The Intersection of the Health Gap and Language Barrier in the United States Health Care System and Its Impact on Afro-Latinas

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On my honor as a University Student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments

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Understanding the Importance of The Health Gap and Language Barrier Intersection

After the banning on the transport of slaves from other countries took effect in the United States (U.S.) in the early 19th century unethical gynecological examinations performed on Black women without their consent influenced the country's slave markets and established gynecology as a medical specialty in the U.S. The U.S.' health care system was built on the backs of Black people, yet the issue of health disparities between Black and white people has plagued the U.S. health care system for centuries. Presently, Black women die at a rate that ranges from three to four times the rate of their white counterparts, a difference in risk that has remained unchanged for the past six decades (Maternal Health Task Force, 2015). The health gap describes the racial disparity in maternal health care in the U.S. Conjointly, there remains a language barrier that exists within the U.S. healthcare system that leads to negative healthcare outcomes for people who either do not speak English or for whom English is their second language (Partida, 2007). Consequently, the barrier that Black women face in order to receive adequate medical care only intensifies when they do not speak the same language as their physician (Partida, 2007). Therefore, this research paper seeks to investigate the intersection of the health gap and language barrier in maternal health care in the U.S. The intersection of these two issues has not been explored in depth, even though Black women continue to die from avoidable complications making this research consequential. The topic is explored through the theoretical lens of co-production. The research question of this paper is: What are the barriers that inhibit Afro-Latinas from receiving adequate medical care? It is also important to note that this study stays focused on Afro-Latinas who are racialized as Black in the U.S. This approach was taken due to the anti-Black racism that has remained persistent in the U.S. and would cause

the healthcare outcome of Black presenting Afro-Latinas to be worse than lighter skin, mestizo, Latinas.

How to Identify the Barriers That Inhibit Afro-Latinas

The central question of this research paper is: What are the barriers that inhibit Afro-Latinas from receiving adequate medical care? The topic remains analyzed through the use of wicked problem framing, historical case studies, and discourse analysis. Wicked problem framing prevails a way of understanding complex and dynamic problems that allows one to gather and assemble evidence in ways that reveal indirect and hidden connections between symptoms and root causes of an issue. This method supports the organization and re-interpretation of a problem that may appear amenable to a technical fix, but remains intractable or unsolved. In this study wicked problem framing acts as a way to lay the foundation for the reader to understand the health gap and language barrier as separate issues. Historical case studies are employed to support answering questions about the stereotypes and implicit biases that led to the formation of the health gap. Discourse analysis holds as a means to interpret data gathered through literature reviews, interviews, and other events that generated dialogue around these issues to provide evidence. This study stands comprised of an examination of the work done by Richard David/James Collins and Karen Paz/Kelly P. Massey through the lens of wicked problem framing. The analysis of historical case studies surrounding the deaths of Kira Johnson and Erica Garner is also a component. Lastly, the employment of discourse analysis throughout this work in conversation with wicked problem framing and historical case studies is used to interpret how the health gap and language barrier intersect. These methods are used to draw the conclusion of this paper.

Understanding the History of The Health Gap and Language Barrier

The History Behind the Health Gap

After 1808, when a federal ban on importing slaves from other countries took effect, the perpetuation of American slavery became dependent on domestic slave births. The domestic slave births aligned with the economic interests of slave owners — who wanted to promote the healthy births of slave children — and the interests of white physicians — who presented themselves as helping slaves but also reaped professional benefits because they were able to experiment on slaves without their consent. As historian Deirdre Cooper Owens notes, the economic incentives of the exploitation of slaves drove medical innovation (Bachynski, 2018). Gynecological examinations of Black women influenced the country's slave markets, and "slavery, medicine and medical publishing formed a synergistic partnership" in the establishment of gynecology as a medical specialty in the U.S. (Bachynski, 2018). Racist beliefs associated with slavery also provided perceived ethical justifications for conducting repeated invasive experiments.

