supremacy culture - still here,”² which is an update to her original work. Below is the list of characteristics Okun included, along with examples of how those characteristics might manifest in midwifery education. Consider which of these might be manifest in your program.

Fear

Are students who do not fit the stereotypical midwifery mold appreciated or feared for upsetting the status quo?

Perfectionism

Are we focused more on right answers than on learning?

Sense of urgency

Is it really essential that late work receives no credit? Are the program's policies helpful in learning?

Defensiveness

Is any criticism of the current structure met with “this is how we’ve always done it” thinking?

Denial

Is your program admitting to and addressing its white supremacy?

Qualified

Are midwives (a predominantly white group in the United States) portrayed as imbued with the duty and ability to fix things and save (minoritized) others?

Quantity over quality

When there is a conflict between covering content and learner processes, which one wins?

Worship of the written word

Are soft skills undervalued? What about clinical skills? Is lived experience dismissed?

Only one right way

Beyond questions of science and safety, are alternative approaches and experiences valued?

Paternalism

Is decision-making shared? Is the decision-making process clear to those who do not have power?

Either/or thinking and the binary construct

Is everything simply right or wrong? Are complex things overly simplified?

Power hoarding

Is there a desire to share decision-making? Are suggestions for change seen as threats to authority?

Fear of open conflict

Is there investment in side-lining conflict? Are students who raise concerns seen as problematic?

Individualism

Do students feel a part of a community? Is there peer accountability or only hierarchical accountability?

'I'm the only one'

Is the most vocal person the leader? Is there a sense that there is a "right" way to do things and that only one person can complete the task in the right way?

Progress equals "bigger," "more"

Is the best metric of your program's success the number of students who enroll?

Objectivity

Do course goals assume linear thinking? Is emotion treated as though it should not be involved in decision-making?

Right to comfort

Do those with power feel entitled to protection from emotional or psychological discomfort?

We understand that there are constraints to program and course design and on requirements placed on programs to facilitate students hitting certain milestones. The purpose of this list is to highlight areas that may be ripe for ongoing work. Awareness is the first step. Given that most midwifery educators are white, these characteristics may feel as commonplace and as inevitable as gravity. They are not.

Resources and Tools for Faculty

Understanding the Impact of Racism in Midwifery Education on Midwifery Students of Color

Appendix A is a summary (written by Emily Stallings) of a presentation given at the 2020 ACNM Inclusion Conference: Dare to Think Different. The presentation was a compilation of qualitative analyses of the data regarding the impact that racism within the current midwifery education programs was having on students of color.

Tools for Self-Reflection

(Jennifer Johnson, Tamika Julien, Catherine Palmer)

Introduction

To build and deliver antiracist midwifery curricula, midwifery educators must create practices of critical self-reflection and bolster their resilience for the ongoing work of reflexivity and self-accountability. The work of being antiracist is a continually evolving journey. Unlike the proficiency gained by completing a competencies checklist, midwifery educators cannot become proficient at antiracism. Rather, it is a process of continued growth, knowledge, and commitment to action that requires self-knowledge and self-critique.

To implement the recommendations offered throughout the Toolkit, the PCS believes that midwifery educators must continually check in with their own understandings of racism, whiteness, white supremacy, anti-Blackness, and their commitment to antiracism, as well as how these concepts are reflected in their educational content. The goal of self-assessment work is to provide faculty with the tools they need to implement antiracist curricula from a place of self-awareness and critical race consciousness. Antiracist curricula will not be effective if facilitators do not understand their own relationship to race and racism.

The following recommendations are meant to guide educators in this work of self-assessment and reflection. The tools and recommendations offered are not the only tools available to critique one's own understanding of antiracism, but the PCS feels they are foundational texts in this process of antiracist learning. Although the PCS recommends revisiting these texts at certain intervals, we encourage individuals to adapt and use these tools in a manner that will best suit individual needs.

In doing this work, we discourage white faculty members from seeking out Black, Indigenous, Latinx, and other people of color (BILPOC) faculty or staff to help them understand racism or their own self-discoveries in the process of reflection. Although it may feel intuitive to seek to understand the phenomenon of racism by talking with those who are most affected by it, it is inappropriate to ask someone to share some of their most vulnerable and painful experiences. BILPOC individuals already live under the emotional and spiritual drain of white supremacy, and asking BILPOC colleagues to explain white supremacy to white people may be retraumatizing. In addition, it reinforces the narrative that BILPOC people are resources available to serve and further the needs of white people. There are many professional antiracism educators who are trained to speak on these complex topics and who are compensated for their time and labor (see Appendix I). Furthermore, the intention of these practices is to cultivate *self-reflection*. This needs to be internal, reflexive work, wherein white educators commit to understanding how they have internalized racism and white supremacy and then come to “organic” conclusions on how that has affected their midwifery and teaching practices.

Recommendations

- A. Before the start of each semester, faculty and preceptors for midwifery programs should complete designated segments (see Appendix C) of the Wells’ Self-Assessment Tool.³
 - a. Discussing results with DEIB staff or among midwifery faculty is advisable, although the PCS recognizes this may not always be possible.
- B. Faculty should read “White privilege: unpacking the invisible knapsack,”⁴ written by Peggy McIntosh (Appendix B), at the start of each academic year. This is optional for non-white faculty.
 - a. Discussing the article with DEIB staff or among midwifery faculty is advisable, although the PCS recognizes this may not always be possible.
- C. All faculty should regularly participate in and engage with the webinars and trainings provided by ACNM around antiracism (see Appendix I). Faculty with an average self-assessment score of 5 or below on the Wells’ Self-Assessment Tool should especially aim to engage with antiracism resources on a regular basis.
- D. Faculty should approve presentation slides in advance to ensure that they are free of racism and racist assumptions. In addition, all guest lecturers should be invited to complete the Wells’ Self-Assessment Tool before their presentation. With continued practice in self-reflection and self-assessment, faculty should feel equipped to invite guest lecturers into their own practices of self-assessment and to select guest lecturers with antiracist perspectives.

Tools for Assessing Program Content for Racism

Before launching into rebuilding all elements of midwifery programs, we recommend assessing existing parts for areas that are most in need of revision or replacement. We provide here tools to help assess curricula and texts for racism. These tools have broad application, from thinking about who is treated as an expert, to the diversity of authors cited for a course, to restructuring course evaluations. Our hope is that these tools can be used in an iterative manner. The desire is not only to uncover and eradicate racism but to develop programs that are antiracist and that help shape antiracist providers.

Curriculum Assessment

(Eva Fried)

Examining and addressing curricula are key pieces to making midwifery education antiracist. The way in which racism and race are framed in relation to health outcomes contributes to how all learners perceive people they will care for and the scientific basis for the care midwives provide. In addition, antiracist curricula have the potential to foster safer learning environments for BILPOC midwifery students whose progression through graduation will increase the number of midwives of color. Both increasing the numbers of BILPOC midwives and working toward antiracist curricula for all learners have the potential to result in improved health outcomes for the people we serve.

This Curriculum Checklist⁵ (Appendix D) was created and shared by Equity in Midwifery Education at EquityMidwifery.org. The author gives several suggestions for how to implement the tool and offers a range of ideas regardless of whether courses need a minor adjustment or a complete makeover. This tool also includes supplemental ideas and links to specific content and language that can be included in courses. As the author suggests, you can begin by taking the first step by setting incremental, antiracist goals for yourself and your program. When you commit to keep learning and improving midwifery education for your students and ultimately for the people and families they will serve, progress will follow.

Text Evaluation

(Heather Bradford & Laura Manns-James)

Much of a student's learning comes from engaging with written references. Some program content may be covered by several different resources, and we recommend assessing textbooks and choosing antiracist content where possible. When there are few options, faculty can, at a minimum, recognize problems with the text and note problematic content for students. Members of the PCS worked to create a tool that faculty can use to assess texts for these purposes.

This Text Evaluation Tool (Appendix E) was developed using the Equity in Midwifery Education website curriculum evaluation checklist⁵ as a starting point. An informal national survey of midwifery education program directors was conducted via the DOME listserv regarding the most used textbooks, as well as antiracism resources and books used in midwifery curricula. From these survey results, the most used textbooks were evaluated to trial the tool (Appendix F). The tool was then refined based on feedback from the PCS, and that version is included herein.

How to Use the Midwifery Text Evaluation Tool

The Midwifery Textbook Evaluation Tool can be used to evaluate any textbook or resource from an antiracism lens. Before using the tool, users are encouraged to familiarize themselves with the Antiracism Glossary (Appendix J) for definitions of terms used within the tool. Faculty are encouraged to use the tool to assess textbooks or resources they are currently using or considering in the future. Alternatively, faculty and students might use the tool together to critique existing textbooks and resources from an antiracism framework.

Tools for Building Antiracist Curricula

Assignment Suggestion: Script Writing

(Carol Bues, Nancy MacMorris-Adix, Emily Stallings)

What is scripting?

As midwives, we can struggle to explain medical information to the people for whom we care in a way that is accurate, compassionate, clear, and concise. As we try different explanations, we find those that seem to hit home and that we use those over and over—essentially, a script! For many, the use of scripts may have first begun as a means of conveying medical information, but scripts can be helpful in guiding nonclinical conversations with people as well. Scripts can be especially useful when preparing for difficult conversations or those that may provoke emotions in ourselves and/or people we serve. Antiracist scripting includes topics such as addressing microaggressions or acknowledging differences in cultures between the midwife and the person receiving care.

Why use scripting in preparing antiracist midwives?

Many midwifery students—particularly those who are white—may still be learning how to talk about race and racism. However, calling out the impact of racism on the health of marginalized peoples is essential to providing effective care. Planning those words and selecting them so they are both authentic and empathetic may take some work. Scripting is part of that planning.

The use of scripting as an assignment provides students space to reflect on their knowledge, experience, and comfort and to draft language that is thoughtful, compassionate, and antiracist. See Appendix G for a Scripting Assignment Handout that can be used as a practical tool for developing these scripting exercises.

Shortcomings of scripting recommendations from the Toolkit

It is important to note that the listed script topics reflect the time in which we are living, and the most appropriate topics will change over time. Further, some topics may be a better fit for some individuals than for others. For this reason, we recommend allowing students to select topics they feel are most important to their growth and work.

In addition, we recognize that asking students to acknowledge and reflect on racism is work that risks creating harm if not done well. Please consider the specific makeup of your student body when designing assignments.

We also recommend considering whether assignments focused on healing from racist acts and healing from historical acts might be a better fit for some students, particularly for students of color. It is important to remember that no group is a monolith, and racism harms all people in some way. Allowing for customization to the greatest degree possible will facilitate the most self-realized and best-prepared midwives.

Writing scripts

Before composing a script, students need to consider their understanding of the subject of the scripts and their own biases. Each script writer should consider a few concepts they want to convey and approach the work as an opportunity to grow as an individual. This is hard, but significant, work.

There are many considerations for writing a script. First, it is important to examine intent and how the words will be received. A script writer should think through possible and/or probable responses to be ready for a full exchange on the topic. Also, in a busy clinical setting, realistic time constraints need to be addressed. Other considerations include using a perspective based on the midwifery model of care, centering the work on the person being served, and being prepared with resources in case the topic requires additional evidence-based support.

As in any interaction with a person being served, the importance of verbal *and* nonverbal communication should be communicated. Remind students to sit down, maintain eye contact (as culturally appropriate), and be aware of their body posture, tone of voice, and speed of speech. Students should also consider the setting in which

they are imagining having the conversation and how that would affect what they say and do.

The assignment

Scripting assignments for the purpose of preparing antiracist midwives serve multiple purposes in a curriculum. They provide an opportunity for students to explore racism in health care and their own prejudices, for faculty to check in on student engagement with these concepts, and for practice translating sometimes complex ideas into a format that could realistically be implemented in the clinical setting.

For this reason, when scripts are being assigned for coursework, we recommend that each script have 2 components. The first component should be a longer, more thorough script and the second a more concise, conversation-friendly version of the script. The first version will allow faculty to assess student engagement with concepts presented, whereas the second will allow for assessment of the student's ability to translate concepts into clinical practice. For the purpose of the Toolkit, the first version will be referred to as the "academic version" and the second as the "clinical version." A detailed assignment guide was created to facilitate the writing of scripts (Appendix H).

For some scripting topics, the differences between the academic version and clinical version may be few. Pertaining to the scripting topics we suggest, those intended for talking with colleagues may not require the same level of transformation if there is a shared level of health literacy.

Assessment

Because the work of antiracism is so personal, it is important for faculty to be sensitive to where each student is in their work. That said, it is important that the script be assessed for how it addresses the topic of racism and that it centers on the person being served. The following are some suggested areas to include in the assessment:

- Does the script fit within the framework of antiracism?
- Does the student have a complete understanding of the concepts and words they are using in the script?
- What level of racism is being addressed (personal, institutional, overt, covert, etc)? Are appropriate levels of racism being discussed?
- Is the language accurate and appropriate for the context?
- Is implementing the "clinical script" feasible in a clinical setting?
- Is the health literacy level of the language in the "clinical script" appropriate?

Scripting topics

Some script topics to address racism are the following (Appendix H):

- Microaggressions/overt racism from colleagues, preceptors, or those above you in the medical hierarchy***
- Microaggressions/overt racism from the people we serve
- The role of racism as a risk factor in health care with people we serve
- Racialized perinatal health outcomes with the people we serve
- Racial discordance between yourself as provider and a person in your care***
- The role of cultural norms in perinatal/reproductive care with cultural competence and humility (eg, discussing lactation with someone from a culture that recommends against feeding the newborn colostrum vs white western medical culture's recommendation to feed the newborn colostrum)***

*** These are script samples included in the Toolkit.

Introduction to Resources, Tools, and Antiracism Glossary

The appendices that follow are a series of resources that include:

1. A summary of a presentation of the impact of racism on midwifery students
2. Self-reflection resources
3. Tools for evaluating program content
4. Classroom assignment resources
5. Resources, definitions, and references

- Appendix A: From Listening to Action: Understanding the Impact of Racism Within Midwifery Education on Midwifery Students of Color
- Appendix B: White Privilege: Unpacking the Invisible Knapsack by Peggy McIntosh
- Appendix C: Wells' Self-Assessment Tool: Anti-Racism³
- Appendix D: Curriculum Assessment Tool
- Appendix E: Midwifery Antiracism Text Evaluation Tool
- Appendix F: Midwifery Textbooks Through an Antiracism Lens: Evaluation Summaries
- Appendix G: Scripting Assignment Handout
- Appendix H: Scripting Examples
- Appendix I: Resource List for Faculty to Engage in Antiracism
- Appendix J: Antiracism Glossary
- Appendix K: References

Appendix A: From Listening to Action: Understanding the Impact of Racism Within Midwifery Education on Midwifery Students of Color

Summation of presentation, “From Listening to Action: Mobilizing EDI Evidence in Midwifery Education” created by members of the Midwifery Equity Consortium: Karline Wilson-Mitchell, Felina Ortiz, Kristin Effland, Judy Lazarus, and Eva Fried.

The primary purposes of the presentation were to present evidence of the manifestations of racism in midwifery education and its impact on midwifery students of color and to translate those themes into antiracist action in midwifery education.

The sources of included information were survey data, webinar, and published articles and texts. These sources captured information from current students (at the time of data collection), recent graduates, educators, and midwives in practice for an extended time. The presentation also included expert reflections and interpretations of the information collected.

The 5 specific sources included were:

- ACNM Midwives of Color (MOC) Survey, May 2020
- “How does racism in midwifery education negatively impact diversity within midwifery and disparities in maternal and child health” conference presentation at the 2019 ACNM Annual Meeting; May 18-22, 2019; Washington, DC
- ACNM CEO listening session with students and faculty at the University of California San Francisco, 2019
- “Women of color entering midwifery: an assessment of unmet needs” by Nancy Anderson, MD, MPH; National Association of Professional Nurse-Midwives (NACPM) webinar, March 2017
- *Into the Light of Day: Reflections on the History of Midwives of Color Within the American College of Nurse-Midwives*; ACNM; 2012⁶

Thematic analysis regarding the ways racism manifests in midwifery education was then performed by identifying and naming assumptions, searching for patterns, organizing into themes, seeking to understand the complexity of themes in addition to their frequency, and then describing the context (including through direct quotes).

