ACOG
The American College of Obstetricians and Gynecologists

ACOG COMMITTEE STATEMENT

NUMBER 11
DECEMBER 2024
(REPLACES COMMITTEE OPINION NUMBER 729, JANUARY 2018)

Addressing Social and Structural Determinants of Health in the Delivery of Reproductive Health Care

This Committee Statement was developed by the American College of Obstetricians and Gynecologists' Committee on Advancing Equity in Obstetric and Gynecologic Health Care in collaboration with Beth Cronin, MD, Michelle Moniz, MD, MSc, and Noah Nattell, MD, MS.

Social and structural determinants of health include historical, social, political, and economic forces, many of which are rooted in racism and inequality, that shape the relationship between environmental conditions and individual health. Unmet social needs can increase the risk of many conditions treated by obstetrician–gynecologists (ob-gyns), including, but not limited to, preterm birth, unintended pregnancy, infertility, cervical cancer, breast cancer, and maternal mortality. An individual health care professional's biases (whether overt or unconscious) affect delivery of care and may exacerbate and reinforce health disparities through inequitable treatment. Obstetrician–gynecologists and other health care professionals should seek to understand patients' health care decision making not simply as patients' individual-level behavior, but rather as the result of intersecting sociopolitical conditions, structural inequities, and social needs that create and maintain inequalities in health and health care. Recognizing the importance of social and structural determinants of health can help ob-gyns and other health care professionals to better understand patients, effectively communicate about health-related conditions and behavior, and contribute to improved health outcomes, including patients' experience of care and their trust in the health care system.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

Based on the principles outlined in this Committee Statement, the American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

Health care professionals should be aware of and understand the social and structural drivers that affect health outcomes. They should acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health.

To provide patient-centered care, each routine office visit should include appropriate questions about social and structural drivers of health that may influence a patient's health and use of the health care system. It is important to be cognizant that screening for social and structural drivers may not elicit open responses from all patients due to perceived stigma or fear of negative consequences (eg, social services involvement) or both.

An individual health care professional's biases (whether overt or unconscious) affect delivery of care and may exacerbate and reinforce health disparities through inequitable treatment.

Obstetrician–gynecologist practices that are part of a community health care clinic or larger networks should encourage their facilities to establish medical–legal partnerships.

Health care professionals should maximize referrals to appropriate services to help improve patients' abilities to fulfill needs identified by screening for social and structural determinants of health.

Health care professionals should be aware of and make allowances for transportation and other logistical difficulties and differences.

Health care professionals should advocate for policy changes that promote safe and healthy living environments.

BACKGROUND

Social determinants of health are the conditions in which a person is born and lives that affect their health; this includes access to safe housing, adequate food, and clean water. Structural determinants of health are the macro-level effects, such as the economic, social, and political systems that influence and drive disparities in health outcomes (1, 2). Social and structural determinants (often abbreviated to "social determinants of health") include historical, social, political, and economic forces, many of which are rooted in racism and inequality, that shape the relationship between environmental conditions and individual health (3). Meanwhile, political determinants of health, as detailed by Daniel E. Dawes, are the policy choices that created the social determinants of health (4).

Traditional biomedical explanations of disease tend to focus on biological and genetic factors, plus individual health behavior to explain who gets sick and from what conditions. Although there is little doubt that genetics and lifestyle play an important role in shaping the overall health of individuals, interdisciplinary researchers have demonstrated how the conditions in the environment in which people are born, live, work, and age play an equal or even more important a role in shaping health outcomes (5–9) (Fig. 1). Environmental factors account for more than one-third of the total deaths in the United States in a year, and evidence suggests that addressing the social needs of individuals results in improved overall health (10–12).