One gynecologist by the name of J. Marion Sims carried out experiments on women's genitalia from 1845 to 1849 without anesthesia, which had recently been introduced. In addition to their status as enslaved people, Black women were considered appropriate subjects for such experiments based on the widespread belief that Black people experienced less pain than white people (Bachynski, 2018). This perception that Black people are less susceptible to pain lives on today. A 2016 survey completed at Princeton University found that about half of white medical students and residents in the sample endorsed false beliefs about biological differences between Black and white patients. For example, twenty-five percent of medical residents agreed that Black people have thicker skin than whites. Strikingly, "participants who endorsed more false

beliefs about biological differences between [B]lack [people] and whites showed a racial bias in the accuracy of their treatment recommendations" (Hoffman et al., 2016). These disparities remain particularly stark in obstetrics and gynecology. Put another way, a Black woman is twenty-two percent more likely to die from heart disease than a white woman, seventy-one percent more likely to perish from cervical cancer, but 243 percent more likely to die from pregnancy- or childbirth-related causes. In a national study of five medical complications that are common causes of maternal death and injury, Black women were two to three times more likely to die than white women who had the same condition. That imbalance has persisted for decades, and in some places, it continues to grow. In New York City, for example, Black mothers are twelve times more likely to die than white mothers, according to the most recent data; from 2001 to 2005, their risk of death was seven times higher. Researchers say that widening gap reflects a dramatic improvement for white women but not for Black women (Martin & Montagne, 2018).

Context Around the Language Gap

Communication continues to be one of the most important factors to having a healthy relationship, especially in a patient-provider relationship. However, in an increasingly diverse healthcare industry, language barriers and limited English-proficiency (LEP) can significantly hinder patient-provider communication (Heath, 2017). Limited English-speaking proficiency (LESP) is a widespread phenomenon across the country. Within the U.S. there are roughly fifty-three million people, forty-one million native Spanish speakers, and approximately 11.6 million bilingual Spanish Speakers live in the U.S. (Scamman, 2018). Eight percent of the fifty-two million Medicare beneficiaries have LEP, according to a 2017 CMS report (Centers For Medicare and Medicaid Services, 2017). Additionally, beneficiaries in urban areas are four times more likely to face language barriers as patients living in rural regions. These language barriers

are due to the fact that two percent of patients living in urban areas have LEP and eight percent of urban beneficiaries have the same limitations. Moreover, LEP persists as a pervasive outside of the Medicare population. About twenty-one percent of the US does not have high English proficiency, per data from the 2013 United States Census Bureau (United States Census Bureau, 2015). These language barriers put about nine percent of the U.S. population at risk for an adverse patient safety event as a result of a language discrepancy, according to a 2012 report from the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality, 2012).

To make matters worse, patients see language barriers as a significant hurdle to managing their health. The Robert Wood Johnson Foundation (RWJF) reports that half of Spanish-speaking patients believe that language limitation stands their biggest barriers to healthcare. Language barriers keep these patients from both engaging in seamless conversations with their doctors and interacting with the healthcare industry at large. The RWJF reported just under half of Spanish-speaking survey respondents say that language issues present a barrier when communicating with doctors or reading printed materials, like forms. The RWJF also found during their interview it was noted by several Spanish speakers that even when translators or Spanish language version of forms were available patients may be reluctant to ask for or use those resources (Heath, 2017).

The combination of racism in the U.S. healthcare system and the language barrier faced by Spanish speakers in healthcare critically affects one group of people, Afro-Latinas. Though there has been extensive research on these issues separately, an evaluation of the intersections of these issues has yet to be done.

Using Co-Production to Understand the Health Gap and Language Barrier Together

Co-production is the STS framework employed in this paper. The issue of health disparities has been rampant within the U.S. for centuries. From the beginning of slavery in the U.S. Black women have been exploited to advance the field of medicine. As new technologies are created due to this exploitation, Black women are than exploited more to create more innovation, and so on and so forth. Additionally, although the U.S. has no official language, it has established itself as a monolingual country, creating a language barrier between patients and providers. Co-production describes a simultaneous process through which modern societies form their epistemic (theory of knowledge) and normative (standard) understandings of the world (Jasanoff, 2004). Hence, co-production as a theory in this study allows one to understand the ways that the exploitation of Black women and the creation of the language barrier affects our current health care system. Dr. Jasanoff outlines in her piece, "States of Knowledge", how scientific ideas and beliefs, and (often) associated technological artifacts, evolve together with the representations, identities, discourses, and institutions that give practical effect and meaning to ideas and objects (Jasanoff, 2004). Thus, the use of co-production allows one to understand the cyclic nature that permits the systems of inequality, that create the language barrier and health gap, to continue to exist, replicate, and thrive. If co-production is applied to any work too broadly, there is a risk that the technology and society being evaluated co-produce each other equally and the justification for preserving the boundary between them dissolves. Under this phenomenon, known as noetic flatness, actor-network theory would be a more appropriate framework to use (Tembo et al., 2019). Furthermore, unless overlapping sets of boundary-work are used, co-production may also fail to account for power differentials within each variable, in this case, within technology and society (Tembo et al., 2019). Subsequently, in this

research paper co-production is applied specifically to racially Black Afro-Latinas to understand how the health gap and language barrier affect them in order to avoid noetic flatness and provide an overlap in the boundaries for this research.