THEMES

Institutional Factors

- Isolation/belongingness
- Aggressions - macro and micro
- Lack of faculty, preceptors, and students of color
- Exclusion of BIPOC midwives from midwifery history/celebration of racist midwives in organizational history
- Repeatedly seeing race, rather than racism, listed as a risk factor for health inequities
- Programs wanting BIPOC graduates and not having structures in place to support this
- Biases in clinical settings: harder time getting placement, being told need more time

Other Factors

- More financial and social responsibilities than white classmates
- Learning in the context of currently living with racism and racial violence and learning in/from a racist institution
- Experience as child/parent/doula informing the choice to become a midwife
- Determination to achieve educational goals
- Preference for distance education

Proposed Antiracist Actions

- Increase scholarships/financial assistance/endowments from programs/schools, affiliates, chapters, and professional organizations
- Reduce membership and conference fees
- Increase retreats, networking, and social media spaces specifically for BIPOC midwives and students
- Support mentorship opportunities
- Highlight the scholarly work and contributions of BIPOC midwives
- Increase opportunities for peer support, which also necessitates increasing recruitment, early pipeline programs, admission, retention, and support
- Increase program transparency, including ongoing evaluations and listing all costs, including “incidentals”
- Use existing resources better
- Commit to hiring and increasing BIPOC faculty and staff (including in academic support) and hire a DEI officer
- Adapt testing and teaching to be inclusive of various learning styles
- Eliminate harmful and traumatic course content
Incorporate the history of BIPOC midwives including *Into the Light of Day*⁶

- Include the impact of racism and social determinants of health (SDOH) into curricula and core competencies
- Do not expect BIPOC faculty/students to do all the teaching about cultural sensitivity/implicit bias and be aware of introversion. Acknowledge the role of historical trauma, the related need to stay safe, and the need to facilitate avenues for increased safety

Appendix B: White Privilege: Unpacking the Invisible Knapsack by Peggy McIntosh

Note: This is an authorized excerpt of “White privilege: unpacking the invisible knapsack” first appeared in Peace and Freedom Magazine, July/August 1989:10-12, a publication of the Women’s International League for Peace and Freedom, Philadelphia, PA.⁴ Copyright 1989, by Peggy McIntosh. Reprinted with permission. The author maintains ownership.

Through work to bring materials from Women’s Studies into the rest of the curriculum, I have often noticed men’s unwillingness to grant that they are over-privileged, even though they may grant that women are disadvantaged. They may say they will work to improve women’s status, in the society, the university, or the curriculum, but they can’t or won’t support the idea of lessening men’s. Denials which amount to taboos surround the subject of advantages which men gain from women’s disadvantages. These denials protect male privilege from being fully acknowledged, lessened or ended.

Thinking through unacknowledged male privilege as a phenomenon, I realized that, since hierarchies in our society are interlocking, there was most likely a phenomenon of white privilege that was similarly denied and protected. As a white person, I realized I had been taught about racism as something that puts others at a disadvantage but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage.

I think whites are carefully taught not to recognize white privilege, as males are taught not to recognize male privilege. So, I have begun in an untutored way to ask what it is like to have white privilege. I have come to see white privilege as an invisible package of unearned assets that I can count on cashing in each day, but about which I was “meant” to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools and blank checks.

Describing white privilege makes one newly accountable. As we in Women’s Studies work to reveal male privilege and ask men to give up some of their power, so one who writes about white privilege must ask, “Having described it, what will I do to lessen or end it?”

After I realized the extent to which men work from a base of unacknowledged privilege, I understood that much of their oppressiveness was unconscious. Then I remembered the frequent charges from women of color that white women whom they encounter are oppressive.

I began to understand why we are justly seen as oppressive, even when we don’t see ourselves that way. I began to count the ways in which I enjoy unearned skin privilege and have been conditioned into oblivion about its existence.

My schooling gave me no training in seeing myself as an oppressor, as an unfairly advantaged person, or as a participant in a damaged culture. I was taught to see myself as an individual whose moral state depended on her individual moral will. My schooling followed the pattern my colleague Elizabeth Minnich has pointed out: whites are taught to think of their lives as morally neutral, normative, and average, and also ideal, so that when we work to benefit others, this is seen as work which will allow “them” to be more like “us.”

I decided to try to work on myself at least by identifying some of the daily effects of white privilege in my life. I have chosen those conditions which I think in my case *attach somewhat more to skin-color privilege* than to class, religion, ethnic status, or geographic location, though of course all these other factors are intricately intertwined. As far as I can see, my African American co-workers, friends, and acquaintances with whom I come into daily or frequent contact in this particular time, place and line of work cannot count on most of these conditions.

1. I can if I wish arrange to be in the company of people of my race most of the time.
2. If I should need to move, I can be pretty sure of renting or purchasing housing in an area which I can afford and in which I would want to live.
3. I can be pretty sure that my neighbors in such a location will be neutral or pleasant to me.
4. I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed.
5. I can turn on the television or open to the front page of the paper and see people of my race widely represented.
6. When I am told about our national heritage or about “civilization,” I am shown that people of my color made it what it is.
7. I can be sure that my children will be given curricular materials that testify to the existence of their race.
8. If I want to, I can be pretty sure of finding a publisher for this piece on white privilege.
9. I can go into a music shop and count on finding the music of my race represented, into a supermarket and find the staple foods that fit with my cultural traditions, into a hairdresser’s shop and find someone who can cut my hair.
10. Whether I use checks, credit cards or cash, I can count on my skin color not to work against the appearance of financial reliability.
11. I can arrange to protect my children most of the time from people who might not like them.

12. I can swear, or dress in second-hand clothes, or not answer letters, without having people attribute these choices to the bad morals, the poverty, or the illiteracy of my race.
13. I can speak in public to a powerful male group without putting my race on trial.
14. I can do well in a challenging situation without being called a credit to my race.
15. I am never asked to speak for all the people of my racial group.
16. I can remain oblivious of the language and customs of persons of color who constitute the world's majority without feeling in my culture any penalty for such oblivion.
17. I can criticize our government and talk about how much I fear its policies and behavior without being seen as a cultural outsider.
18. I can be pretty sure that if I ask to talk to "the person in charge," I will be facing a person of my race.
19. If a traffic cop pulls me over or if the IRS audits my tax return, I can be sure I haven't been singled out because of my race.
20. I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children's magazines featuring people of my race.
21. I can go home from most meetings of organizations I belong to feeling somewhat tied in, rather than isolated, out-of-place, outnumbered, unheard, held at a distance, or feared.
22. I can take a job with an affirmative action employer without having co-workers on the job suspect that I got it because of race.
23. I can choose public accommodations without fearing that people of my race cannot get in or will be mistreated in the places I have chosen.
24. I can be sure that if I need legal or medical help, my race will not work against me.
25. If my day, week, or year is going badly, I need not ask of each negative episode or situation whether it has racial overtones.
26. I can choose blemish cover or bandages in "flesh" color and have them more less match my skin.

I repeatedly forgot each of the realizations on this list until I wrote it down. For me, white privilege has turned out to be an elusive and fugitive subject. The pressure to avoid it is great, for in facing it I must give up the myth of meritocracy. If these things are true, this is not such a free country; one's life is not what one makes it; many doors open for certain people through no virtues of their own.

In unpacking this invisible knapsack of white privilege, I have listed conditions of daily experience that I once took for granted. Nor did I think of any of these perquisites as bad for the holder. I now think that we need a more finely differentiated taxonomy of privilege, for some of these varieties are only what one would want for everyone in a just society, and others give license to be ignorant, oblivious, arrogant and destructive.

I see a pattern running through the matrix of white privilege, a pattern of assumptions that were passed on to me as a white person. There was one main piece of cultural turf; it was my own turf, and I was among those who could control the turf. *My skin color was an asset for any move I was educated to want to make.* I could think of myself as belonging in major ways and of making social systems work for me. I could freely disparage, fear, neglect, or be oblivious to anything outside of the dominant cultural forms. Being of the main culture, I could also criticize it fairly freely.

In proportion as my racial group was being made confident, comfortable, and oblivious, other groups were likely being made inconfident [*sic*], uncomfortable, and alienated. Whiteness protected me from many kinds of hostility, distress and violence, which I was being subtly trained to visit, in turn, upon people of color.

For this reason, the word “privilege” now seems to me misleading. We usually think of privilege as being a favored state, whether earned or conferred by birth or luck. Yet some of the conditions I have described here work systematically to over empower certain groups. Such privilege simply *confers dominance* because of one’s race or sex.

I want, then, to distinguish between earned strength and unearned power conferred systemically. Power from unearned privilege can look like strength when it is in fact permission to escape or to dominate. But not all of the privileges on my list are inevitably damaging. Some, like the expectation that neighbors will be decent to you, or that your race will not count against you in court, should be the norm in a just society. Others, like the privilege to ignore less powerful people, distort the humanity of the holders as well as the ignored groups.

We might at least start by distinguishing between positive advantages, which we can work to spread, and negative types of advantage, which unless rejected will always reinforce our present hierarchies. For example, the feeling that one belongs within the human circle, as Native Americans say, should not be seen as privilege for a few. Ideally it is an *unearned entitlement*. At present, since only a few have it, it is an *unearned advantage* for them. This paper results from a process of coming to see that some of the power that I originally saw as attendant on being a human being in the United States consisted in unearned advantage and conferred dominance.

I have met very few men who are truly distressed about systemic, unearned male advantage and conferred dominance. And so, one question for me and others like me is whether we will be like them, or whether we will get truly distressed, even outraged, about unearned race advantage and conferred dominance, and, if so, what will we do to lessen them. In any case, we need to do more work in identifying how they actually

affect our daily lives. Many, perhaps most, of our white students in the U.S. think that racism doesn't affect them because they are not people of color, they do not see "whiteness" as a racial identity. In addition, since race and sex are not the only advantaging systems at work, we need similarly to examine the daily experience of having age advantage, or ethnic advantage, or physical ability, or advantage related to nationality, religion, or sexual orientation.

Difficulties and dangers surrounding the task of finding parallels are many. Since racism, sexism, and heterosexism are not the same, the advantages associated with them should not be seen as the same. In addition, it is hard to disentangle aspects of unearned advantage which rest more on social class, economic class, race, religion, sex, and ethnic identity than on other factors. Still, all of the oppressions are interlocking, as the Combahee River Collective Statement of 1977 continues to remind us eloquently.

One factor seems clear about all of the interlocking oppressions. They take both active forms, which we can see, and embedded forms, which as a member of the dominant group one is taught not to see. In my class and place, I did not see myself as a racist because I was taught to recognize racism only in individual acts of meanness by members of my group, never in invisible systems conferring unsought racial dominance on my group from birth.

Disapproving of the systems won't be enough to change them. I was taught to think that racism could end if white individuals changed their attitudes. But a "white" skin in the United States opens many doors for whites whether or not we approve of the way dominance has been conferred on us. Individual acts can palliate, but cannot end, these problems.

To redesign social systems, we need first to acknowledge their colossal unseen dimensions. The silences and denials surrounding privilege are the key political tool here. They keep the thinking about equality or equity incomplete, protecting unearned advantage and conferred dominance by making these taboo subjects. Most talk by whites about equal opportunity seems to me now to be about equal opportunity to try to get into a position of dominance while denying that *systems* of dominance exist.

It seems to me that obliviousness about white advantage, like obliviousness about male advantage, is kept strongly inculcated in the United States so as to maintain the myth of meritocracy, the myth that democratic choice is equally available to all. Keeping most people unaware that freedom of confident action is there for just a small number of people props up those in power and serves to keep power in the hands of the same groups that have most of it already.

Although systemic change takes many decades, there are pressing questions for me and I imagine for some others like me if we raise our daily consciousness on the perquisites of being light-skinned. What will we do with such knowledge? As we know from watching men, it is an open question whether we will choose to use unearned advantage to weaken hidden systems of advantage, and whether we will use any of our arbitrarily awarded power to try to reconstruct power systems on a broader base.

Appendix C: Wells' Self-Assessment Tool: Anti-Racism³

Accountability (Self)

- How often do you say or do something (e.g., make a comment, ask a question, or behave/react in a way that is rooted in a racist attitude, assumption, or stereotype)? (This includes things you think, say, or do in the presence of other people AND things you think, say, or do that other people might not know about.)

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

- When you say or do something rooted in a racist attitude, assumption, or stereotype, what emotional response does it bring up for you? (This includes the emotions you feel in the moment, whether in the presence of other people or alone, and the emotions you feel later on.)

Guilt	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Shame	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Embarrassment	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Frustration (with self)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Defensiveness	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Anxiety (about what others think of you)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Concern (about how your actions made others feel)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

- When you say or do something rooted in a racist attitude, assumption, or stereotype, what intellectual response does it bring up for you?

Rationalization (that you lacked bad intent)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Recognition of internalized racism	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Awareness of the need for unlearning	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Acknowledgment of impact on others	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

- When you say or do something rooted in a racist attitude, assumption, or stereotype in the presence of other people, how often do you acknowledge/name it to others without being called out for it first?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

- When other people point out that you said or did something rooted in a racist attitude, assumption, or stereotype, what are your behavioral impulses?

Explain intent (what you did/didn't mean)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Ask them to explain harm/educate you	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Question their experience/"interpretation"	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

Think or say they are overreacting	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
React to or comment on their tone	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Cause more harm with your comments/actions	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Verbally acknowledge accountability	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Apologize for impact/harm	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

6. How often do you acknowledge—*after the fact*—that you said or did something rooted in a racist attitude, assumption, or stereotype (i.e., when you did something that no one called out and you decide later on to acknowledge what you previously did in their presence)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

7. How often do you acknowledge—*after the fact*—that you reacted badly to being called out for saying or doing something rooted in a racist attitude, assumption, or stereotype (i.e., when you go back to someone who called you out and acknowledge that the way you responded was problematic and/or caused additional harm)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

8. How often do you consciously and intentionally monitor your own interpersonal behaviors in terms of how you “take up space” (dominate conversations, interrupt other people, talk over other people, co-opt other people’s ideas, dismiss other people’s ideas, fail to ask other people to share their perspectives, etc.) in ways that marginalize the engagement of Black, Indigenous and people of color?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

9. How often do you consciously and intentionally monitor the assumptions you make about Black, Indigenous and students of color (preparedness, ability, effort, etc.) and how those assumptions impact how you do or do not engage with them?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

10. How often do you consciously and intentionally monitor the assumptions you make about Black, Indigenous and colleagues of color (preparedness, ability, effort, etc.) and how those assumptions impact how you do or do not engage with them?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

11. How often do you consciously and intentionally monitor the evaluations and judgments you make about Black, Indigenous and students of color in ways that center white/western cultural notions of what is “normal,” “appropriate,” or “professional” (e.g., appearance, attire, language, behavior, communication styles)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

12. How often do you consciously and intentionally monitor the evaluations and judgments you make about Black, Indigenous and colleagues of color in ways that center white/western cultural notions of what is “normal,” “appropriate,” or “professional” (e.g., appearance, attire, language, behavior, communication styles)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Accountability (Others)

1. How often do you remain silent when other people say or do something rooted in a racist attitude, assumption, or stereotype in your presence?

Friends	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Family members	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Neighbors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Community members	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Colleagues (staff members)	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Colleagues (faculty members)	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Supervisors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Administrators	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Students (student employees)	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Students (general)	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)

2. When you choose to remain silent when other people say or do something rooted in a racist attitude, assumption, or stereotype in your presence, what are your motivating factors?

Discomfort with “confrontation”	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Discomfort with having difficult dialogues	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Uncertain about how to respond	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Don’t want to “cause a scene”	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Don’t want to cause discomfort	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Don’t want to damage relationship(s)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Fear of backlash/argument	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Concern about backlash/retaliation	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Self-care (avoid attack/abuse)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

3. When you choose to remain silent when other people say or do something rooted in a racist attitude, assumption, or stereotype in your presence, what emotional response does it bring up for you? (This includes the emotions you feel in the moment and the emotions you feel later on.)

Guilt	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Shame	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Weakness	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Frustration (with self)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Failure (personal or professional)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Anxiety (about how others view your silence)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Concern (about impact on others present)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

4. How often do you initiate a conversation—*after the fact*—with other people about something rooted in a racist attitude, assumption, or stereotype that they said or did in your presence (i.e., when you go back to someone and share that you did not respond to their action at the time but feel that it is important to still address it)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

5. How often do you initiate a conversation—*after the fact*—with people who were potentially impacted by something rooted in a racist attitude, assumption, or stereotype that someone said or did in your presence (i.e., when you go back to someone and acknowledge the impact of your silence/inaction in the moment when the behavior occurred)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

6. When other people say or do something rooted in a racist attitude, assumption, or stereotype in your presence and you do respond, what are your motivating factors?

To call out the person/behavior	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
To be seen as “getting it”	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
To be seen as “showing up”	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
To explain/school the person	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
To create space for dialogue	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
To invite the person to reflect on their actions	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
To not be complicit through silence	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
To respond so those impacted don’t have to	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

7. When other people say or do something rooted in a racist attitude, assumption, or stereotype in your presence and you do respond, what characterizes the way you engage with them?

Accusatory	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Condemning	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Shaming	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Canceling (no space for growth or accountability)	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Understanding	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

Compassionate	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)
Empathetic	0 (none)	1	2	3	4	5	6	7	8	9	10 (very strong)

8. When other people say or do something rooted in a racist attitude, assumption, or stereotype in your presence and you do respond, how effective does your response tend to be?