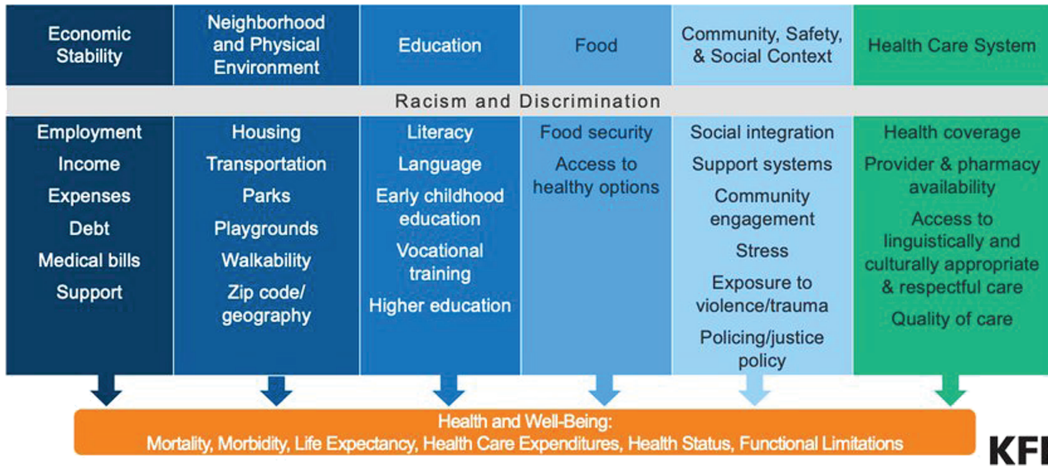

Fig. 1. Social Determinants of Health. Reprinted from Artiga S, Hinton E. Beyond health care: the role of social determinants in promoting health and health equity. Kaiser Family Foundation; 2018. Accessed May 18, 2024. https://files.kff.org/attachment/issue-brief-beyond-health-care

It is well established that social determinants of health are responsible for a large proportion of health inequities that exist in the United States. Structural inequities are the totality of ways in which societies foster discrimination through laws and policies in housing, education, employment, health care, criminal justice, and other social sectors. Structural racism and other structural inequities lead to inequitable distribution of resources, with clear consequences for access to health care and health outcomes. Physical conditions, such as lack of access to safe housing, clean drinking water, nutritious food, and safe neighborhoods, contribute to poor health. Sociopolitical conditions, such as the following, all shape the psychological and biological processes that ultimately influence individuals' health and the health of communities: structural racism; police violence targeting Black and Brown individuals; gender inequity; discrimination against lesbian, gay, bisexual, transgender, queer+ (LGBTQ+) individuals; poverty; lack of access to quality education and jobs that pay a livable wage; and mass incarceration (9, 13–16). Such social conditions not only influence individual health but also work to create cycles that perpetuate intergenerational disadvantage.

Unmet social needs can increase the risk of many conditions treated by obstetrician-gynecologists, including, but not limited to, preterm birth, unintended pregnancy, infertility, cervical cancer, breast cancer, and maternal mortality (17). The social determinants of health approach also acknowledges intersectionality, a term first coined in 1989 by legal scholar Kimberl Crenshaw, which describes the overlapping categories of social identities, such as gender, race, class, disability status, sexual orientation, and related structures of oppression and discrimination, as they manifest in health care and outcomes. The reproductive justice framework, first developed in 1994 by the Women of African Descent for Reproductive Justice (18), acknowledges this interconnected nature of social and structural forces as they come to bear, in part, on people's sexual and reproductive health (19). A shared history of discrimination among Black patients negatively influences health outcomes due to mistrust of health care systems (20). This also may be true for LGBTQ+ patients seeking sexual and reproductive health care (21). The intersection between individuals with disabilities and social determinants of health is complex—socioeconomic status, exclusion from education and employment, and poor living conditions add to the risk of poor health outcomes for those with disabilities (22). Immigration status also is a social and structural determinant of health. For example, undocumented immigrants may not access health care because of lack of coverage or may fear deportation if they present to a health care facility (23, 24). In addition to the mistrust of the health care system, historical racist practices in medical care have contributed to negative outcomes. Continual work needs to be done to eliminate implicit biases and to examine the role that racism plays in ongoing inequitable outcomes.