Health Disparities and Afro-Latinas

The barriers that inhibit Afro-Latinas from receiving adequate medical care is what inhibits most marginalized people from receiving quality health care, the social determinants of health. The social determinants of health include economic stability, neighborhood and built environment, health and health care, education and social and community context. Health disparities are based on these social determinants of health. (Braveman, 2014). However, due to intersecting systems of oppression, Afro-Latinas face a more difficult time navigating the U.S. healthcare system. Additionally, due to their intersectional position, the fight for health equity for Afro-Latinas is lacking when compared to the newly emergent fight for health equity for Black American and Latinx, specifically mestizo, communities.

The Existence of the Health Gap

Health disparities, like racism, have historic origins in the transatlantic slave trade and colonialism because the slave trade created a culture of oppression and an accepted institutionalized hierarchy system (Jones, 2000). From the beginning of medicine in this country, health care access was dependent on financial means, allowing health disparities to persist into the 19th century. Therefore, due to the lack of intergenerational wealth within marginalized communities, again stemming from slavery, a system has been co-produced where health care has not been accessible to Black people. Due to the economic barriers Black people faced health disparities have continued into the present (Issac, 2013). Still, even though the financial aspect of

health care is one that remains a large contributor to health disparities in the U.S., there are many different factors that inhibit Afro-Latinas' access to quality medical care.

In regards to the health gap in 2008, two physicians in Chicago set out to solve a mystery: why do African American women have babies that are born underweight, at twice the rate of white American women? Pediatric neonatologists, Richard David and James Collins specialize in the care of infants who come into the world too early or dangerously underweight and often both. Like virtually expert in their field, they were troubled by the striking racial differences in rates of premature and low birth-weight babies (Public Broadcasting Service, 2008). The posed the question: what could account for the differences? In the documentary *Unnatural Causes,* it was reported that Collins originally hypothesized that socioeconomic differences drove the disparity in premature delivery between Black and white people. It is well known that Black people have a lower, collectively, socioeconomic status than white people; due to a lack of access to higher education and, as stated above, intergenerational wealth. Collins thought once you corrected for both these factors, that the gap would go away, but Collins and David discovered the gap did not go away. Their work found that the gap actually widened as education and socioeconomic status improved. They then began to look at it from a bigger and broader perspective, and started to realize, lifelong minority status exists as the main catalyst for health disparities within the Black community exist (Public Broadcasting Service, 2008).

David claims that "There is something about growing up as a Black female in the U.S. that is not good for your childbearing health" (Public Broadcasting Service, 2008). Collins and David then began to explore whether being a member of a particular minority group might affect pregnancy outcomes, and they came up with a controversial hypothesis; the unequal treatment of African Americans in American society is the cause of the low birth weights and premature birth

rates for African American babies. In other words, racism is taking a heavy toll on African-American children even before they leave their mother's wombs. It is an idea that's slowly gaining acceptance. David states "We're in the midst of a paradigm shift. [fifteen] years ago, racism as a risk factor was almost never heard of in a scientific paper; whereas now it is much more a possibility" (Public Broadcasting Service, 2008).This paradigm shift that David is discussing is one of the many parts of the co-production that affects the health gap and language barrier. Paradigm shifts are what make co-production the most appropriate STS framework to use in this study because these shifts exist with a cycle of humans needing better medical care so more technologies are created and so on and so forth. Yet, the shift that David is discussing is a more recent development in a long history of Black women being exploited in the name of advancing medicine. Co-production gives one the historical framing needed in order to grasp the current position of Black women in the social hierarchy and how intersecting levels of oppression work together to further subjugate Afro-Latinas who are racialized as Black.