They reject the validity of the concerns you raise	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
They dismiss the significance of the harm	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
They reduce your response to an attack on them	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
They are able to process/discuss the issue with you	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
They realize why their action was racist	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
They realize how their action was harmful	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)

9. How often do you actively and intentionally center or re-center Black, Indigenous and students of color when you are in spaces where they are marginalized by the behaviors of others (e.g., actively solicit their perspectives, redirect attention to them when they are interrupted or spoken over, openly credit their ideas when they are co-opted by others)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

10. How often do you actively and intentionally center or re-center Black, Indigenous and colleagues of color when you are in spaces where they are marginalized by the behaviors of others (e.g., actively solicit their perspectives, redirect attention to them when they are interrupted or spoken over, openly credit their ideas when they are co-opted by others)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Hiring Practices (Students)

1. How often do you use active outreach and recruitment strategies to attract a racially diverse pool of student applicants?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

2. How successful have you been at hiring racially diverse student employees?

0 (unsuccessful) 1 2 3 4 5 6 7 8 9 10 (very successful)

3. How often do you include in job descriptions the expectation that student employees will develop and implement the capacity to respond to manifestations of racism in the workplace?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

4. How often do you include interview questions in the hiring process that you can use to assess prospective student employees' commitment to being actively anti-racist?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
5. How often do you include interview questions in the hiring process that you can use to assess prospective student employees' awareness of the way racism manifests on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
6. How often do you include interview questions in the hiring process that you can use to assess prospective student employees' understanding of the impact of racism on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
7. How often do you include interview questions in the hiring process that you can use to assess prospective student employees' comfort with responding to manifestations of racism on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
8. How often do you include scenarios or case studies in the hiring process that you can use to assess prospective student employees' ability to effectively respond to manifestations of racism on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Hiring Practices (Staff)

1. How often do you use active outreach and recruitment strategies to attract a racially diverse pool of full-time staff applicants?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
2. How successful have you been at hiring racially diverse full-time staff members?
0 (unsuccessful) 1 2 3 4 5 6 7 8 9 10 (very successful)
3. How often do you include in job descriptions the expectation that full-time staff members will develop and implement the capacity to respond to manifestations of racism in the workplace?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

4. How often do you include interview questions in the hiring process that you can use to assess prospective full-time staff members' commitment to being actively anti-racist?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

5. How often do you include interview questions in the hiring process that you can use to assess prospective full-time staff members' awareness of the way racism manifests on campus?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

6. How often do you include interview questions in the hiring process that you can use to assess prospective full-time staff members' understanding of the impact of racism on campus?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

7. How often do you include interview questions in the hiring process that you can use to assess prospective full-time staff members' comfort with responding to manifestations of racism on campus?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

8. How often do you include scenarios or case studies in the hiring process that you can use to assess prospective full-time staff members' ability to effectively respond to manifestations of racism on campus?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Supervision (Students)

1. When you onboard/train student employees, do you intentionally discuss expectations related to workplace climate and the environment you expect them to help create and maintain in terms of being actively anti-racist?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

2. When you onboard/train student employees, do you provide opportunities for them to learn how to respond when other people say or do something rooted in a racist attitude, assumption, or stereotype?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

3. When you onboard/train student employees, do you explicitly state that you not only invite but expect them to come to you with concerns about the way racism is manifesting in the workplace (e.g., policies, practices, attitudes, comments, behaviors)?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
4. Do you have established processes through which student employees can anonymously report concerns about the way racism is manifesting in the workplace that you actively invite them to utilize and remind them of regularly?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
5. How often do you check in with student employees to discuss their perception of how effectively the workplace is being actively anti-racist?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
6. How often do you ask student employees to share examples of comments or behaviors rooted in a racist attitude, assumption, or stereotype that they have observed in the workplace in order to use them as case studies for collective reflection and skill building around practicing anti-racism?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
7. How often do you ask student employees to critically self-reflect on where they are at in terms of their own anti-racism?

Comfort with responding to racist behaviors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Strategies for responding to racist behaviors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
How often they respond to racist behaviors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
What they need to be better prepared to respond	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
8. How often do you include assessment of anti-racist practices in the formal evaluation of student employees?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
9. How often do you check in with Black, Indigenous, and student employees of color about the impact of racism on campus and what resources/support they might need?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
10. How often do you adapt the way you provide mentoring and support for Black, Indigenous, and student employees of color to be mindful of the barriers associated with racism and to offer culturally responsive supervision?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Supervision (Staff)

1. When you onboard/train new full-time staff, do you intentionally discuss expectations related to workplace climate and the environment you expect them to help create and maintain in terms of being actively anti-racist?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

2. When you onboard/train new full-time staff, do you provide opportunities for them to learn how to respond when other people say or do something rooted in a racist attitude, assumption, or stereotype?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

3. When you onboard/train new full-time staff, do you explicitly state that you not only invite but expect them to come to you with concerns about the way racism is manifesting in the workplace (e.g., policies, practices, attitudes, comments, behaviors)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

4. Do you have established processes through which full-time staff can anonymously report concerns about the way racism is manifesting in the workplace that you actively invite them to utilize and remind them of regularly?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

5. How often do you check in with full-time staff to discuss their perception of how effectively the workplace is being actively anti-racist?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

6. How often do you ask full-time staff to share examples of comments or behaviors rooted in a racist attitude, assumption, or stereotype that they have observed in the workplace in order to use them as case studies for collective reflection and skill building around practicing anti-racism?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

7. How often do you ask full-time staff to critically self-reflect on where they are at in terms of their own anti-racism?

Comfort with responding to racist behaviors 0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Strategies for responding to racist behaviors 0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

How often they respond to racist behaviors 0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

What they need to be better prepared to respond 0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

8. How often do you include assessment of anti-racist practices in the formal evaluation of full-time staff members?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

9. How often do you check in with Black, Indigenous, and full-time staff of color about the impact of racism on campus and what resources/support they might need?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

10. How often do you adapt the way you provide mentoring and support for Black, Indigenous, and full-time staff of color to be mindful of the barriers associated with racism and to offer culturally responsive supervision?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Student Development (e.g., programming, advising, mentoring, etc. of students generally, as opposed to student employees specifically)

1. As part of the student development work you do with students, do you intentionally discuss expectations related to campus climate and the environment they can help create and maintain in terms of being actively anti-racist?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

2. As part of the student development work you do with students, do you provide opportunities for them to learn how to respond when other people say or do something rooted in a racist attitude, assumption, or stereotype?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

3. As part of the student development work you do with students, do you explicitly state that you invite them to come to you with concerns about the way racism is manifesting on campus (e.g., policies, practices, attitudes, comments, behaviors)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

4. Do you have established processes through which students can anonymously report concerns about the way racism is manifesting on campus that you actively invite them to utilize and remind them of regularly?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

5. How often do you check in with students to discuss their perception of the way racism is manifesting on campus?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

6. How often do you ask students to critically self-reflect on where they are at in terms of their own anti-racism?

Comfort with responding to racist behaviors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
Strategies for responding to racist behaviors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
How often they respond to racist behaviors	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)
What they need to be better prepared to respond	0 (never)	1	2	3	4	5	6	7	8	9	10 (regularly)

7. How often do you check in with Black, Indigenous, and students of color about the impact of racism on campus and what resources/support they might need?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

8. How often do you adapt the way you provide mentoring and support for Black, Indigenous, and students of color to be mindful of the barriers associated with racism and to offer culturally responsive development?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Professional Framework

1. How often does your office/department/program actively center anti-racism in your work (in practice, as opposed to simply ideologically or rhetorically)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

2. How often do the staff members in your office/department/program collaborate to identify concrete goals for implementing anti-racism in your work?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

3. How often does your office/department/program publish/share (with colleagues, administrators, students, etc.) concrete goals for anti-racism that you have committed to implementing (with accompanying timelines for accountability)?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

4. How often does your office/department/program meet to collectively do work associated with concrete goals for anti-racism that you have committed to implementing?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

5. How often does your office/department/program report out (to colleagues, administrators, students, etc.) on your progress toward concrete goals for anti-racism that you have committed to implementing?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Personal/Professional Development

1. How committed are you to actively engaging in personal and professional development of anti-racist practices as an ongoing, lifelong process?

0 (not committed) 1 2 3 4 5 6 7 8 9 10 (very committed)

2. How often do you actively seek to identify your own knowledge and skill gaps with respect to anti-racist practices?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

3. How comfortable are you with accepting and acknowledging that you will continue to make mistakes and cause harm due comments, questions, or behaviors rooted in racist attitudes, assumptions, or stereotypes that you still need to unlearn?

0 (very uncomfortable) 1 2 3 4 5 6 7 8 9 10 (very comfortable)

4. How often do you participate in formal/structured professional development opportunities (conferences, workshops, webinars, etc.) focused on racism/anti-racism?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

5. How often do you read books focused on racism/anti-racism?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

6. How often do you read articles focused on racism/anti-racism?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

7. How often do you listen to podcasts focused on racism/anti-racism?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
8. How often do you actively follow individuals/sites focused on racism/anti-racism?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
9. How often do you center the voices/analyses of Black, Indigenous, and people of color when trying to understand news/issues/etc. that focus on racism/anti-racism?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
10. How often do you actively reflect on (individually) the way racism manifests in U.S. culture?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
11. How often do you actively discuss with others (friends/colleagues) the way racism manifests in U.S. culture?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
12. How often do you actively reflect on (individually) the way racism manifests on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
13. How often do you actively discuss with others (friends/colleagues) the way racism manifests on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
14. How often do you actively reflect on (individually) the way racism manifests in the work of your office/department/program?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
15. How often do you actively discuss with others (friends/colleagues) the way racism manifests in the work of your office/department/program?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
16. How often do you actively reflect on (individually) strategies for addressing, combatting, or dismantling racism in U.S. culture?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

17. How often do you actively discuss with others (friends/colleagues) strategies for addressing, combatting, or dismantling racism in U.S. culture?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

18. How often do you actively reflect on (individually) strategies for addressing, combatting, or dismantling racism on campus?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

19. How often do you actively discuss with others (friends/colleagues) strategies for addressing, combatting, or dismantling racism on campus?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

20. How often do you actively reflect on (individually) strategies for addressing, combatting, or dismantling racism in the work of your office/department/program?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

21. How often do you actively discuss with others (friends/colleagues) strategies for addressing, combatting, or dismantling racism in the work of your office/department/program?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

22. How often do you actively practice strategies (as a method of skill building) for responding when other people say or do something rooted in a racist attitude, assumption, or stereotype?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

23. How often do you actively seek out resources related to strategies for supporting Black, Indigenous, and students of color?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

24. How often do you actively discuss with others (friends/colleagues) strategies for supporting Black, Indigenous, and students of color?

0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Advocacy/Accountability (Institutional)

1. How often do you raise concerns (to supervisors or administrators) about manifestations of racism on campus (policies, practices, attitudes, behaviors, etc.)?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
2. How often do you actively advocate (to supervisors or administrators) for changes to existing campus policies or practices that disproportionately impact Black, Indigenous, and students of color?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
3. How often do you engage in discussions with colleagues about how their actions (practices, attitudes, behaviors, etc.) impact Black, Indigenous, and students of color?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
4. How often do you actively support or help students as they work to identify goals or strategies related to anti-racist advocacy on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)
5. How often do you actively help students understand how to effectively navigate the institution/administration in terms of enabling them to successfully engage in anti-racist advocacy on campus?
0 (never) 1 2 3 4 5 6 7 8 9 10 (regularly)

Note: This tool uses the language of BIPOC rather than BILPOC. Our subgroup did not feel qualified to alter the tool.

This tool was developed by Renee Wells, Director of Education for Equity and Inclusion at Middlebury College, who granted permission to reproduce this tool in this publication.

Appendix D: Curriculum Assessment Tool



Midwives and aspiring midwives of color* and others who are underrepresented have been advocating for equity in midwifery education long before the creation of this checklist & the accompanying web-based resource. With that in mind, this resource aims to amplify the voices and perspectives of these important and all too often ignored members of our community and serve as a living repository for the transformative ideas and tools necessary to bring about equity and social justice in midwifery education and training.

Department/Program or School-Wide Suggestions:

- Encourage faculty to use this checklist to help them revise their courses/syllabi and apply the checklist to the entire curriculum as well
- Consider the possibility of paying a stipend to have diverse advisors help review curriculum
- Use the Equity Agenda Guideline for Midwifery Education & Training Programs (www.equitymidwifery.org) to guide the actions of your institution's/program's change team efforts
- Encourage each instructor to create their own syllabus statement equity and social justice
- Develop a religious holiday policy and acknowledge if the schedule is based on Christian holidays
- Consider course evaluation question(s) specifically asking about inequity and racism
- Ensure adequate orientation to mission & equity/antiracism/social justice commitments/statements for new faculty and staff and ongoing trainings for faculty, staff & admin
- Ensure that the library has a copy of *Teaching for Diversity and Social Justice*¹⁸ (Adams & Bell, 2016) available to loan, Routledge/Taylor & Francis Group

Suggested Activity for Individuals:

Make a commitment to yourself. What will you do to help infuse equity and social justice into your curriculum/classroom in the next 1 month, 3 months, 9 months, and 12 months? Be specific and realistic. Choose at least one thing to do for each time period. Ideas: I will:

- Make specific adjustments to my syllabus (list them)
- Create your own syllabus statement regarding equity and social justice
- Use one or more curriculum checklist(s) to evaluate my syllabus
- Sign up for continuing education/training workshop
- Read an article/book or explore a relevant webpage/site in-depth

- Meet with a colleague to share ideas & learn together
- Follow someone on social media who can help me learn more
- Sign up for racial equity tools or other similar resource and read within a week of it arriving
- Watch relevant webinars or videos
- Join a local community group such as the Coalition of Anti-Racist Whites
- Learn more about a local or national organization working on social justice

Extensive Web Resource for Midwifery Educators: <https://www.equitymidwifery.org/>

- See the “Social Justice” section of this page
- Curriculum Tools: <https://www.equitymidwifery.org/curriculum>
- Books, articles and more: <https://www.equitymidwifery.org/facultystafftraining>
- Climate & the Hidden Curriculum: <https://www.edglossary.org/hidden-curriculum/>
- Critical Consciousness: <https://www.equitymidwifery.org/criticalconsciousness>
- Power & Privilege: <https://www.equitymidwifery.org/power-privilege>
- Webinars <https://www.equitymidwifery.org/webinars>

*See additional curriculum checklists at <https://www.equitymidwifery.org/curriculum>

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DRAFT Course/Syllabus/Curriculum Revision Checklist

**EQUITY
IN MIDWIFERY EDUCATION**

Topic/Potential Areas for Improvement	✓	Description/Things to Consider	Notes to self	Resources
Noticing Who is Given Expert Status	— — —	<ul style="list-style-type: none"> Consider who has been set up as the “experts” on the topics taught Consider who has written required reading materials. Are they all white? Mostly white? Acknowledge if no other options Diversity of guest speakers to balance perspectives, ideally paid for their time 		
Focusing on Strength & Resilience, Not just Disparities/Inequities	— — — — —	<ul style="list-style-type: none"> Tone and language regularly emphasize the strength & resilience of communities and individuals especially when examining inequities Convey the concept of inequities rather than disparities Consider tone and focus when discussing sensitive topics ie. GDM Risk in indigenous populations displaced from traditional foods vs genetics Strengths-based interventions Consider activities that increase motivation and hope by fostering a growth mindset 		https://www.equitymidwifery.org/healingresourcesfocusingonstrengths
Reconsider Content and Highlight Diverse Resources	— — —	<ul style="list-style-type: none"> Acknowledge historical realities that impact experience ie. Legacy of enslaved persons being forced to feed white babies their milk Consider Including the “Lived Experience” of pregnant/PP families Consider adding “Recommended Reading” if unsure about requiring it 		https://www.equitymidwifery.org/curriculum
Enabling Students to see themselves in the course/curriculum content & establish a sense of belonging and connection	— — — — — —	<ul style="list-style-type: none"> Values Affirmations exercise Consider allowing students to pick projects or assignment topics Are any communities invisible in your course/curriculum content? Evaluate how your course/curriculum contributes to students’ sense of belonging especially for first generation and non-majority students Options for group work ie. Having students work out a problem as a group, having students “teach” each other a concept, taking quizzes in groups, exchanging ideas in pairs or triads How do you help students develop a connection to the material? 		Verschelden, C. (2017). <i>Bandwidth recovery: Helping students reclaim cognitive resources lost to poverty, racism, and social marginalization</i> . Stylus Publishing, LLC.
Emphasizing Community Connections	— —	<ul style="list-style-type: none"> Highlight national, regional & local organizations run by and working with/for diverse populations ie. Sister Song, NLIRH, NAABB, NBMA, etc Assignments encourage connection such as interviews, research, etc 		

