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Healthcare of Black Women

In American history, different minority groups have been confronted with many challenges. These obstacles often involved aspects of everyday life others took for granted, such as equal access to employment, a home, education, and adequate health care. Two groups, especially Blacks and women, have had difficulties in attaining health care that was equivalent to their peers. With a past filled with segregation and dehumanization from Whites, along with centuries of misogynistic science from male physicians, Black women have a history of consuming health care in a manner that does not lead to optimal health.

During slavery in the United States, the masters provided health care to Black slaves, only because the slaves were seen as property that helped to earn a profit (Jones, 1981). The masters were protecting their investment. After slavery, Blacks were suddenly on their own, with no one to teach them about how to maintain their health. The health care of freed Blacks in the South was a low priority. *Bad Blood* depicts White physicians blaming the increase in Black deaths, along with the decline of Black births, on the freed population (Jones, 1981). They were seen as lazy, unclean, and not caring about their overall well-being. The book also reveals that Blacks were seen as immoral, and having uncontrollable, animalistic sexual behavior. White doctors believed that this belief justified the high prevalence of syphilis in the Black community. To protect the White population, the healthcare sector eventually reached out to Blacks. This is seen in the phrase “Black illnesses threatened not only whites’ health, but also white pocketbooks (34).” Even with the extension of healthcare to Blacks, it was of poor quality.

Segregated hospitals had abhorrent conditions. One witness at the time noted, “The negro hospitals I have seen are warranted to repel and even terrify...the negro (Jones, 40).” Even if Blacks were allowed to consume healthcare, the price was often beyond their means. In the rural South, poor Blacks went without doctor visits, even when medically necessary, because they could not afford the fee-for service care (Jones, 1981).

Females, along with Blacks, have also faced inequalities and injustice in the health care industry. Beginning in the nineteenth century, physicians and scientists have used sociology and psychology to justify the placement of women as inferior to men. Carl Vogt used cranium studies to state that women had less of a mind than men (1996). The first law of thermodynamics was even applied to women’s social status. According to this law, energy can neither be created no destroyed. When women used their energy to excel in education, employment, or any other area outside of their gender role, this energy was removed from their reproductive organs, leading to illness. In other words, “her biology should rule her life (Astbury, 1996).” *Crazy for You: The Making of Women’s Madness* illustrates consequences of taking energy away from a woman’s reproductive needs. George Stanley Hall equated higher education in women to insanity. This is because “Intellectual pursuits...were undoubtedly perilous undertakings, and women who foolishly engaged in them were likely to ‘unsex’ themselves and go mad in the process (51).” These ideas among male scientists and physicians persisted well into the twentieth century, interfering with a woman’s ability to acquire health care for her needs. She would be told by her physician to not pursue anything outside the home, for it would compromise her health. These consequences from the pursuit of wisdom could also justify physicians from withholding facts from a female patient, since she was considered to be innately unable to comprehend such things.

Suppression of female sexuality also played its part in women's injustice in the health care sector. The "double standard" in American society dictates that males are allowed to be aggressive and participate early in sexual experimentation, while females are to be chaste and wait for the one they love (Masters, 1994). In the 1860s, clitoridectomies were performed in the United States "... as a solution to masturbation, nymphomania, depression and marital dissatisfaction" (Astbury, 1996). The types of orgasms a woman could achieve were even equated to her maturity. A clitoral orgasm—the stronger and easier one for women to achieve—was seen as infantile, while a vaginal orgasm—which can be acquired from coitus and is usually more difficult for women to achieve—was seen as mature (77-78). These views and practices contributed to many of women's sexual difficulties (Masters, 1971), which often were not addressed or treated.