The Existence of The Language Barrier

In regards to the language barrier, on average, the life expectancy of Latinas - generally mestizo women - is 77.1 years in contrast to Asian women living 86.8 years, white women living 79.6 years, and Black women for 74.9 years.(Ramos et al., 2010; Danaei et al., 2010) The higher life expectancy of Latinas compared to Black women supports the Latino paradox. The Latino health paradox (or Hispanic paradox) refers to the phenomenon that despite having lower incomes and less access to health-care services, Latinas in the U.S. have lower mortality rates and longer life expectancy than their non-Latina counterparts (McCarthy, 2015). The Latino mortality estimates and facilitated comparisons with other groups do not separately specify Latino mortality patterns by nativity or national origin (Lariscy et al., 2015; Balcazar et al.,

2015) Latino immigrants generally exhibit fifteen to twenty percent lower mortality than U.S.-born Latinos, most likely because immigrants are self-selected on good health-enhancing attributes relative to nonimmigrants (Lariscy et al., 2015). The Latino paradox also includes the classical immigrant assimilation model, which states that immigrants gradually adopt the behaviors of the dominant cultural group over time. Linear increases in assimilation generally occur progressively across successive generations (Balcazar et al., 2015). An example of the increase in assimilation is found in the context of if a first-generation, non-citizen child develops bronchitis, subsequent generations were also significantly more likely to have bronchitis (Balcazar et al., 2015). In addition, compared to first-generation non-citizens, third and fourth generations were also significantly more likely to have allergies (Balcazar et al., 2015).

According to census reports, the median age for Latinas that live in the U.S. is 26.6 years; where fifty-six percent are married and fifty-eight percent have children younger than 18 years (Ramos et al., 2010). Hence, a large percentage of Latinas in the U.S. are in the most likely giving birth. About half of the Latinx people self-reported that they speak English less than *very well,* defining them as individuals with LEP (Parés-Avila et al., 2011). Children of Latino parents with LEP disproportionately experience poor primary care access and quality health care compared to Latino children in English-speaking families (DeCamp et al., 2013). It was reported that another study exploring the experiences and expectations of LEP Latina mothers with pediatric primary care addressed the challenges of health-care disparities and made suggestions for improvement (DeCamp et al., 2013). A major concern identified for Latina mothers was the level of attentiveness that was measured by the doctor taking his or her time with each patient. Mothers reported that many times they felt rushed during doctor visits and preferred longer wait times with caring, patient doctors because quality health care is ‘worth the wait.’ (DeCamp et al.,

2013). Due to job demands, mothers sought out health-care providers with evening and weekend hours and preferred clinics that had Spanish-speaking providers, which allow for direct communication between provider and parent. Clinics without Spanish-speaking providers used nurses for interpretation, and clinics without Spanish-speaking staff limited communication between patients and providers, which results in misinformation and frustration (DeCamp et al., 2013). The limited communication between patient and provider makes it so Latinx people are co-produced into a health care system that is not accessible to them; a system that Black people are also subjected to. Overcoming these barriers can potentially increase quality health-care benefits for all Latina populations.

Paz and Massey concluded that a thorough understanding of the socioeconomic profile of Latinas will raise consciousness to the social inequalities that may potentially place them at high risk for certain health conditions. They reported that these inequalities could also limit access to quality health care (Ramos et al., 2010). Scholastically, forty-three percent of Latinas have a 12^{th} grade education or less and only eleven percent have a bachelor's degree or higher, compared to twelve and twenty-six percent, respectively, for white women (Ramos et al., 2010). Without a strong educational background, Latinas are more likely to be employed in low-paying, part-time, or seasonal jobs and experience twice the rate of unemployment (7.7%) compared to white women (3.3%) (Ramos et al., 2010). Recent documented weekly income for a full-time employed Latina was $570 compared to $621 for Black women, $745 for white women, and $943 for Asian women (United States Bureau Of Labor Statistics, n.d.). As a result, Latinas are vulnerable to poverty-related health conditions and may lack health insurance or financial means to pay for quality health care due to economic disadvantages (Ramos et al., 2010).

Paz and Massey also concluded that Latinas are one of the fastest growing populations in the U.S. and thus becoming a prevalent demographic. Health policies and considerations are not being met by health-care providers in the U.S. Ethnic and gender-specific data and research is limited. This limited research leads to many gaps and higher health-care disparities. Increased awareness of health disparities and further research is needed to address the health-care needs of this specific population (Paz & Massey, 2016). As concluded by Paz and Massey in their study, the need for further research is a phenomenon that can also be seen in the Black female population when evaluating historical case studies. The first case study that is examined is about Kira Johnson, a highly educated and affluent Black woman who died during what was supposed to be a routine Cesarean section (C-section). The second case study is about Erica Garner who was an activist who reportedly died of heart attack stemming from asthma shortly after giving birth.