Considering implications for vulnerable/resilient populations or those on the margins	—	<ul style="list-style-type: none"> Assess whether your course/curriculum content considers implications/impacts for vulnerable/resilient populations (of pregnant/PP families) or those on the margins such as racial/ethnic/religious minorities, refugees, immigrants, those living in medically underserved rural or urban areas or persons who are hungry, homeless, mentally ill, incarcerated, low income, LGBTQI2S, disabled, etc. 		
Assessing Terminology/ Language	— — —	<ul style="list-style-type: none"> Person first language including regarding obesity, diabetes and Down Syndrome Avoid co-opting language ie. "pow wow" Gender-inclusive language (Syllabus, power points, worksheets, etc.) 		
Reconsidering the Content of Questions Posed & Case Study Examples	— — —	<ul style="list-style-type: none"> Avoid stereotyping Consider who is given visibility in your case examples Consider impacts on some of the most vulnerable (and yet resilient) pregnant/birthing/postpartum persons 		https://www.equitymidwifery.org/climate-inclusion
Assessing methods of Evaluation	— — — — — —	<ul style="list-style-type: none"> Anonymous mid-quarter feedback option Course/curriculum evaluations that specifically ask about whether students perceive racism or other differentisms and if content seems relevant to diverse communities they hope to serve, etc. Examine your course's/curriculum's methods of evaluating student learning and competency and consider the limitations of multiple choice only Consider creating a structure that encourages revisions, redos, second tries, frequent specific feedback, consistent support Consider standards-based grading (no penalty for early on failures, just need to master the content by the end of the term) Consider some deadline flexibility vs 100% strict and inflexible 		https://docs.wixstatic.com/ugd/c25c02_231139f27615417ebe69e7a772c9c6ce.pdf
Allowing for Diversity of Expression & Reactions	— —	<ul style="list-style-type: none"> Evaluate the type and diversity of reflections you invite from students ie. journaling, etc Consider allowing students to request alternate readings and related assignments if assigned reading triggers undue stress for them as a result of their cultural background Consider if any topics in your course/curriculum might warrant a "trigger warning" or acknowledgement of need to turn off camera, leave, say stop 		

Adopting Inclusive Excellence in Assessment	— — —	<ul style="list-style-type: none"> Expand options for response format beyond writing, ie, student choice: power point, short essay, voice recordings, videotaped role play, webpage, etc Offer synchronous classes/Live Sessions if distance education Assessment Early and often, but not necessarily with a penalty attached and adding study guides as needed due to help counter the underperforming educational system that results from institutional racism 		https://www.google.com/amp/s/mobile.nytimes.com/2015/09/13/magazine/a-prescription-for-more-black-doctors.amp.html
Mapping Student Demographics	— —	<ul style="list-style-type: none"> Check that everywhere that states/Provinces are referenced, that the US/Canadian Territories also acknowledged as existing Consider including articles relevant to the demographics and/or interests of the students you will be teaching ie. postpartum support related to race/ethnicity, country (or parents') of origin, religious minorities, LGBTQI2S, Deaf persons, incarcerated persons, etc 		
Addressing all Learning Styles & enabling students to recover lost bandwidth	— — — — — — —	<ul style="list-style-type: none"> Consider including a Learning styles assessment Include audio-visual resources Offer synchronous class options (if relevant) Reference relevant poetry, art, song Small group work Gamification Activities that require movement Consider employing strategies that enable students to build self-efficacy ie. seeing a peer succeed at a task, using verbal persuasion and affirmations, reducing stress and anxiety, using collaborative, conceptual, and creative pedagogies 		
Reviewing content for cultural appropriation	—	<ul style="list-style-type: none"> Examine course/curriculum content for cultural appropriation ie. smudging, etc 		
Crafting a Syllabus Statement	— — —	<ul style="list-style-type: none"> Consider crafting a syllabus statement or revising your teaching philosophy to set the tone for your classroom environment and demonstrate that you value and respect difference Highlight what you want your students to know about your expectations regarding creating and maintaining a classroom space where differences are respected and valued Consider directing students to campus resources for further support ie. academic, psychosocial, peer, quality advising, mentorship, safe spaces, etc. 		https://www.brown.edu/sheridan/teaching-learning-resources/inclusive-teaching/statements

Integrating Important Concepts	— —	<p>Does your course/curriculum include or take into account at least one of the following? Consider how these concepts might be incorporated in this course & larger curriculum</p> <ul style="list-style-type: none"> ● Health equity ● Social justice ● Unconscious/Implicit Bias ● Disparities/Inequities/Resilience ● Historical trauma/Cultural healing ● Health literacy ● Reproductive/Birth justice ● Social Determinants of Health (including racism as a risk factor vs race) ● Structural competency ● Structural Violence ● Structural Humility ● Power and Privilege ● Critical Consciousness ● Life Course Perspective ● Weathering Theory ● Why people have a hard time talking about race/racism ● Implicit Bias ● Racial Anxiety ● Stereotype and Identity Threat ● Ally/Accomplice ● Microaggressions and microinvalidations ● Framework for quality apologies ● Multicultural sources of wealth/ ● Strengths-based approach ● Cultural Competency vs. cultural humility ● Overcoming Stereotype Threat/Wise Feedback ● Intersectionality ● Growth mindset ● Positive racial climate 		https://www.equitymidwifery.org/facultystafftraining https://www.equitymidwifery.org/power-privilege https://www.equitymidwifery.org/criticalconsciousness
Committing to Lifelong Learning	— — —	<ul style="list-style-type: none"> ● Consider what commitments you want to make this term to expanding your fund of knowledge regarding social justice, antiracism, equity in education, etc. ● Consider how you can equip yourself to feel better prepared to address and confront racism and other differentisms when they rear their ugly head ● Make a plan for revisiting the important concepts listed above and regularly reconsidering how they might be incorporated in each course/curriculum 		https://www.equitymidwifery.org/wheretostart https://www.equitymidwifery.org/aboutwhy https://www.tolerance.org/magazine/publications/speak-up

*See additional Curriculum Checklists at <https://www.equitymidwifery.org/curriculum>

Appendix E: Midwifery Antiracism Text Evaluation Tool

This tool may be used to assess textbooks and other resources used in midwifery education to determine strengths and limitations from an antiracist lens. Consider your answers to these questions holistically when you have completed reviewing the text. What are the text's strengths? What are the limitations? What might improve a future edition? How might you use the results to frame the textbook for student users? How might you use it *with* students to assess their own readings? Consider making notes of page numbers where this content is found.

Before filling out this tool, please familiarize yourself with terms from the Antiracism Glossary (Appendix J).

1. What is the name of the text that you are reviewing (please include title, edition and year published)?

2. What is your relationship to this text? (pick one)
 - I am familiar with it
 - Prior to this review, it was new to me

3. Does the text include content that addresses these health equity concepts?
Please check all that apply. Before you answer, please familiarize yourself with these terms.
 - Health equity
 - Social justice
 - Social determinants of health
 - Reproductive/birth justice
 - A definition of race as a socially-constructed phenomenon rather than a biological or genetic phenomenon
 - None of the above

4. Consider providing examples and page numbers for health equity content (whether included or excluded).

5. Does the text include content that addresses these dimensions of racism and associated health effects? Please check all that apply. Before you answer, please familiarize yourself with these terms.
- Structural racism
 - Historical racial trauma
 - Power and privilege
 - Unconscious or implicit bias
 - Microaggressions and/or microinvalidation
 - Stereotype or identity threat
 - Intersectionality
 - Critical race theory
 - Life course theory
 - Weathering theory
 - Why people have a hard time talking about race
 - White fragility
 - None of the above
6. Consider providing examples and page numbers for dimensions of racism and associated health effects here (whether included or excluded).
7. Does the text include content that addresses antiracism history, action and perspectives? Please check all that apply. Before you answer, please familiarize yourself with these terms.
- BILPOC midwives'/healers' contributions to society / the profession
 - Race-associated health disparities clearly and consistently attributed to racism
 - Cultural humility
 - A framework for quality apologies
 - Cultural healing
 - Fostering a positive racial climate
 - Allyship
 - Antiracist action
 - None of the above
8. Consider providing examples and page numbers for antiracism history, actions and perspectives (whether included or excluded).

9. Does the textbook include language perpetuating racist ideologies that needs to be removed or updated? Please describe below.

For example, when considering sickle cell anemia, the following blanket statement perpetuates a false equivalence of race and genetics: “Black or African American people are more likely to have sickle cell trait.” Instead, the following is more accurate and does not equate race with genetics or biology: “People whose genetic ancestry is based in areas where malaria was endemic are more likely to carry sickle cell trait. For example, the following regions: ...”

10. Are BILPOC contributors clearly evident in this text? For example, as editors, authors, or major contributors.

- Yes
- No
- Other:

11. Does the tone and language regularly emphasize the strength and resilience of communities and individuals when examining inequities? Please explain.

12. Does the content convey the concept of inequities rather than disparities? Please explain.

13. Does the content discuss racism and acknowledge historical realities when discussing risk based on race or ethnicity?

14. Assess the visual content of this text. Are all persons or bodies white? Are all clinicians white? Alternatively, is diversity portrayed in the visual illustrations?

15. Do cases or vignettes, if present, highlight BILPOC individuals without stereotyping?

16. Does the text refer the reader to useful antiracism resources or authors for further learning?

17. Any other comments about this text?

Appendix F: Midwifery Textbooks Through an Antiracism Lens: Evaluation Summaries

A summary of commonly used midwifery textbooks is below. Reviewers included Laura Manns-James, Eva Fried, Cat Palmer, Emily Stallings, Heather Bradford, Nancy MacMorris-Adix, Allyson Royer-Esquivel, Kimberly Garcia, and Jennifer Johnson. Please note that other readers/evaluators might identify additional racist or antiracist content that our reviewers missed. These are meant to serve as helpful examples and not as definitive reviews.

1. *Gynecologic Health Care, 4th edition* (Schuiling & Likis, 2022)⁷

This textbook addresses structural racism, historical racial trauma, bias, critical race theory, intersectionality, life course theory, weathering theory, power, and privilege. Chapter 2 is authored by BILPOC writers and focuses on racism and health inequities related to racism. It includes implicit bias and how to reduce or address it. There is a particularly strong explanation about how racism-associated stress becomes “embodied,” leading to poor health outcomes. This book contains all the health equity concepts mentioned in the evaluation tool: health equity, social justice, social determinants of health (SDOH), reproductive justice, power, and privilege, as well as a definition of race as a socially constructed phenomenon rather than a biological or genetic one.

The book has only a few color plates or illustrations, but those that are present demonstrate diversity. It does not include vignettes or cases. Chapter 2 contains graphic depictions of violence to illustrate the history of medical racism. The editors of the book are both white. The book addresses the need for more clinicians of color and the reasons for that need. It also includes questions to address cultural humility and self-reflection. Appendix 2-A includes useful resources for additional learning.

Although chapter 2 clearly advocates for racial differences or disparities to be addressed in light of the context of racism, another chapter occasionally treats race as a biological rather than a social construct and needs to be updated. For example, there is acknowledgement of earlier puberty among Black girls in the United States on p. 43, but there is no discussion of the links between stress, racism, and early puberty. Similarly, Tanner stages are recommended to be avoided to stage individuals of Asian ethnicity without any discussion of why this suggestion is made. These examples in the book equate race with biology, which can perpetuate racist ideology.

Chapter 2 mentions community-based projects to reduce health inequities, but the strengths and resilience of BILPOC communities are not otherwise highlighted in the book. BILPOC clinicians' contributions to society and the profession are also not included or described.

With these limitations in mind, chapter 2 is a strong contribution to naming and explaining how racism impacts health, and it provides strategies for antiracist action and further learning.

2. **Delivered by Midwives: African American Midwifery in the Twentieth Century South, 1st edition** (Luke, 2018)⁸

This book contains most of the health equity concepts mentioned in the evaluation tool: health equity, social justice, SDOH, and reproductive justice. The text additionally addresses structural racism, historical racial trauma, unconscious or implicit bias, and intersectionality. It also refers readers to other antiracism resources for additional learning.

The text focuses on BILPOC midwives' contributions to society and the profession and includes the concept of cultural humility. There are few images in the text, but Black families are featured prominently. The author does not appear to be a BILPOC individual.

The text does not include a clear definition of race as a social construct, and although it refers to health inequities, it does not always contextualize them as resulting from racism. The style of the text summarizes historical events, relying on historical texts for material; however, it does not always ground these events in an antiracism/critical race theory perspective.

3. **Human Labor & Birth, 5th Edition** (Oxorn, 1986)⁹

This book does not address any health equity concepts and includes no discussion of racism dimensions or antiracism perspectives or strategies. BILPOC editors and contributors appear to be absent. All illustrations are anatomical drawings. This textbook uses very bland, anatomically relevant language to depict each topic. Although it generally reads as unbiased, it is devoid of content that specifically relates to the BILPOC pregnancy/birth experience and the medical consequences of racism.

4. **A History of Midwifery in the United States: The Midwife Said Fear Not, 1st edition** (Varney Burst & Thompson, 2016)¹⁰

This book does address the health equity concepts of SDOH and reproductive/birth justice. However, it does not address dimensions or manifestations of racism, and it does not include antiracism concepts and strategies. The book does not seem to address race or racism in any way except to explain extremely briefly that Black granny midwives in the south were pushed out of practice because of Jim Crow laws and segregation. It does devote several paragraphs to midwives historically working with “vulnerable populations” and briefly mentions the work of midwives who were slaves; however, it is almost entirely about white midwives advancing practice in the United States. There are several references to women’s rights, but the book excludes any references about Black women still being left out of midwifery education even after white women were allowed in. Only 5 sentences in the entire book refer directly to non-white/non-European midwives, and those references are brief. In mentioning native and Indigenous midwives, the text reads, “not much is known about these midwives, but we know they existed.” There are no BILPOC authors. All persons depicted in the book are white.

5. **Into the Light of Day: Reflections on the History of Midwives of Color Within the American College of Nurse-Midwives** (Holmes, 2012)⁶

The focus of the book is how racism has impacted midwives of color in the ACNM, including barriers to establishing the Midwives of Color Committee as a standing committee, as well as barriers to increasing the numbers of BILPOC midwives. Throughout the book, references are made to marginalized communities and the midwives who care for them. Disparities in the opportunity for BILPOC individuals to pursue midwifery education and careers is also addressed. The depiction of BILPOC midwives in this historical work is one of strength, persistence, and grace in the face of considerable odds. The text ends with 5 suggestions for action. It lists references but does not give recommendations for further learning. Because this text is so short (35 pages) and it provides essential context about the history of racism within ACNM and the profession, it is an important tool for students to use to understand issues that should remain prioritized for ACNM in the years ahead.

6. **Varney’s Midwifery, 6th edition** (King et al, 2019)¹¹

The book includes content that addresses power and privilege (p. 70). A definition of race as a socially constructed phenomenon rather than a biological or genetic phenomenon is included. Racism is defined at 4 levels: institutionalized, personally

mediated, internalized, and systemic. It also includes content that addresses dimensions of racism: structural racism, historical racial trauma, power and privilege, unconscious or implicit bias, intersectionality, and weathering theory. Health care provider bias is discussed, with a focus on implicit racial bias and how it impacts provider client interactions, treatment decisions, treatment adherence, and health care outcomes. The book includes a table of factors that establish positions within a social hierarchy (gender, race, socioeconomic status, nation, ethnicity, sexual orientation, religion, ability/disability, age, immigration status, body size, and language), suggesting intersectionality. There are no images which indicate a specific skin tone, and there are some BILPOC chapter contributors (chapter 3: Jyeshtha Serbin, Kim Dau, Betty Carrington, Heather Clarke, Carolyn Curtis, Nicolle Gonzales, Pat Loftman, Felina Ortiz, Susan Stemmler, and Karline Wilson-Mitchell; chapter 31: Marsha Jackson), but none of the main editors are BILPOC.

There are some sections that conflict with defining race as a social construct, including pelvic anatomy, risk factors for gestational diabetes mellitus, anemia, and genetic testing.

The interventions mentioned in the book to address SDOH are not comprehensive. For example, on p. 81, the options listed include bundling of prenatal care, CenteringPregnancy, home-visiting programs, and accountable care organizations. Then the text reads, "one intervention that has not yet been given significant attention is increasing diversity among the health care workforce."

However, there are 3 sections (starting on p. 81) on racial diversity in the workforce. The text reads that "racism limits access to midwifery education. Studies of midwives of color have found that institutional and interpersonal racism is pervasive in midwifery education programs, clinical settings, and professional organizations, and this racism poses a barrier to persons of color joining the midwifery profession." The 3 sections highlight traditional Hispanic midwives (curandera-parteras) by Felina Ortiz; grand midwives of African ancestry by Pat Loftman, Betty Carrington, Heather Clarke, Carolyn Curtis, and Karline Wilson-Mitchell; and Indigenous midwives and the Indian Health Service by Susan Stemmler and Nicolle Gonzales.