These persistent prejudicial attitudes in medicine's past regarding Blacks and women have had a discouraging effect on healthcare consumption for Black women. The Jim Crow system in the South created laws that forced Blacks to engage in daily activities—attending school and entertainment venues, using restrooms and water fountains, and public transportation—segregated from Whites. These tactics kept Black women in a low societal place. Even if a Black woman could afford fee-for-service care, she would be taken to hospitals or doctors that provided care that White males would consider substandard. Women's health issues were not a high priority until the women's liberation movement in the late 1960s (Morgen, 2002). Women began educating themselves on their health and sexuality, and publishing media such as *Our Bodies, Ourselves* to spread this knowledge to other women. Self-help and education debunked myths about women's health. After this movement revolutionized healthcare access for women—abortion was legalized, side effects and warning labels were

included with a prescription of oral contraceptives and the creation of women's health centers (2002)—Black women's issues still were not being addressed. While White middle-class women highly prioritized access to legal abortions, Black women and those of other minorities complained of sterilization abuse in their communities and excessive prescription of oral contraceptives (2002). Also, some poor women did not have easy access to abortion due to the cost (2002). This neglect catalyzed Black feminist groups and conferences. Black women began to work within their own groups and collectively with other majority feminist groups to achieve appropriate access to health care (2002).

Even with all the progress made by these groups, Black women are still in poor health. Statistics from the Centers for Disease Control and Prevention (CDC) depict this in many disease categories. According to sexually transmitted disease statistics during 2006 by the CDC, Black women had a rate of chlamydia seven times that of White women. Black women aged fifteen to nineteen years had a rate of gonorrhea fourteen times that of White women in the same age group. Black women contracted syphilis at a rate sixteen times that of White women, while congenital syphilis was seen at a rate more than fifteen times higher than Whites. Breast cancer is the most common cancer in women. The CDC shows that between 1975 and 2004, White women had the highest incidence of breast cancer, while Black women were second. However, during the same time period, Black women had the highest fatalities from the disease. Cardiovascular disease also has more Black women suffering than White women. In 2002, Black women died more from heart disease than White women (169.7 per 100,000 versus 131.2 per 100,000). CDC statistics from 2005 show that sixty-four percent of women diagnosed with human immunodeficiency virus (HIV) were Black, while only nineteen percent were White. During the period from 1980 to 2005, the CDC depicts that Black women had the highest

prevalence of diabetes, while White women had the lowest. In 2005, the rate for Black women was twice that of White women.

Several reasons explain these statistics. Many Black women, especially those who grew up in the earlier twentieth century, refuse preventive care; a physician is only seen when the condition becomes intolerable. This habit may stem from two causes: distrust and poverty. The older population may still harbor distrust of physicians, and believe their care will remain substandard. This theory can be seen in a study performed at a hospital in urban Chicago, Illinois. A focus group of Black males and females revealed that some of them initially do not trust their physicians (Jacobs, 2006). Participants discussed the possibilities of experimentation (one described how a friend's wife was given drug after drug until she went into a coma), a physician's lack of interest in a patient if he or she is unable to pay, a physician's deeper concern about White patients versus the Black patient in the office, and being placed with an incompetent physician. The participants also revealed that this distrust can cause them to seek medical care less frequently, or forgo medical care altogether (2006).

There are also Black women who would like to use preventive care, but cannot afford it. These women may not have adequate health insurance to cover their needs, or have no insurance at all. Even though Medicaid—insurance provided by state governments for the poor—exists in the United States, some women may not qualify for the benefits. They may earn money beyond the qualifying minimum income, or not fulfill other requirements such as age. The Department of Health and Human Services website even states that “Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the designated eligibility groups.” Inadequate health insurance can lead to higher deductibles and

co-payments. Inadequate health insurance can also mean that some services—such as urgent care or dental care—may not be covered by the insurance plan at all. These situations lead to higher charges upon receipt of care. Without any health insurance, all charges will need to be fully paid by the patient. Again, a poor Black woman may not have the means to cover these charges; therefore, necessary health care is avoided.

A lack of health literacy in the Black female community also explains the harsh statistics. Health literacy is defined as “the wide range of skills and competencies that people develop to seek out and comprehend, evaluate, and use health information and concepts to make informed choices, reduce health risks and increase quality of life” (Zarcadoolas, 2005). A Black woman may be able to afford preventive care and visit her physician, but may be unable to interpret any information given to her during the visit. This can be seen in patients who do not understand the reason for their prescriptions. A stronger example is seen in patients who think that pain is a strong indicator of breast cancer; if their breasts are not painful, then they may think a mammogram is unnecessary (Wood, 2007). By the time the cancer is detected, invasive and expensive methods may be the only way to treat it, if at all.