Historical Case Study One: Kira Johnson

On September 14, 2018 Charles Johnson, the husband of Kira Johnson made a testimony in front of Congress about his wife's death in which he stated:

> *"On April 12, 2016 my life partner, my best friend and amazing Mom, Kira lost her life after a routine scheduled c-section at Cedars Sinai delivering our 2nd son, Langston Johnson. Kira had delivered our first son, Charles V, via cesarean section, so we were both prepared for the process, procedure and recovery. After delivering another perfect baby, I was sitting next to Kira by her bedside in the recovery room. That is when I first noticed blood in her catheter. I notified staff immediately. A series of test were ordered. Along with a CT scan to be performed "STAT". I understood "STAT" to mean the CT scan would be performed immediately. Hours passed and Kira's symptoms escalated throughout the rest of the afternoon and into the evening. We were told by the medical staff at Cedars Sinai Kira was not a priority and we waited for her CT scan to be done...we waited for the hospital to act so she could begin her recovery. Kira kept telling me, "Charles, I'm so cold; Charles, I don't feel right." She repeated these same words to me for several hours. After more than 10 hours of waiting. After 10 hours of watching my wife's condition deteriorate. After 10 hours of watching Kira suffer in excruciating pain needlessly. After 10 hours of begging and pleading them to help her. The medical staff at Cedars Sinai finally took action. As they prepared Kira for surgery, I was holding her*

> *hand as we walked down the hall to the operating room. Kira looked at me and said, "Baby, I'm scared." I told her, without doubt, everything was going to be fine. The doctor told me I would see her in 15 minutes. Kira was wheeled into surgery and it was discovered that she had massive internal bleeding caused by horrible medical negligence that occurred during her routine C-section. She had approximately 3litters of blood in her abdomen. Kira died at 2:22 a.m. April 17, 2016. Langston was 11 hours old."*

Mrs. Johnson's story is tragic, devastating and it perfectly captures a reality experienced by Black women all over the U.S. regardless of education level or socioeconomic status.

In the Public Broadcasting Service documentary, *Unnatural Causes*, David Williams, a sociologist at the Harvard School of Public Health made the point that "Persons who are higher in socioeconomic status, persons who have more income or more education or better jobs or more wealth, live longer, and have fewer health problems than those who are lower in socioeconomic status." Camara Phyllis Jones a medical epidemiologist at the Centers for Disease Control and Prevention stated that "Education, for example, predicts infant mortality for both Black women and white women. And the more educated you are, the less likely you are to have a low birth-weight baby, a preterm baby, or an infant death." It is not uncommon that women who are poorest and least educated are those whose babies are at greatest risk in any racial group. Yet the babies of Black mothers with higher education are still at greater risk than what anyone would anticipate. For comparison, infant mortality among white American women with a college degree or higher is about four deaths per thousand births (Public Broadcasting Service, 2008). In contrast, among Black women with the same level of education, infant mortality is about ten per thousand births – almost three times higher. In fact, Black mothers with a college degree have worse birth outcomes than white mothers without a high school education (Public Broadcasting Service, 2008). Michael Lu an obstetrician at the David Geffen School of Medicine, UCLA asks "Think about this. We're talking about African-American doctors, lawyers, and business executives. And they still have a higher infant mortality rate than non-

Hispanic white women who never went to high school in the first place." We are talking about the Kira Johnson's of the world, women who did everything that they were "supposed to". She went to school, was highly educated, married a man and together they were able to buy into a certain kind of life that was supposed to afford them all of the privileges and protections of what is supposed to be the "American dream" and yet she still was not safe. All that money, education, and "doing what she was supposed to" did not protect her.

Historical Case Study Two: Erica Garner

Conversely, Erica Garner is a Black woman who was not like Kira Johnson in life but whose death is still similar. Erica Garner was the daughter of Eric Garner, a 43-year old Black man who was murdered by an illegal chokehold at the hands of the New York Police Department (NYPD) for allegedly selling loose, untaxed cigarettes. After her father's death she, like many others, demanded police accountability and became entrenched in activism work. However, Erica died shortly after the birth of her son Eric, named after her father, in August 2017, Erica Garner suffered a heart attack. Doctors subsequently found that her heart was enlarged. On December 23, 2017, she suffered a second heart attack, after which she fell into a coma. She was left with "major brain damage," leading to her death on December 30, 2017 at the young age of 27 years old. Despite Ms. Garner's death not being directly caused by a birthing incident, this case study is still relevant to this study for a couple of reasons. First, it can be inferred that the birth of her son put enough strain on her body to at least exacerbate, if not cause, her heart condition. Second, the intense levels of racism that Erica Garner had to face and fight on a consistent basis can be considered one of the main contributors to her death.