The authors do refer the reader to useful antiracism resources. Resources regarding racial health disparities (see the table on p. 84) list the Agency for Healthcare Research and Quality and the Department of Health Policy, School of Public Health at George Washington University titled, *Racial and Ethnic Disparities in Health Care: A Chartbook*. Resources on SDOH (table on p. 85) include a Centers for Disease Control and Prevention site on SDOH, Federal Office of Rural Health Policy, and

Healthy People 2020. Regarding the lack of racial diversity within the midwifery profession, it refers to 2 resources which outline the challenges to identify actions which diversify the profession. These include a review article (Nov/Dec 2016 issue in the *Journal of Midwifery & Women's Health*) and an ACNM Diversity and Inclusion Task Force document called *Shifting the Frame: A Report on Diversity and Inclusion*.

7. **Pharmacology for Women's Health, 2nd edition** (Brucker & King, 2017)¹²

Throughout the textbook, race is consistently used as a risk factor rather than racism and is framed as a physical/biological reality. For example, treatment for hypertension is racialized without further explanation. Race-associated health disparities are referenced frequently, but they are not attributed to racism. The word "racism" does not appear in the book. The textbook continually conflates "ethnicity" and "race," using the terms interchangeably. Furthermore, the authors conflate both ethnicity and race with ancestry. "Racial/ethnic groups" is often used to refer to people who descend from a particular geographic area. For example, in chapter 3, "Pharmacogenetics," there is content that contains multiple references to "racial and ethnic groups" in which the authors are actually referring to ancestry or genotypes. Furthermore, the chapter ends with a section on ethics and pharmacogenomics, which does not include a discussion on medicine becoming racialized or how certain racialized groups may be targeted or left out of pharmacogenomic research and application. Chapter 3 (and the text overall) would benefit from clear definitions of ethnicity, race, ancestry, genotype, and phenotype, and should clarify how race has historically been used as a proxy for genotypes and/or ancestry in research and application. "Black(s)," as a racial group, is not capitalized throughout the book, but "White(s)" as a racial group is. The authors use the descriptor "black patients" or "black people" and then refer to "Whites" as a group of people.

The text does not place health inequities within a larger, systemic context, so the resilience of communities and/or individuals is completely ignored. Health inequities are not acknowledged as inequities, but rather as disparities. The authors refer to disparities in the incidence and prevalence of certain diseases (cardiovascular disease, diabetes mellitus, chlamydia, gonorrhea, syphilis, trichinosis, HIV, uterine fibroids, lactose intolerance, bone fractures and osteoporosis, and adverse side effects of DepoProvera), but there is not an exploration as to why there are disparities in patient outcomes.

The authors acknowledge economic and racial disparities among vaccination rates and note that "minority racial and ethnic groups remain at greater risk for under

immunization across the United States” (p. 121), but they do not discuss the history of medical experimentation on these groups, historical distrust of medical systems, or systemic barriers. The authors note that “patterns of distribution of elevated blood lead levels often reflect racial and income disparities related to quality of housing, nutrition, and other environmental factors” (p. 79), but they do not explain further why these disparities may exist. The statement implies that certain racial groups (who are unnamed but presumed to be non-white, as non-white groups are traditionally those subjected to racialization) have lower-quality “housing, nutrition, and other environmental factors,” but it does not explain systemic reasons for these inequities. On p. 775, the authors note that SPF (ie, sun protection factor in sunscreen) has only been tested among white people, “raising some questions about [its] applicability to individuals of other racial or ethnic groups.” There is no further discussion on how to protect non-white people from skin cancer, or why non-white people were left out of SPF research. The authors discuss diabetes on p. 492 and acknowledge that “non-Hispanic Blacks, American Indians, Asian/Pacific Islanders, and Hispanic/Latina American women (are) more likely to have diabetes” and are the “racial and ethnic minorities who have the most difficulty accessing health care and the populations most likely to experience some of the common complications of diabetes.” However, there is no discussion as to why these groups are more likely to have diabetes, why they have the most difficulty accessing health care, or why they are the most likely to experience complications.

8. **Prenatal and Postnatal Care, 2nd edition** (Jordan et al, 2018)¹³

The book includes content on health equity and SDOH. It also has a chapter dedicated to “health disparities,” and the authors acknowledge racial disparities in patient outcomes but do not name racism as the cause. The book also has a chapter titled, “Diversity and inclusiveness in the childbearing year,” which defines race as a concept of dividing people on physical attributes [that are] usually the result of genetic ancestry (p. 313). Altogether, the authors frame inequities as rooted in racism, though they do not use the term itself.

The book includes content that addresses the dimensions of racism, including structural racism, power and privilege, unconscious or implicit bias, microaggressions and/or microinvalidations, stereotype and identity threat, and weathering theory. For example, in the chapter on breastfeeding, the author notes systemic reasons why lactation is less common among Black individuals (specifically, unequal access to quality care and support). Biases, microaggressions, weathering, and stereotyping are also noted in the chapter on diversity and inclusivity. Weathering is also discussed in a chapter on risk assessment.

The textbook contains minimal content that addresses antiracism history, action, and perspectives. The diversity and inclusion chapter only has information on cultural humility. The chapter on genetic testing and counseling refers to race affecting maternal serum screening results (p. 185). That chapter also includes a table outlining inherited traits; one column is labeled “Ethnicity and Carrier Frequency,” and within that column, the rate of “African Americans” with sickle cell disease traits is noted, and the rate of spinal muscular dystrophy for Asian individuals is noted.

The term *inequities* instead of *disparities* is used in some passages. This topic is explored in a chapter titled, “Health disparities and social issues in pregnancy.” However, the diversity and inclusion chapter does explicitly use the term “inequities.”

There is one photo that features a parent and baby who appear to be white. The diversity and inclusion chapter does have boxes that highlight selected traditions from different religious, ethnic, and/or ancestral groups, but they are relatively stereotyped.

9. **Labor Progress Handbook, 4th edition** (Simkin et al, 2017)¹⁴

This textbook does not include content that addresses health equity concepts, dimensions of racism and its associated health effects, antiracism history, action, or perspectives. It does not mention race, racism, inequities, or disparities.

There is a section on trauma-informed care in chapter 2 (primarily focused on sexual abuse survivors) but no acknowledgment of racism as trauma.

The visual content includes line drawings only. The people in the drawings are portrayed with a variety of hair types.

10. **Clinical Practice Guidelines for Midwifery and Women’s Health, 6th edition** (Tharpe et al, 2022)¹⁵

This book is primarily a clinical resource and addresses health disparities, health inequity, or structural/systemic racism. Health equity and disparities are addressed in chapter 1, clearly attributing disparate outcomes to racism. On p. 14, “New data are continually published about health conditions associated with race, ethnicity, genetics, lifestyle, behavior, and other factors. It is important to keep in mind that risks related to race and ethnicity are often based in social inequalities rather than inherent biology. Because genetics do not correlate well with race, it is essential to

identify genetic risks as such." Systemic racism is acknowledged throughout the text as a contributor to health inequities. For example, on p. 4, the text says, "visual markers of race or culture can be associated with longstanding exposure to systemic bias and overt acts of racism which can influence client's *[sic]* participation in their care as well as their health outcomes." The section "Chronic stress and oppression, the epigenome, and health disparities" (pp 6-7) elucidates potential pathophysiologic linkages between stress, structural racism, and eventual health outcomes. Racism and discrimination are included in a list of possible traumas in the "Trauma-Informed Care" appendix. The text avoids conflating race with biology and explains racial differences in condition prevalence, when these are mentioned, as resulting from or contributed to by systemic racism.

The book addresses clinician bias in chapter 1. This chapter includes a subsection called "Respectful care" that includes recognition that midwives must reflect their own status within society. White fragility is alluded to but not expressly mentioned as a barrier to self-awareness and corrective action around biases (p. 6): "Midwives are encouraged to summon the personal courage needed to become more self-aware, recognizing that the process will likely be uncomfortable at times, and that the path to health equity and better outcomes for mothers and babies includes a willingness to engage about bias." Awareness of bias alone is acknowledged as insufficient to change behavior or communications, alluding to microaggressions without using the term.

The book promotes antiracist actions without specifically naming them as such. A clear statement that clinicians are responsible for creating cultural safety for each client and for examining personal biases and assumptions is included in the "Respectful care" section. Cultural humility is explicitly defined and promoted as a lifelong commitment to self-awareness. Providers are encouraged to participate in spaces where they are in the minority and have opportunities to learn about other cultures; intentional reflection and self-awareness about situational discomfort are encouraged and framed as lifelong practices. Addressing implicit and explicit bias is specifically mentioned but is not framed as antiracist.

Little or no historical information is contained about BILPOC midwives or their contributions to the profession. However, 2 assistant editors are BILPOC midwives, as are some contributors and reviewers. There is little in this text about the strength and resilience of BILPOC communities. There are few references to resources for further learning beyond an implicit bias self-assessment.

11. **Battling Over Birth: Black Women and the Maternal Health Care Crisis** (Oparah et al, 2018)¹⁶

This book centers on the voices of Black birthing people sharing perspectives on their pregnancy and birth experiences. The issue of racism and its impact on all aspects of the lives of Black people is central throughout the book. Chapter 4.5 addresses the impacts of racism, poverty, environmental exposures, and intimate partner violence. The text addresses structural racism, historical racial trauma, power and privilege, unconscious or implicit bias, microaggressions and microinvalidations, stereotype and identity threat, intersectionality, critical race theory, and weathering theory.

The section on prenatal care addresses health inequities as rooted in racism. The text describes the experiences of Black women in prenatal care, barriers to prenatal care and health insurance, relationships with medical providers, lack of cultural humility in providers, stress, miscarriage, and resiliency and ends with a section on the Midwifery Model of Care as a solution. The textbook does not have language perpetuating racist ideologies. There are many BILPOC contributors.

The text clearly attributes health disparities to racism and addresses the lack of access to quality care and to culturally competent providers. The book contains no imagery other than the front cover featuring a Black pregnant person and child. Vignettes are expressed in the words of the people receiving care without editorializing. The text does not refer readers to resources for further learning but makes very specific recommendations for action to health educators and medical schools; birth worker organizations and activists; policy makers; partners, families, and friends; faith-based organizations and community organizations; and Black women and pregnant persons.

Because the birth experiences of Black women are presented in their own words, without edits, this text gives a strong perspective of what clients experience in midwifery and perinatal care. The book centers on the experience of Black women/pregnant people, providing solid information to students that confronts stereotypes and serves as an essential call to action.

12. **Williams Obstetrics, 25th edition** (Cunningham et al, 2018)¹⁷

This clinically focused text contains acknowledgments that racialized health injustices in reproductive health care have occurred, but it does not address health equity, SDOH, or racism. No antiracist concepts are included in the text. Illustrations

are few but do show variations in skin tone; however, no individuals with medium to dark skin tones are portrayed in the chapter on dermatology. Most of the authors and editors appear to be white. Racial differences in prevalence rates of various conditions are described but not explained, affirming an inappropriately biological rather than a sociological understanding of race and ethnicity.

Appendix G: Scripting Assignment Handout

You will write a script to use in a clinical situation that addresses racism in some way. Below are some questions to consider and some potential prompts for your script.

Preparing

- Remember that the focus of these scripts is addressing racism.
- Can you speak to your own racialized experience? Do you understand levels of racism? Do you know how racism is “baked into” (ie, embedded in) medicine and health care in the United States?
- Approach this work with a growth mindset. Recognize that the conversations might be difficult, but that is part of growth.
- What are the top 3 to 5 concepts you want to convey? Are there keywords you want to be sure to include? Do you have a thorough understanding of those words and concepts?

Considerations

- Think about the impact of your words, not only the intent. What will the recipient’s perspective be?
- Nonverbal communication is important, because there is more to these conversations than the words. Remember to sit down; maintain eye contact (as culturally appropriate); and be aware of body posture, tone of voice, and speed of speech. In what setting are you imagining having the conversation?
- How much time will you have for the conversation?
- How does the conversation and the content of the conversation fit within the midwifery model of care?
- Can the conversation be crafted in a way that is empowering? (Particularly when it is with a client)
- Is the script at an appropriate health literacy level for the general population?

Some possible script topics to address racism involve addressing:

- Microaggressions/overt racism from colleagues, preceptors, or those higher than you in the medical hierarchy
- Microaggressions/overt racism from clients
- The role of racism in health with clients; racism as a risk factor
- Racialized perinatal health outcomes with clients
- Racial discordance between yourself as provider and a client

- The role of cultural norms in perinatal/reproductive care with cultural competence and humility (eg, discussing lactation with someone from a culture that recommends against feeding a newborn colostrum vs white western medical culture's recommendation to feed a newborn colostrum)

Appendix H: Scripting Examples

Addressing microaggressions/overt racism from colleagues, preceptors, or those higher than you in the medical hierarchy

- *Academic version*

I wanted to bring up what you said the other day, when you complimented me for being an extremely articulate person. I wanted to let you know that comment hurt me. I know you to be a thoughtful and considerate preceptor. I wanted to make you aware of this because I'm almost certain you didn't know that that was a harmful thing to say. I want to thank you for sharing that as a compliment. I am sure you are not aware of this, but recognizing a Black person as articulate has a long history. When Black people get the compliment of being called "articulate," there is the assumption that Black people are not generally articulate, and therefore this an outlier. And for me, that is harmful because I don't want to be seen as the outlier/as an exception to the rule. I want to make sure that when you're thinking about me being articulate, you're not using it as a way to distance me from other Black people and the success that they have achieved. So even though I know that wasn't your intent, even though I recognize that this was a compliment for you, I'm wondering what your thinking was there? Can you tell me more about what you were thinking when you said this?

- *Clinical version*

I wanted to circle back to when you complimented me on being articulate the other day. I know you're considerate and didn't intend harm, but using that specific word to compliment Black people has a long, tricky history. By complimenting me on being articulate, it makes it sound like the majority of Black people aren't articulate, that this makes me stand out. I wanted to check in on your meaning when you said that—can you tell me more about what you meant?

Addressing racial discordance between yourself as provider and a client

- *Academic version*

Our lives are all shaped by our culture and our lived experiences. These impact more than just ideas and attitudes; they impact our health. Because we have different lived experiences, I want you to know that I may inadvertently make assumptions based on my life that are not true for you. Please know you are encouraged to tell me if you think I am either ignoring the impacts of your lived experience or assuming our experiences are the same. I will continue to work on this shortcoming and try to do better. For example, I might suggest a flu vaccine because contracting flu in pregnancy is more dangerous than at other times in your life. Your experience and concern about vaccines, based on real experiences in a racist society, may make you concerned about the risks of vaccines. In the past, racist, and sometimes dangerous, health policies and clinical experiments have targeted particularly vulnerable Black and brown communities. I will work to be sensitive and understanding of your concerns.

- *Clinical version*

I wanted to take a minute and acknowledge that we're all shaped by what we experience in our lives, our families, where we grow up, all of it. I approach things one way because of all those things and because of how I was trained for my job. I'm working to be more aware of my own biases. If I'm ever off-base or say something that feels skewed, please tell me, if you feel up to it—no pressure. But please know, I'm continuing to work on my shortcomings and trying to keep doing better.

Addressing the role of cultural norms in perinatal/reproductive care with cultural competence and humility (eg, discussing lactation with someone from a culture that recommends against feeding a newborn colostrum vs white western medical culture's recommendation to feed a newborn colostrum)

- *Academic version*

One of my jobs as your nurse-midwife is to counsel you on what evidence says is optimal for your health and the health of your baby. The evidence I'm talking about is based in scientific research. Scientific researchers value certain kinds of information; they are looking for things that they know how to measure. While we may not think of it this way, science and "western" medicine have a point of view. So, the scientific evidence I share is rooted in that culture.

But there are many ways of knowing and many ways of being. Your personal understanding of what's best for you and your family and your communal knowledge both contain wisdom and insights scientific evidence might not—and that I don't.

So, when you hear me mention that early lactation is a healthy choice and leads to optimal outcomes for the newborn, that's me speaking from the medical culture I'm trained in. Scientific research has found colostrum to be the optimal food for a newborn and it's perfectly suited for their body's needs. But I've not seen scientific research that compares the health of newborns who got colostrum followed by mature milk and those who did not get colostrum but did receive mature milk. That's where the assumptions of medical culture come in. There's the assumption that babies who don't get colostrum won't get mature milk.

I do think there's value to the information gathered in those scientific studies and I'd be happy to share more of that with you. I understand, though, that there are many unique factors every family considers when choosing how to feed their newborn. I want you to know I respect your decisions and am here to support you in those.

- *Clinical version*

I want to be honest that what I was taught about lactation always compared babies who were breast/chestfed immediately to babies who were only ever given formula or only had early milk and then went to formula. The scientific research I was taught has its own biases - they didn't consider babies who don't get early milk but do get mature milk because the researchers only included the feeding habits that they were familiar with. The research that looks at what's in early milk - colostrum - does find that it's an optimal food for newborns. Those studies don't know what you know, though, about what's best for your family.