While there are problems with this population’s health care consumption, there are some solutions to improving the health of Black women. Currently, many cities nationwide have some form of a health center solely for women; whether it is affiliated with a hospital system, or operated by an organization, such as Planned Parenthood. One can easily find a facility nearby just by performing an internet search for “women’s health centers” or “Black women’s health centers.” Sandra Morgan details the evolution of feminist health clinics nationwide in her book, *Into our Own Hands* (2002). While conflicting opinions between the middle-class operators and working class staff led to closure of some facilities, others managed to survive internal and

external political pressures. Morgan discusses how these movements also altered practices of mainstream clinics and facilities; from disclosing medication given to new mothers in an obstetrical unit in Florida to recognizing the occupation of midwifery and education about breast cancer.

Along with the presence of these centers, education is extremely important in improving health care for Black women. Presently, women are encouraged by female experts in the medical field to become more knowledgeable and assertive about their personal and sexual health needs. This can be easily done with internet access, reading health periodicals, and texts that inform women about optimal health. There are also ways to help Black women with low health literacy. Nurses are being taught how to discuss care (prescriptions, testing, treatment, etc.) with women at a level the patients can understand, but at the same time, is not condescending (Wood, 2007). This approach is not specific to Black female patients. However, its broad approach should show Black women that all patients will receive the same amount of care. This should help reduce the distrust Black women may harbor towards health care providers. Education can also come from private entities. According to their website, The Health Literacy Foundation is an organization that “funds potential health literacy initiatives, partners with funds community-based organizations, builds coalitions, creates national programming and projects, and connects beneficiaries with the resources that they may not otherwise receive” ([Health Literacy Foundation](#)). The information is dispensed while being sensitive to a group’s culture, education level, and socioeconomic status. The foundation also has a project called the MedServe Professional Health Corps. According to their website, this organization consists of professionals who provide healthcare to those “regardless of their socioeconomic status, educational attainment, ethnicity, gender, or age” ([Health Literacy](#)

Foundation). Patient self-education, health care worker intervention, and the involvement of a far-reaching foundation can help Black women become more aware of the necessity of preventive care.

Private entities can help address poor healthcare in Black women by funding projects to eradicate health disparities amongst various groups. The Commonwealth Fund, according to their website, is “a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.” This foundation funds various programs such as studies depicting the trends in health disparities, evaluating community health centers and the care they provide, and encouraging public policy that aids the underserved in receiving adequate health care. An example of what the foundation supports can be seen in “Racial and Ethnic Disparities in US Health Care: A Chartbook.” This work describes health care disparities in areas such as access and quality of health care. Graphs and charts vividly illustrate the magnitude of the differences between various groups.

Another source of programs to challenge health disparities are universities. The chartbook funded by the Commonwealth Fund is based at the Maya Angelou Research Center on Minority Health at Wake Forest University. Case Western Reserve University has a Center for Reducing Health Disparities. The university partners with local hospitals, churches, the Cleveland Department of Public Health, and other community organizations to address health care needs of the city's underserved population. The center has ongoing projects that tackle issues such as obesity, renal care, cancer, and AIDS. These projects bring aid to members of the community that may not otherwise receive it.

Although past theories and attitudes have negatively affected healthcare consumption for Black women, there has been some improvement. The women's liberation movement paved the way for self-help and education. Black women's groups emerged from this to address their concerns. This revolution catalyzed the creation of women's health centers nationwide and changed how mainstream medicine addressed women's health care needs. An increase in health literacy would bring much improvement to Black women approaching the health care process. With more health literacy, Black female patients will be able to comprehend the reasons for prescriptions, tests, and methods of treatment. Increased health literacy will empower this group of patients to manage their health before a serious health complication arises. More progress is needed, but more and more Black women are taking advantage of self-help and education to have control over their well-being and access to optimal health.

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For More Information

Department of Health and Human Services <<http://www.hhs.gov>>.

Black Women's Health <<http://www.blackwomenshealth.com>>.

Black America Web <<http://www.blackamericaweb.com>>.

Wisconsin African American Eliminating Health Disparities Institute

<http://www.bhcw.org/program_wi_aa_disparities_institute.htm>.

HOTGIRLS (Helping our Teen Girls) <<http://www.helpingourteengirls.org>>.

Center to Reduce Cancer Health Disparities <<http://www.crchd.cancer.gov>>.

RESULTS: Health Disparities <<http://www.results.org>>.