In an interview with Vice News, Assistant Professor of African American Studies at Northwestern University, kihana miraya ross, begged the question "When has racism not killed?"

She stated in the interview with Vice, “Whether that's in the form of outright murder as in the case of Erica Garner's father, or health related or even black-on-black crime that stems from racialized capitalism, racialized housing disparities, and the numerous traumas both individual and collective that come from existing as the antithesis to everything pure, clean, and white — being raced as Black has always killed us” (Douglas, 2018). Even though, Daniel Pantaleo, the officer who choked Eric Garner to death was never charged with homicide, and in fact remains on modified duty with the NYPD. Racism has a devastatingly long impact for Black people — particularly Black women – in the U.S., even when police officers are not involved. Bridget Goosby, PhD., a sociologist at the University of Nebraska Lincoln, specifically cited heart problems among low-income Black women, and higher rates of obesity and diabetes for those women as a whole (Douglas, 2018). And for middle-class Black women, being tokenized in mostly white work spaces can create social isolation. An experience where hitting a special kind of “glass ceiling” is linked to discrimination that opens the door to chronic disease and shorter life spans. This assertion was affirmed by the Institute of Medicine’s 2002 report “Unequal Treatment” where a quality panel of medical experts confirmed that while Black and brown patients have unequal health outcomes, they also get unequal healthcare compared to whites, even when other factors, like insurance status, are equal. “Racism is a significant stressor in the lives of African American women, and our results contribute to a growing body of evidence indicating that experiences of racism can have adverse effects on health,” Patricia Coogan, the professor and epidemiologist who led the study, said at the time (Douglas, 2018).

Goosby also pointed to birth disparities between Black and white women, a phenomenon that has not changed since Jim Crow, she said. The odds of low birth weight are 1.6 times larger for Black babies than white babies, and preterm birth is 1.9 times larger even when factoring in

social economic status. ProPublica reported, “For much of American history, these types of disparities were largely blamed on Blacks’ supposed innate susceptibility to illness—their “mass of imperfections,” as one doctor wrote in 1903—and their own behavior. But now many social scientists and medical researchers agree, the problem is not race but racism,”(Douglas, 2018). Erica Garner and Kira Johnson were different in so many ways but alas the one thing that they have in common, being Black women, seems to be the only factor that predetermined their death.

The Effect on Afro-Latinas

The research that has been pulled paints a clear picture of the difficulty in finding quality health care as a Black woman or a Latinx person who is LEP. However, combining these two identities makes the possibility of finding quality health care nearly impossible. As stated earlier in this work, Latinas – which includes Afro-Latinas – are one of the fastest growing demographics in the U.S. and, on average, are at prime child bearing age. Meaning that the American society is leaving one of fastest growing and most disenfranchised populations without care, leading to horrendous implications in the fight against health disparities and for health equity.

Limitations

Though conclusive results were found as a result of this study, there are some limitations. First, this research is reliant on the work done by others so this study is not able to focus solely on Afro-Latinas since no work has been done exclusively on their health care, especially not their maternal health. Instead, in this study, the health gap and language barrier had to be evaluated separately and a conclusion had to be drawn from the correlation between these two issues rather than an independent study being done on Afro-Latinas who are racialized as Black in the U.S. Conjointly, this research would have far more validity if it were completed by experts

in the field of Black studies, specifically Afro- Latinx studies, sociology and public health. These researchers would add more validity to the project because they would be able to set a proper frame to analyze the issue and dedicate the resources that this research desperately needs. Even though, this study does have its limitations, this work is still able to encapsulate the work that needs to be done in order to provide Afro-Latinas with quality health care.

How Do We Move Forward?

Through the use of historical case studies about Kira Johnson and Erica Garner, wicked problem framing to evaluate the research completed by Richard David and James Collins and Karen Paz and Kelly P. Massey and discourse analysis to evaluate all of the data it has been determined that the social determinants of health are what is inhibiting Afro-Latinas from receiving proper medical care. This research holds significance because even though in current popular discourse there exists a conversation about Black women who are dying due to an inept medical system, there continues to be a fast-growing portion of the population whose stories are not being told. As we as a society move towards a world with more health equity, we cannot leave behind those who are the most marginalized or else all of these efforts will prove to be moot.

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