Appendix I: Resource List for Faculty to Engage in Antiracism

Books

- DiAngelo R. *White Fragility: Why It's So Hard for White People to Talk About Racism*. Beacon Press; 2018.
- Hollins CD, Govan I. *Diversity, Equity, and Inclusion: Strategies for Facilitating Conversations on Race*. Rowman & Littlefield; 2015.
- Kendall M. *Hood Feminism: Notes From the Women That a Movement Forgot*. Bloomsbury Publishing; 2020.
- Kendi IX. *How to Be an Antiracist*. One World; 2019.
- Kendi IX. *Stamped From the Beginning: The Definitive History of Racist Ideas in America*. Hachette Book Group, Inc; 2017.
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Webinars

- Collection of antiracism webinars from ACNM available here: <https://www.midwife.org/diversification-and-inclusion>
 - Includes:
 - What is Race & Why Does It Matter to Me?
 - Anti-Racist Strategies for White Midwives: Tools for Self-Examination & Action
 - The Power of Language: Thinking more Critically About the Words We Use
 - Know Black Midwifery History In America: It Matters!
 - Resilience, Resistance, and Recourse: Advancing as a BILPOC Student in a Racist Structure
 - Resilience, Resistance, and Recourse: Thriving through Systemic Racism
- Collection of antiracism webinars from Equity in Midwifery Education. <https://www.equitymidwifery.org/facultystafftraining>
 - Includes:
 - Incorporating Antiracism Coursework into a Cultural Competency Curriculum
 - Curriculum Tools for Discussing Race & Racism in Midwifery
 - Infusing Equity & Diversity into Clinical teaching
 - AACU Vision for Equity
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Trainings and Conferences

- The Annual White Privilege Conference (WPC). <https://www.theprivilegeinstitute.com/>
- Crossroads Antiracism Training Workshops. <https://crossroadsantiracism.org/>
- The National Association for Multicultural Education: Advancing and Advocating for Social Justice and Equity. <https://www.nameorg.org/>
- National Conference on Race & Ethnicity in American Higher Education (NCORE). <https://www.ncore.ou.edu/en/>

- Minority Health Conference. University of North Carolina at Chapel Hill.
<https://minorityhealth.web.unc.edu/>
- The People's Institute for Survival and Beyond Undoing Racism Workshop.
<https://pisab.org/workshops-in-your-area/>
- The Racial Equity Institute Workshops.
<https://www.racialequityinstitute.com/new-events>
- The Great Unlearn. <https://rachelcargle.com/the-great-unlearn/>

Organizations

- Canadian Race Relations Foundation
<https://www.crrf-fcrr.ca/en>
- Racial Equity Tools
<https://www.racialequitytools.org/>
- Showing Up for Racial Justice
<https://surj.org/>

Appendix J: Antiracism Glossary

The definitions in this glossary are from other authors and have been quoted or paraphrased for ACNM use. See citations for the origin of each definition.

Accountability

In the context of racial equity work, accountability refers to the ways in which individuals and communities hold themselves to their goals and actions and acknowledge the values and groups to which they are responsible.

To be accountable, one must be visible, with a transparent agenda and process. Invisibility defies examination; it is, in fact, employed to avoid detection and examination. Accountability demands commitment. It might be defined as “what kicks in when convenience runs out.” Accountability requires some sense of urgency and one to become a true stakeholder in the outcome. Accountability can be externally imposed (legal or organizational requirements) or internally applied (moral, relational, faith based, or recognized as some combination of the 2) on a continuum from the institutional/organizational level to the individual level. From a relational point of view, accountability is not always “doing it right”; sometimes it is really about what happens after it is done wrong.¹⁹

Adverse impact

The impact, whether intended or not, of employment practices that disproportionately affect groups such as visible minorities and women. Though a practice may appear to be neutral, it has discriminatory effects on groups protected by human rights and/or employment legislation.²⁰

Ally

1. Someone who makes the commitment and effort to recognize their privilege (based on gender, class, race, sexual identity, etc) and who works in solidarity with oppressed groups in the struggle for justice. Allies understand that it is in their own interest to end all forms of oppression, even those from which they may benefit in concrete ways.¹⁹
2. Allies commit to reducing their own complicity or collusion in the oppression of those groups and invest in strengthening their own knowledge and awareness of oppression.²¹

Note: Those who are the best arbiters of whether someone is or is not an ally are those with whom an alliance is made; that is, it is not a term that people should necessarily ascribe to themselves.

Ancestry

A line of people from whom one is descended; family or ethnic descent.²⁰

Anti-Black

The Council for Democratizing Education defines anti-Blackness as being a 2-part formation that voids Blackness of value, while also systematically marginalizing Black people and their issues. The first form of anti-Blackness is overt racism. Beneath this anti-Black racism is the covert structural and systemic racism which categorically predetermines the socioeconomic status of Black people in this country. The structure is held in place by anti-Black policies, institutions, and ideologies.

The second form of anti-Blackness is the unethical ignoring and/or disregarding of anti-Black institutions and policies. This disregard is the product of class, race, and/or gender privilege certain individuals experience because of anti-Black institutions and policies. This form of anti-Blackness is protected by the first form of overt racism.¹⁹

Antiracism

The active process of identifying and eliminating racism by changing systems, organizational structures, policies, practices, and attitudes, so that power is redistributed and shared equitably. Antiracism examines and disrupts existing power imbalances. To practice antiracism, a person must first understand the following:

- How racism affects the lived experience of people of color and Indigenous people
- How racism is systemic and manifested in both individual attitudes and behaviors as well as formal policies and practices within institutions
- How both white people and people of color can, often unknowingly, participate in racism through perpetuating inequitable systems
- That dismantling racism requires dismantling systems that perpetuate inequity such as exploitative capitalism²²

Antiracist

Someone who expresses an antiracist idea or supports an antiracist policy or action that yields racial equity.²²

Antiracist education

Antiracist education is based in the notion of race and racial discrimination as being embedded within the policies and practices of institutional structures. Its goal is to aid students in understanding the nature and characteristics of these discriminatory barriers and to work to dismantle them.²⁰

Antiracist ideas

Any idea that suggests that racial groups are equal in all of their apparent differences and that there is nothing wrong with any racial group. Antiracists argue that racist policies are the cause of racial injustices.¹⁹

Barrier

An overt or covert obstacle which must be overcome for equality and progress to be possible.²⁰

Bias

A subjective opinion, preference, prejudice, or inclination, often formed without reasonable justification, that influences the ability of an individual or group to evaluate a particular situation objectively or accurately.²⁰

Bigotry

Intolerant prejudice that glorifies one's own group and denigrates members of other groups.¹⁹

BIPOC

Acronym for Black Indigenous people of color.

BILPOC

Acronym for Black Indigenous Latinx people of color.

Black Lives Matter

A political movement to address systemic and state violence against African Americans. Per the Black Lives Matter organizers, "In 2013, 3 radical Black organizers—Alicia Garza, Patrisse Cullors, and Opal Tometi—created a Black-centered political will and movement building project called #BlackLivesMatter. It was in response to the acquittal of Trayvon Martin's murderer, George Zimmerman. The project is now a member-led global network of more than 40 chapters. Members organize and build local power to intervene in violence inflicted on Black communities by the state and vigilantes. Black Lives Matter is an ideological and political intervention in a world where Black lives are systematically and intentionally targeted for demise. It is an affirmation of Black folks' humanity, our contributions to this society, and our resilience in the face of deadly oppression."¹⁹

Caucusing (affinity groups)

White people and people of color have work to do separately and together. Caucuses provide spaces for people to work within their own racial/ethnic groups. For white people, a caucus provides time and space to work explicitly and intentionally on understanding white culture and white privilege, and to increase one's critical analysis around these concepts. A white caucus also puts the onus on white people to teach each other about these ideas rather than rely on people of color to teach them (as often occurs in integrated spaces). For people of color, a caucus is a place to work with their peers on their experiences of internalized racism both for healing and to work on liberation.¹⁹

Censorship

The act of implementing a policy or program designed to suppress, either in whole or in part, the production of or access to information, such as sources, literature, the performing arts, music, theater/movies, letters, documents, or ideologies which are considered unacceptable or dangerous for political, moral, or religious reasons.²⁰

Collusion

When people act to perpetuate oppression or prevent others from working to eliminate oppression. An example is able-bodied people who object to strategies for making buildings accessible because of the expense of doing so.¹⁹

Colonization

Some form of invasion, dispossession, and subjugation of a people. The invasion need not be military; it can begin—or continue—as geographical intrusion in the form of agricultural, urban, or industrial encroachments. The result of such incursion is the dispossession of vast amounts of lands from the original inhabitants. This is often legalized after the fact. The long-term result of such massive dispossession is institutionalized inequality. The colonizer/colonized relationship is by nature an unequal one that benefits the colonizer at the expense of the colonized.

Ongoing and legacy colonialism affect power relations in most of the world today. For example, white supremacy as a philosophy was developed largely to justify European colonial exploitation of the Global South (including enslaving African peoples, extracting resources from much of Asia and Latin America, and enshrining cultural norms of whiteness as desirable both in colonizing and colonizer nations).¹⁹ See also: Decolonization.

Colorblindness

One mainstream approach to race in the United States is to insist that race is unimportant (or unseen) and does not impact a person's achievements or abilities. However, because of racism, people of different races have different lived experiences. Espousing a colorblind ideology that race does not matter ignores the actual differences in lived experience that people have based on how others perceive and respond to them in conscious, subconscious, and systemic ways. Becoming conscious of how race affects one's experiences in the world, or becoming color-conscious, is an important step in addressing racism.²²

Colorism

A prejudice or discrimination against individuals with a dark skin tone, typically among people of the same ethnic or racial group; a form of oppression that is expressed through the differential treatment of individuals and groups based on skin color. Typically, favoritism is demonstrated toward those with lighter complexions, whereas those with darker complexions experience rejection and mistreatment. Colorism is an extension of white supremacy.

Alice Walker is credited with first using the term “colorism.” Walker used the term in a 1983 essay titled “If the present looks like the past, what does the future look like?” that appeared in her book *In Search of Our Mothers' Gardens*.^{20,23}

Critical race theory

The critical race theory (CRT) movement is a collection of activists and scholars interested in studying and transforming the relationships among race, racism, and power.

The CRT movement considers many of the same issues that conventional civil rights and ethnic studies take up but places them in a broader perspective that includes economics, history, and even feelings and the unconscious. Unlike traditional civil rights, which embraces incrementalism and step-by-step progress, CRT questions the very foundations of the liberal order, including equality theory, legal reasoning, Enlightenment rationalism, and principles of constitutional law.²⁴

Cultural appropriation

Theft of cultural elements for one's own use, commodification, or profit—including symbols, art, language, and customs—often without understanding, acknowledgment, or respect for its value in the original culture. This results from the assumption of a dominant (ie, white) culture's right to take other cultural elements.¹⁹

Cultural assimilation

The process by which minority groups come to resemble majority groups. The process does not function outside white supremacy and the belief that the default culture is that of white people and is inherently preferable or superior.²⁵

Cultural competency in health care

The ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.²⁶

Note: Cultural competency is often criticized as too limited and descriptive to create real change. It may continue to play a role at the organizational level, for example, in the provision of essential services dependent on the recognition of varied needs of diverse populations.

Cultural humility

The “ability to maintain an interpersonal stance that is other oriented (or open to the other) in relation to aspects of cultural identity that are most important to the (person).”

Cultural humility has 3 specific facets:

- A dedication to lifelong self-critique
- Recognition of power dynamics and imbalances and a dedication to challenging them
- Affiliation with advocacy groups/organizations^{27,28}

Cultural misappropriation

Distinguished from the neutrality of cultural exchange, appreciation, and appropriation because of the instance of colonialism and capitalism; cultural misappropriation occurs when a cultural fixture of a marginalized culture/community is copied, mimicked, or recreated by the dominant culture against the will of the original community and, above all else, commodified. One can understand the use of “misappropriation” as a distinguishing tool because it assumes that 1) there are instances of neutral appropriation; 2) the specifically referenced instance is nonneutral and problematic, even if benevolent in intention; 3) some act of theft or dishonest attribution has taken place; and 4) moral judgment of the act of appropriation is subjective to the specific culture which is being engaged.¹⁹

Cultural racism

Representations, messages, and stories conveying the idea that behaviors and values associated with white people or “whiteness” are automatically “better” or more “normal” than are those associated with other racially defined groups. Cultural racism shows up in advertising, movies, history books, definitions of patriotism, and policies and laws. Cultural

racism is also a powerful force in maintaining systems of internalized supremacy and internalized racism. It does that by influencing collective beliefs about what constitutes appropriate behavior, what is seen as beautiful, and the value placed on various forms of expression. All of these cultural norms and values in the United States have explicitly or implicitly racialized ideals and assumptions (eg, what “nude” means as a color, which facial features and body types are considered beautiful, and which child-rearing practices are considered appropriate).¹⁹

Culture

A social system of meaning and custom that is developed by a group of people to ensure its adaptation and survival. These groups are distinguished by a set of unspoken rules that shape values, beliefs, habits, patterns of thinking, behaviors, and styles of communication.¹⁹

Decolonization

Active resistance against colonial powers and a shifting of power towards political, economic, educational, cultural, psychic independence and power that originate from a colonized nation’s indigenous culture. This process occurs politically, and also applies to personal and societal psychic, cultural, political, agricultural, and educational deconstruction of colonial oppression.

Per Eve Tuck and K. Wayne Yang, “Decolonization doesn’t have a synonym.” It is not a substitute for “human rights” or “social justice,” though undoubtedly, they are connected in various ways. Decolonization demands an Indigenous framework and a centering of Indigenous land, Indigenous sovereignty, and Indigenous ways of thinking.¹⁹

Denial

Refusal to acknowledge the societal privileges (see also: Privilege) that are granted or denied based on an individual’s ethnicity or other grouping. Those who are in a stage of denial tend to believe “people are people. We are all alike regardless of the color of our skin.” In this way, the existence of a hierarchical system or privileges based on ethnicity or race can be ignored.²⁹

Diaspora

The voluntary or forcible movement of peoples from their homelands into new regions . . . a common element in all forms of diaspora; these are people who live outside their natal (or imagined natal) territories and recognize that their traditional homelands are reflected deeply in the languages they speak, religions they adopt, and the cultures they produce.³⁰

Discrimination

1. The unequal treatment of members of various groups based on race, gender, social class, sexual orientation, physical ability, religion, and other categories.¹⁹
2. (In the United States), the law makes it illegal to discriminate against someone on the basis of race, color, religion, national origin, or sex. The law also makes it illegal to retaliate against a person because the person complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit. The law also requires that employers reasonably accommodate applicants’ and employees’ sincerely held religious practices, unless doing so would impose an undue hardship on the operation of the employer’s business.³¹

Note: Ibram X. Kendi writes that discriminating based on race is not an inherently racist act. He says, “if racial discrimination is defined as treating, considering, or making a distinction in favor or against an individual based on that person’s race, then racial discrimination is not inherently racist. The defining question is whether the discrimination is creating equity or inequity.”³²

Diversity

Includes all the ways in which people differ, and it encompasses all the different characteristics that make one individual or group different from another. Diversity is all inclusive and recognizes everyone and every group as part of the diversity that should be valued. A broad definition includes not only race, ethnicity, and gender—the groups that most often come to mind when the term “diversity” is used—but also age, national origin, religion, disability, sexual orientation, socioeconomic status, education, marital status, language, and physical appearance. It also involves different ideas, perspectives, and values.

It is important to note that many activists and thinkers critique diversity alone as a strategy. For instance, Baltimore Racial Justice Action states, “Diversity is silent on the subject of equity. In an anti-oppression context, therefore, the issue is not diversity, but rather equity. Often when people talk about diversity, they are thinking only of the ‘nondominant’ groups.”¹⁹

Employment equity

A program designed to remove barriers to equality in employment for reasons unrelated to ability, by identifying and eliminating discriminatory policies and practices, remedying the effects of past discrimination, and ensuring appropriate representation of the designated groups (eg, women, Aboriginal peoples, persons with disabilities, and visible minorities). Employment equity can be used as an active effort to improve the employment or educational opportunities of members of minority groups and women through explicit actions, policies, or programs.²⁰

Environmental racism: see Racism

Equity

The process by which resources are distributed according to need. Equity is fairness.²²

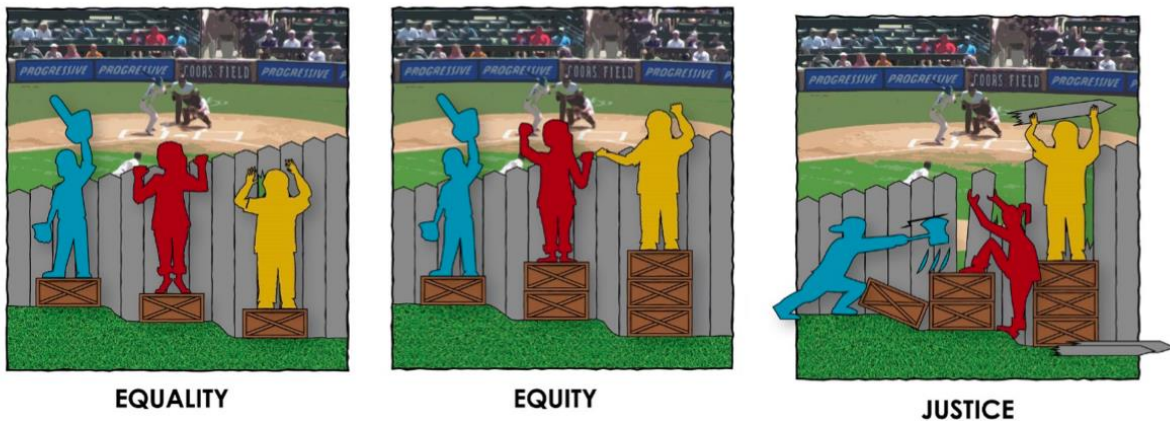


Image credit: Paul Kuttner

Equality

A state/outcome that is the same among different groups of people. Equality is sameness.²²

Ethnicity

Ethnicity, like race, is a social construct that has been used for categorizing people based on perceived differences in appearance and behavior. Historically, race has been tied to biology and ethnicity to culture, though the definitions are fluid and have shifted over time, and the 2 concepts are not clearly distinct from one another. According to the American Anthropological Society, “ethnicity may be defined as the identification with population groups characterized by common ancestry, language, and custom. Because of common origins and intermarriage, ethnic groups often share physical characteristics which also then become a part of their identification—by themselves and/or by others. However, populations with similar physical appearance may have different ethnic identities, and populations with different physical appearances may have a common ethnic identity.” Race and ethnicity, which are social constructions, are often conflated with, and used as a surrogate for, ancestry. Ancestry more specifically and accurately identifies ancestral genetic lineage than does race or ethnicity.²²

Genocide

The United Nations defines genocide as any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial, or religious group: killing members of the group; causing serious bodily or mental harm to members of the group; deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; imposing measures intended to prevent births within the group; and forcibly transferring children of the group to another group.²⁰

Global South

Refers broadly to the regions of Latin America, Asia, Africa, and Oceania. It denotes regions outside Europe and North America which are mostly though not entirely low- to middle-income countries and often politically or culturally marginalized. The Global South does not correlate precisely with the Southern Hemisphere; some countries in the Northern Hemisphere may be considered part of the Global South, and some countries in the Southern Hemisphere may not be considered part of the Global South. The use of the phrase “Global South” marks a shift from a central focus on development or cultural difference toward an emphasis on geopolitical relations of power.

Note: Terms such as “developing country” carry an implication of a hierarchy of nations which share a singular goal. The term “Third World” is othering and originates in the Cold War mentality that the United States and allies were the First World, the (former) Union of Soviet Socialist Republics (USSR) and its allies were the Second World, and all remaining countries were simply the Third World.³³

Health equity

Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including

powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.³⁴

Health inequities

Systematic differences in the health statuses of different population groups. These inequities have significant social and economic costs both to individuals and societies.³⁵

Implicit bias

Also known as unconscious or hidden bias, implicit biases are negative associations that people unknowingly hold. They are expressed automatically, without conscious awareness. Many studies have indicated that implicit biases affect individuals' attitudes and actions, thus creating real-world implications, even though individuals may not even be aware that those biases exist within themselves. Notably, under certain circumstances, implicit biases have been shown to overpower individuals' stated commitments to equality and fairness, thereby producing behavior that diverges from the explicit attitudes that many people profess.¹⁹

Inclusion

Authentically bringing traditionally excluded individuals and/or groups into processes, activities, and decision-making/policy making in a way that shares power.¹⁹

Indigeneity

Indigenous populations are the existing descendants of the peoples who inhabited the present territory of a country wholly or partially at the time when persons of a different culture or ethnic origin arrived there from other parts of the world, overcame them, by conquest, settlement or other means, and reduced them to a nondominant or colonial condition; today, they live more in conformity with their particular social, economic, and cultural customs and traditions than with the institutions of the country of which they now form part, under a state structure which incorporates mainly national, social, and cultural characteristics of other segments of the population that predominate.

Examples are the Maori in the territory now defined as New Zealand; Mexicans in the territory now defined as Texas, California, New Mexico, Arizona, Utah, Nevada, and parts of Colorado, Wyoming, Kansas, and Oklahoma; and Native American tribes in the territory now defined as the United States.¹⁹

Individual racism: see Racism

Institutional racism: see Racism

Integration

The process of amalgamating diverse groups within a single social context, usually applied to interracial interactions in housing, education, political, and socioeconomic spheres or activity. People who are integrated still retain their cultural identity. Integration is the implemented policy that ends segregation.²⁰

Internalized dominance

Individuals are unconsciously conditioned to believe they are superior or inferior in status, thereby affecting their social interaction. Internalized domination or dominance is likely to involve feelings of superiority, normalcy, and self-righteousness, together with guilt, fear, projection, and denial of demonstrated inequity.²⁰

Internalized oppression

Patterns of mistreatment of racialized groups and acceptance of the negative messages of the dominant group become established in their cultures, and members assume roles as victims.²⁰

Internalized racism: see Racism

Interpersonal racism: see Racism

Intersectionality

1. Per Kimberlé Williams Crenshaw, “Intersectionality is simply a prism to see the interactive effects of various forms of discrimination and disempowerment. It looks at the way that racism, many times, interacts with patriarchy, heterosexism, classism, xenophobia—seeing that the overlapping vulnerabilities created by these systems actually create specific kinds of challenges. ‘Intersectionality 102,’ then, is to say that these distinct problems create challenges for movements that are only organized around these problems as separate and individual. So, when racial justice doesn’t have a critique of patriarchy and homophobia, the particular way that racism is experienced and exacerbated by heterosexism, classism etc, falls outside of our political organizing. It means that significant numbers of people in our communities aren’t being served by social justice frames because they don’t address the particular ways that they’re experiencing discrimination.”

2. Exposing (one’s) multiple identities can help clarify the ways in which a person can simultaneously experience privilege and oppression. For example, a Black woman in America does not experience gender inequalities in exactly the same way as a white woman, nor racial oppression identical to that experienced by a Black man. Each race and gender intersection produces a qualitatively distinct life.¹⁹

Intolerance

Bigotry or narrow-mindedness which results in a refusal to respect or acknowledge persons of different backgrounds.²⁰

Isms

A way of describing any attitude, action, or institutional structure that subordinates (oppresses) a person or group because of their target group, color (racism), gender (sexism), economic status (classism), older age (ageism), religion (eg, anti-Semitism), sexual orientation (heterosexism), language/immigrant status (xenophobia), etc.³⁶

Macroaggression

An act of racism towards everyone of that race.³⁷

Marginalization

With reference to race and culture, the experience of persons outside the dominant group who face barriers to full and equal participating members of society. Marginalization refers also to the process of being “left out” of or silenced within a social group.²⁰

Marginalized populations

Groups and communities that experience discrimination and exclusion (social, political, and economic) because of unequal power relationships across economic, political, social, and cultural dimensions.³⁸

Microaggression

The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.¹⁹

Microinterventions

The everyday words or deeds, whether intentional or unintentional, that communicate to targets of microaggressions validation of their experiential reality, their value as a person, affirmation of their racial or group identity, support and encouragement, and reassurance that they are not alone.

Microinterventions have 2 primary functions. First, they serve to enhance psychological well-being and provide targets, allies, and bystanders with a sense of control and self-efficacy. Second, they provide a repertoire of responses that can be used to directly disarm or counteract the effects of microaggressions by challenging perpetrators. They are interpersonal tools that are intended to counteract, change, or stop microaggressions by subtly or overtly confronting and educating the perpetrator.³⁹

Microinvalidations

Communications that subtly exclude, negate, or nullify the thoughts, feelings, or experiential reality of a person of color. For instance, white people often ask Asian American persons where they were born, conveying the message that they are perpetual foreigners in their own land.³⁹

Model minority

A term created by sociologist William Peterson to describe the Japanese community, whom he saw as being able to overcome oppression because of their cultural values.

While individuals employing the model minority trope may think they are being complimentary, in fact, the term is related to colorism and its root, anti-Blackness. The model minority myth creates an understanding of ethnic groups, including Asian Americans, as a monolith, or as a mass whose parts cannot be distinguished from each other. The model minority myth can be understood as a tool that white supremacy uses to pit people of color against each other to protect its status.¹⁹

Movement building

The effort of social change agents to engage power holders and the broader society to address a systemic problem or injustice while promoting an alternative vision or solution. Movement building requires a range of intersecting approaches through a set of distinct stages over a long-term period. Through movement building, organizers can:

- Propose solutions to the root causes of social problems;
- Enable people to exercise their collective power;
- Humanize groups who have been denied basic human rights and improve conditions for the groups affected;
- Create structural change by building something larger than a particular organization or campaign; and
- Promote visions and values for society based on fairness, justice, and democracy.¹⁹

Multicultural competency

Cultural competency is the ability to understand another culture well enough to be able to communicate and work with people from that culture. Multicultural competence is fluency in more than one culture in whichever cultures are part of your surroundings.⁴⁰

Multiculturalism

The coexistence of diverse cultures, where culture includes racial, religious, or cultural groups and is manifested in customary behaviors, cultural assumptions and values, patterns of thinking, and communicative styles.⁴¹

Oppression

The systematic subjugation of one social group by a more powerful social group for the social, economic, and political benefit of the more powerful social group. Rita Hardiman and Bailey Jackson state that oppression exists when the following 4 conditions are found:

- The oppressor group has the power to define reality for themselves and others;
- The target groups take in and internalize the negative messages about them and end up cooperating with the oppressors (thinking and acting like them);
- Genocide, harassment, and discrimination are systematic and institutionalized, so that individuals are not necessary to keep it going; and
- Members of both the oppressor and target groups are socialized to play their roles as normal and correct.¹⁹

Oppression = Power + Prejudice¹⁹

People of color

Often the preferred collective term for referring to non-white racial groups. Racial justice advocates have been using the term “people of color” (not to be confused with the pejorative “colored people”) since the late 1970s as an inclusive and unifying frame across different racial groups who are not white to address racial inequities. Although “people of color” can be a politically useful term and describes people with their own attributes (as opposed to what they

are not, eg, “non-white”), it is also important whenever possible to identify people through their own racial/ethnic group, as each has its own distinct experience and meaning and may be more appropriate.¹⁹

Power

Power is unequally distributed globally and in US society; some individuals or groups wield greater power than do others, thereby allowing them greater access and control over resources. Wealth, whiteness, citizenship, patriarchy, heterosexism, and education are some key social mechanisms through which power operates. Although power is often conceptualized as power over other individuals or groups, other variations are power with (used in the context of building collective strength) and power within (which references an individual’s internal strength). Learning to “see” and understand relations of power is vital to organizing for progressive social change.

Power may also be understood as the ability to influence others and impose one’s beliefs. All power is relational, and the different relationships either reinforce or disrupt one another. The importance of the concept of power to antiracism is clear: racism cannot be understood without understanding that power is not only an individual relationship but a cultural one, and that power relationships are shifting constantly. Power can be used malignantly and intentionally, but need not be, and individuals within a culture may benefit from power of which they are unaware.¹⁹

Prejudice

A prejudgment or unjustifiable, and usually negative, attitude of one type of individual or group toward another group and its members. Such negative attitudes are typically based on unsupported generalizations (or stereotypes) that deny the right of individual members of certain groups to be recognized and treated as individuals with individual characteristics.¹⁹

Privilege

Unearned social power accorded by the formal and informal institutions of society to *all* members of a dominant group (eg, white privilege, male privilege). Privilege is usually invisible to those who have it because we are taught not to see it; nevertheless, it puts them at an advantage over those who do not have it.¹⁹

Race

The concept of race was constructed as a tool to categorize people with the purpose of validating racism. Race has no biological basis. During historical projects such as colonialism and slavery, race was artificially imposed on people in different political positions to create a moral hierarchy used to justify the harm inflicted by inequitable systems, exploitive capitalism, and white supremacy. Although the construct of race is dynamic and evolves with changing social, political, and historical norms, the construct perpetuated the false idea that there are static, innate characteristics that apply to sets of people despite diverse origins, life experiences, and genetic makeups. However, race is distinct from ancestry; ancestry denotes people’s shared traits based on genetic similarities of their ancestors and accounts for the complexity of geographic variation and fluidity. Although race is socially constructed, the consequences of this

social construct are experienced individually and collectively by communities in the form of racism. The effects of racism can be seen in differential outcomes in health, wealth, socioeconomic status, education, and social mobility in the United States.²²

Racial and ethnic identity

An individual's awareness and experience of being a member of a racial and ethnic group; the racial and ethnic categories that an individual chooses to describe themselves based on such factors as biological heritage, physical appearance, cultural affiliation, early socialization, and personal experience.¹⁹

Racial anxiety

The heightened levels of stress and emotion that we confront when interacting with people of other races. People of color experience concern that they will be the subject of discrimination and hostility. White people, meanwhile, worry that they will be assumed to be racist. Studies have shown that interracial interaction can cause physical symptoms of anxiety and that our nonverbal behaviors—making eye contact, using welcoming gestures or a pleasant tone of voice, for example—can be affected as well. When everyone in a conversation is anxious that it will turn negative, it often does. This causes a kind of feedback loop in which the fears and anxieties of both white people and people of color are confirmed by their everyday interactions.⁴²

Racial discrimination

According to the International Convention on the Elimination of All Forms of Racial Discrimination (to which Canada is a signatory), racial discrimination is “any distinction, exclusion, restriction, or preference based on race, color, descent, or national or ethnic origin which nullifies or impairs the recognition, enjoyment or exercise of human rights and fundamental freedoms in the political, economic, social, cultural, or any other field of public life.”²⁰

Racial equity

The condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares. When we use the term, we are thinking about racial equity as one part of racial justice, and thus we also include work to address root causes of inequities and not just their manifestation. This includes elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race or fail to eliminate them.¹⁹

Racial healing

Racial healing recognizes the need to acknowledge and tell the truth about past wrongs created by individual and systemic racism and to address the present consequences. It is a process and tool that can facilitate trust and build authentic relationships that bridge divides created by real and perceived differences. We believe it is essential to pursue racial healing before doing change-making work in a community.⁴³

Racial identity development theory

Racial identity development theory discusses how people in various racial groups and with multiracial identities form their particular self-concept. It also describes some typical phases in the remaking of that identity based on learning and awareness of systems of privilege and structural racism, cultural and historical meanings attached to racial categories, and factors operating on the larger sociohistorical level (eg, globalization, technology, immigration, and increasing multiracial population).¹⁹

Racial inequity

When 2 or more racial groups are not standing on approximately equal footing, such as the percentages of each ethnic group in terms of dropout rates, single-family-home ownership, and access to health care.¹⁹

Racial justice

The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice—or racial equity—goes beyond “antiracism.” It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.¹⁹

Racial justice (is defined) as the proactive reinforcement of policies, practices, attitudes, and actions that produce equitable power, access, opportunities, treatment, impacts, and outcomes for all.⁴⁴

Racial profiling

Any action undertaken for purported reasons of safety, security, or public protection that relies on assumptions about race, color, ethnicity, ancestry, religion, or place of origin rather than on reasonable suspicion to single out an individual for greater scrutiny or differential treatment. Profiling can occur because of a combination of the above-listed factors, and age and/or gender can influence the experience of profiling. In contrast to criminal profiling, racial profiling is based on stereotypical assumptions because of one’s race, color, ethnicity, etc, rather than relying on actual behavior or on information about suspected activity by someone who meets the description of a specific individual.²⁰

Racial reconciliation

Reconciliation involves 3 ideas. First, it recognizes that racism in America is both systemic and institutionalized, with far-reaching effects on both political engagement and economic opportunities for minorities. Second, reconciliation is engendered by empowering local communities through relationship building and truth telling. Last, justice is the essential component of the conciliatory process—justice that is best termed as restorative rather than retributive, while still maintaining its vital punitive character.¹⁹

Racial trauma (or race-based traumatic stress [RBTS])

The mental and emotional injury caused by encounters with racial bias and ethnic discrimination, racism, and hate crimes.⁴⁵

Racialization

The very complex and contradictory process through which groups come to be designated as being of a particular “race” and on that basis are subjected to differential and/or unequal treatment. Put simply, racialization (is) the process of manufacturing and using the notion of race in any capacity. Although white people are also racialized, this process is often rendered invisible or normative to those designated as white. As a result, white people may not see themselves as part of a race but still maintain the authority to name and racialize “others.”¹⁹

Racism

- Racism = race prejudice + social and institutional power
- Racism = a system of advantage based on race
- Racism = a system of oppression based on race
- Racism = a white supremacy system

Racism is different from racial prejudice, hatred, or discrimination. Racism involves one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices.¹⁹

The following are definitions of specific manifestations/institutions of racism:

Behavioral racism

Making individuals responsible for the perceived behavior of racial groups and making racial groups responsible for the behavior of individuals.³²

Biological racism

The idea that races are meaningfully different in their biology and that these differences create a hierarchy of value.³²

Cultural racism

The creation of a cultural standard and imposing a cultural hierarchy among racial groups.³²

Environmental racism

A systemic form of racism in which toxic wastes are introduced into or near marginalized communities. People of color, Indigenous peoples, the working class, and poor communities suffer disproportionately from environmental hazards and the location of dangerous, toxic facilities, such as incinerators and toxic waste dumps. Pollution of lands, air, and waterways often causes chronic illness to the inhabitants and changes to their lifestyle.²⁰

Individual racism

The beliefs, attitudes, and actions of individuals that support or perpetuate racism. Individual racism can be deliberate, or the individual may act to perpetuate or support racism without knowing that is what he or she is doing.

Examples:

- Telling a racist joke, using a racial epithet, or believing in the inherent superiority of white people over other groups
- Avoiding people of color whom you do not know personally but not white people whom you do not know personally (eg, white people crossing the street to avoid a group of Latinx young people, locking their doors when they see African American families sitting on their doorsteps in a city neighborhood, or not hiring a person of color because “something doesn’t feel right”)
- Accepting things as they are (a form of collusion).¹⁹

Institutional racism

Refers specifically to the ways in which institutional policies and practices create different outcomes for different racial groups. The institutional policies may never mention any racial group, but their effect is to create advantages for white people and oppression and disadvantage for people from groups classified as people of color. In addition, as Camara Jones notes, “. . . institutionalized racism is often evident as inaction in the face of need.”¹⁹

Examples:

- Government policies that explicitly restricted the ability of people to obtain loans to buy or improve their homes in neighborhoods with high concentrations of African American people (also known as “red-lining”)
- City sanitation department policies that concentrate trash transfer stations and other environmental hazards disproportionately in communities of color.¹⁹

Internalized racism

The situation that occurs in a racist system when a racial group oppressed by racism supports the supremacy and dominance of the dominating group by maintaining or participating in the set of attitudes, behaviors, social structures, and ideologies that undergird the dominating group’s power. It involves the following 4 essential and interconnected elements:

- **Decision-making:** Because of racism, people of color do not have the ultimate decision-making power over the decisions that control their lives and resources. As a result, on a personal level, we may think white people know more about what needs to be done for them than they do. On an interpersonal level, we may not support each other’s authority and power, especially if it is in opposition to the dominating racial group. Structurally, there is a system in place that rewards people of color who support white supremacy and power and coerces or punishes those who do not.
- **Resources:** Resources, broadly defined (eg, money, time), are unequally in the hands and under the control of white people. Internalized racism is the system in place that makes it difficult for people of color to obtain access to resources for their own communities and to control the resources of their community. People of color learn to believe that serving and using resources for themselves and their particular community is not serving “everybody.”

- Standards: With internalized racism, the standards for what is appropriate or “normal” that people of color accept are white people’s or Eurocentric standards. People of color have difficulty naming, communicating, and living up to their deepest standards and values, and holding themselves and each other accountable to them.
- Naming the problem: There is a system in place that misnames the problem of racism as a problem of or caused by people of color and blames the disease—emotional, economic, political, etc—on people of color. With internalized racism, people of color might, for example, believe they are more violent than are white people and not consider state-sanctioned political violence or the hidden or privatized violence of white people and the systems they put in place and support.¹⁹

Interpersonal racism

Racism that occurs between individuals. Once we bring our private beliefs into our interaction with others, racism is now in the interpersonal realm. Examples are public expressions of racial prejudice, hate, bias, and bigotry between individuals.¹⁹

Structural racism

1. The normalization and legitimization of an array of dynamics—historical, cultural, institutional, and interpersonal—that routinely provide advantage to white persons while producing cumulative and chronic adverse outcomes for people of color. Structural racism encompasses the entire system of white domination, diffused and infused in all aspects of society, including its history, culture, politics, economics, and entire social fabric. Structural racism is more difficult to pinpoint in a particular institution because it involves the reinforcing effects of multiple institutions and cultural norms, past and present, continually reproducing old and producing new forms of racism. Structural racism is the most profound and pervasive form of racism; all other forms of racism emerge from structural racism.
2. For example, we can see structural racism in the many institutional, cultural, and structural factors that contribute to lower life expectancy for African American and Native American men than for white men. These include higher exposure to environmental toxins; dangerous jobs and unhealthy housing stock; higher exposure to and more lethal consequences for reacting to violence, stress, and racism; lower rates of health care coverage; access and quality of care; and systematic refusal by the nation to fix these things.¹⁹

Systemic racism

This is an interlocking and reciprocal relationship between the individual, institutional, and structural levels which function as a **system of racism**. These various levels of racism operate together in a lockstep model and function together as a whole system. These levels are:

- **Individual** (within interactions between people)
- **Institutional** (within institutions and systems of power)
- **Structural or societal** (among institutional and across society)¹⁹

Racist

One who is supporting a racist policy through their actions or interaction or expressing a racist idea.

Note: Kendi notes that the term “racist” is action-specific. One can be acting as a racist while upholding a racist idea, but that does not mean that individual's identity is fixed as a racist.³²

Racist idea

Any idea that suggests that one racial group is inferior or superior to another racial group in any way.³²

Racist policy

Any measure that produces or sustains racial inequity between or among racial groups. Policies are written and unwritten laws, rules, procedures, processes, regulations, and guidelines that govern people. There is no such thing as a nonracist or race-neutral policy; every policy in every institution in every community in every nation is producing or sustaining either racial inequity or equity between racial groups. Racist policies are also expressed through other terms such as “structural racism” or “systemic racism.” Racism itself is institutional, structural, and systemic.¹⁹

Reparations

States have a legal duty to acknowledge and address widespread or systematic human rights violations in cases where the state caused the violations or did not seriously try to prevent them. Reparation initiatives seek to address the harms caused by these violations. They can take the form of compensating for the losses suffered, which helps overcome some of the consequences of abuse. They can also be future oriented—providing rehabilitation and a better life for victims—and help change the underlying causes of abuse. Reparations publicly affirm that victims are rights holders entitled to redress.¹⁹

Reproductive justice

The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.

Reproductive justice is a theoretical framework conceptualized and drafted in 1994 by a group of Black women who called themselves Women of African Descent for Reproductive Justice. Reproductive justice is not a synonym for reproductive rights. The framework addresses the failure of the reproductive rights movement—led largely by middle-class white women—to acknowledge intersecting factors such as race and class and inability to uplift the needs of the most marginalized.⁴⁶

Restorative justice

A theory of justice that emphasizes repairing the harm caused by crime and conflict. It places decisions in the hands of those who have been most affected by a wrongdoing and gives equal concern to the victim, the offender, and the surrounding community. Restorative responses are meant to repair harm, heal broken relationships, and address the underlying reasons for the offense. Restorative justice emphasizes individual and collective accountability. Crime and

conflict generate opportunities to build community and increase grassroots power when restorative practices are employed.¹⁹

Segregation

The social, physical, political, and economic separation of diverse groups of people based on racial or ethnic groups. This particularly refers to ideological and structural barriers to civil liberties, equal opportunity, and participation by minorities within the larger society.²⁰

Settler colonialism

Colonization in which colonizing powers create permanent or long-term settlement on land owned and/or occupied by other peoples, often by force. This contrasts with colonialism, where colonizers focus only on extracting resources back to their countries of origin. Settler colonialism typically includes oppressive governance, dismantling of Indigenous cultural forms, and enforcement of codes of superiority (such as white supremacy). Examples include white European occupations of land in what is now the United States, Spain's settlements throughout Latin America, and the Apartheid government established by white Europeans in South Africa.

Per Dino Gilio-Whitaker, "Settler colonialism may be said to be a structure, not an historic event, whose endgame is always the elimination of the Natives in order to acquire their land, which it does in countless seen and unseen ways. These techniques are woven throughout the US's national discourse at all levels of society. Manifest Destiny—that is, the US's divinely sanctioned inevitability—is like a computer program always operating unnoticeably in the background. In this program, genocide and land dispossession are continually both justified and denied."¹⁹

Social determinants of health (SDOH)

The interrelated social, political, and economic factors that create the conditions in which people live, learn, work, and play. The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, affecting the health of individuals, groups, and communities in different ways. SDOH include the following:

- Race/racialization
- Gender/gender identity
- Ethnicity
- Indigeneity
- Colonization
- Migrant and refugee experiences
- Religion
- Culture
- Discrimination/social exclusion/social inclusion
- Education/literacy
- Health literacy
- Occupation/working conditions
- Income/income security
- Employment/job security
- Early life experiences
- Disability

- Nutrition/food security
- Housing/housing security
- Natural and built environments
- Social safety net/social protection
- Access to health services⁴⁷

Social justice

A concept premised upon the belief that each individual and group within society is to be given equal opportunity, fairness, civil liberties, and participation in the social, educational, economic, institutional, and moral freedoms and responsibilities valued by the society.²⁰

Social oppression

Oppression that is achieved through social means and that is social in scope; it affects whole categories of people. This kind of oppression includes the systematic mistreatment, exploitation, and abuse of a group (or groups) of people by another group (or groups). It occurs whenever one group holds power over another in society through the control of social institutions, along with society's laws, customs, and norms. The outcome of social oppression is that groups in society are sorted into different positions within the social hierarchies of race, class, gender, sexuality, and ability. Those in the controlling, or dominant, group benefit from the oppression of other groups through heightened privileges relative to others, greater access to rights and resources, a better quality of life, and overall greater life chances. Those who experience the brunt of oppression have fewer rights, less access to resources, less political power, lower economic potential, worse health, higher mortality rates, and lower overall life chances.¹⁹

Stereotype

A preconceived generalization of a group of people. This generalization ascribes the same characteristic(s) to all members of the group, regardless of their individual differences.²⁰

Structural racialization

The dynamic process that creates cumulative and durable inequalities based on race. Interactions between individuals are shaped by and reflect underlying and often hidden structures that shape biases and create disparate outcomes even in the absence of racist actors or racist intentions. The presence of structural racialization is evidenced by consistent differences in outcomes in education attainment, family wealth, and even life span.¹⁹

Structural racism: see Racism

Systemic discrimination

The institutionalization of discrimination through policies and practices which may appear neutral on the surface but which have an exclusionary impact on particular groups. This occurs in institutions and organizations, including the government, where the policies, practices, and procedures (eg, employment systems, job requirements, hiring practices, and promotion procedures) exclude and/or act as barriers to racialized groups.²⁰

Systemic racism: see Racism

Targeted universalism

Setting universal goals pursued by targeted processes to achieve those goals. Targeted universalism is a platform to operationalize programs that move all groups toward the universal policy goal and is a way of communicating and publicly marketing such programs in an inclusive manner.⁴⁸

Tolerance

A liberal attitude toward those whose race, religion, nationality, etc, are different from one's own. Because it has the connotation of "to put up with," the term "acceptance" is now preferred.²⁰

Weathering theory/hypothesis

Evidence of early health deterioration among Black individuals and racial differences in health are evident at all socioeconomic levels. To account for early health deterioration among Black individuals, Arline T. Geronimus proposed the "weathering" hypothesis, which posits that Black individuals experience early health deterioration as a consequence of the cumulative effects of repeated experience with social or economic adversity and political marginalization. On a physiological level, persistent, high-effort coping with acute and chronic stressors can have a profound effect on health. The stress inherent in living in a race-conscious society that stigmatizes and disadvantages Black individuals may cause disproportionate physiological deterioration, such that a Black individual may show the morbidity and mortality typical of a white individual who is significantly older. Not only do Black individuals experience poor health at earlier ages than do white individuals, but this deterioration in health accumulates, producing ever-greater racial inequality in health with age through middle adulthood.⁴⁹

White fragility

Multicultural education scholar Dr Robin DiAngelo describes white fragility as "a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium. Racial stress results from an interruption to what is racially familiar." White fragility may be learned and is often a subconscious emotional response resulting from white people lacking experience to develop the tools for constructive engagement across racial divides. It is nefarious in that it works to protect, maintain, and reproduce white privilege by centering the emotions of white people in dialogues about racism, thus impeding discussions about racist systems that need dismantling.²²

White privilege

The unquestioned and unearned set of advantages, entitlements, benefits, and choices bestowed on people solely because they are white. Generally, white people who experience such privilege do so without being conscious of it.

- Structural white privilege: A system of white domination that creates and maintains belief systems that make current racial advantages and disadvantages seem normal. The system includes powerful incentives for maintaining white privilege and its

consequences, and powerful negative consequences for trying to interrupt white privilege or reduce its consequences in meaningful ways. The system includes internal and external manifestations at the individual, interpersonal, cultural, and institutional levels.

- The accumulated and interrelated advantages and disadvantages of white privilege are reflected in racial/ethnic inequities in life expectancy and other health outcomes, income and wealth, and other areas of life, in part through different access to opportunities and resources. These differences are maintained in part by denying that these advantages and disadvantages exist at the structural, institutional, cultural, interpersonal, and individual levels and by refusing to redress them or eliminate the systems, policies, practices, cultural norms, and other behaviors and assumptions that maintain them.
- Interpersonal white privilege: Behavior between people that consciously or unconsciously reflects white superiority or entitlement.
- Cultural white privilege: A set of dominant cultural assumptions about what is good, normal, or appropriate that reflects Western European white world views and dismisses or demonizes other world views.
- Institutional white privilege: Policies, practices and behaviors of institutions—such as schools, banks, nonprofits, or the Supreme Court—that have the effect of maintaining or increasing accumulated advantages for those groups currently defined as white, and maintaining or increasing disadvantages for those racial or ethnic groups not defined as white. Institutions survive and thrive even when their policies, practices, and behaviors maintain, expand, or fail to redress accumulated disadvantages and/or inequitable outcomes for people of color.^{19,50}

White supremacy

The idea (ideology) that white people and the ideas, thoughts, beliefs, and actions of white people are superior to those of people of color. Although most people associate white supremacy with extremist groups like the Ku Klux Klan and the neo-Nazis, white supremacy is ever present in our institutional and cultural assumptions that assign value, morality, goodness, and humanity to the white group while casting people and communities of color as worthless (worth less), immoral, bad, and inhuman and “undeserving.” Drawing from CRT, the term “white supremacy” also refers to a political or socioeconomic system where white people enjoy structural advantage and rights that other racial and ethnic groups do not, both at a collective and an individual level.¹⁹

White supremacy culture

1. The dominant, unquestioned standards of behavior and ways of functioning embodied by the vast majority of institutions in the United States. These standards may be seen as mainstream, dominant cultural practices; they have evolved from the United States’ history of white supremacy. Because it is so normalized, white supremacy can be hard to see, which only adds to its powerful hold. In many ways, it is indistinguishable from what we might call US culture or norms—a focus on individuals over groups, for example, or an emphasis on the written word as a form of professional communication. But white supremacy culture operates in even more subtle ways, by actually defining what “normal” is, and likewise, what “professional,” “effective,” or even “good” is. In turn, white culture also defines what is not good, “at risk,” or “unsustainable.” White culture values some ways—ways that are more familiar and come more naturally to those from a white, Western tradition—of thinking, behaving, deciding, and knowing, while devaluing or rendering invisible other ways, and it does this without ever having to explicitly say so.

2. An artificial, historically constructed culture which expresses, justifies, and binds together the US white supremacy system. It is the glue that binds together white-controlled institutions into systems and white-controlled systems into the global white supremacy system.¹⁹

Whiteness

Whiteness goes beyond white skin; it refers to a systematic prioritization that advantages white people and disadvantages people of color. The fundamental premise of the concept of whiteness is that being white is the standard and being a person of color is a deviation from this norm. Whiteness influences everyone because it is a ubiquitous set of cultural assumptions to which we are all pressured to conform. It is, essentially, the proverbial water in which we all swim. For example, consider what understood to be “normal” when Band-Aid describes a pale tan bandage as “skin tone,” when a patient expresses surprise that their doctor is Black, or when a person’s name is described as “unusual” when it is really just unfamiliar to someone. The normative ideals of whiteness often go unnamed, unexamined, and unquestioned. This has tangible consequences, and often violent effects, for those who do not default to the norms of whiteness. Whiteness, and its consequent white supremacy, permeate medicine and health care in complex and nuanced ways. A discussion or critique of whiteness is not a critique of white people, but of a system from which they benefit and often uphold.²²

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