Examples of Social and Structural Determinants of Health

Awareness of the broader historical and contemporary social contexts that influence health supports respectful, patient-centered care that incorporates lived experiences, optimizes health outcomes, improves communication, and can help reduce health and health care inequities. For example, a pregnant patient with gestational diabetes who has not checked her blood sugar may be labeled as irresponsible or nonadherent. An approach that recognizes the effects of social determinants of health may probe deeper and discover that the patient lacks stable housing and forgets to bring her glucometer each time she moves to another family member's or friend's house. Communicating with this patient about the importance of blood sugar monitoring as the only strategy to address glycemic control would be ineffective. Rather, linking to services to address her housing issues would be much more likely to enable her to manage her gestational diabetes. Another example is a pregnant patient with poor weight gain who is evaluated for medical comorbidities, when deeper questioning into the etiology reveals she was fired from her job and cannot afford enough food for herself and her two children. Ordering tests or discussing the importance of good nutrition in pregnancy would be meaningless if not accompanied by referrals for food assistance. Another commonly encountered scenario influenced by social determinants of health is the ability of patients to arrive at scheduled appointments on time. Many patients with low incomes rely on often unpredictable public transportation and may arrive late to appointments and be forced to reschedule, which creates the impression of nonadherence. Such examples highlight the importance of inquiry into the underlying reasons for these care challenges. In fact, asking about certain social factors can be timesaving in some circumstances, because they can help to address systemic barriers to health care. This strategy has been shown to reduce health care professional burnout and decrease health disparities and also may reduce health care spending (25).

Screening, Social Interventions, and Referrals

Most physicians recognize the important role social determinants play in health outcomes. In one survey, 85% of physicians felt that patients' social needs were as important to address as their medical needs, yet 80% felt they were not confident in addressing them (26). Indeed, addressing the root cause of many of these problems requires wide-reaching, policy-level changes, and most

health care settings are generally under-resourced to address the social needs of individual patients. However, tools have been developed to assist clinicians in screening for some conditions, such as food insecurity and housing instability, and to incorporate these questions into electronic medical records (25, 27). Including social-indicator prompts in physician-encounter tools has been shown to increase referrals to social services (25). See Table 1 for examples of screening questions for social determinants of health.

Providing referrals to housing or food services while patients are in the clinic can improve their health care usage (25). It is critical that health care professionals use evidence-based, patient-centered approaches to address unmet social needs; many patients referred to social interventions never use them due to factors such as fear of discrimination, cost concerns, and lack of availability during times that work for their family schedule (28). Patients are more likely to engage with social interventions if they believe they will benefit them, the referral is presented in an acceptable way that matches their preferences, the activity is accessible, and transportation to the first session is supported, if needed (28). The provision of interventions to address unmet social needs has been described in an approach called "structural competency" (9). This framework recognizes that the way society is structured (for example, through racial, economic, and gender inequalities) influences clinical interactions and health outcomes. Structural competency aims to help health care professionals intervene on these upstream contributions to disparate health outcomes and to recognize that these structural explanations have limitations and are not comprehensive (9).

Cultural Awareness, Humility, and Sensitivity: Approaches to Care

In the 1990s, a concerted recognition emerged among health care professionals and educators that patients come from diverse cultural backgrounds that may influence their understanding of health and illness, interactions with health care professionals and institutions, and engagement with treatment recommendations (29). This was formalized into the framework of "cultural competence," which provided health care professionals with tools to address cultural differences in their patient care interactions. It aims, in part, to understand patients' health-related behaviors as resulting from their cultural beliefs, beliefs that may influence patients' health care decision making. Title VI of the Civil Rights Act of 1964 requires recipients of federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons with limited English proficiency (30). Although this approach has elevated discussions of diversity in health care settings, an overemphasis on culture frequently conveys stereotyped representations of individuals from various ethnic groups

Table 1. Sample Screening Tool for Social and Structural Determinants of Health

Domain	Question
Food	In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?
Utility	In the last 12 months, has your utility company shut off your service for not paying the bills?
Housing	Are you worried that, in the next 2 months, you may not have stable housing?
Child care	Do problems getting childcare make it difficult for you to work, study, or get to health care appointments?
Financial resources	In the last 12 months, have you needed to see a doctor but could not because of cost?
Transportation	In the last 12 months, have you ever had to go without health care because you did not have a way to get there?
Exposure to violence	Are you afraid you might be hurt in your apartment building, home, or neighborhood?
Education or health literacy	Do you ever need help reading materials you get from your doctor, clinic, or the hospital?
Legal status	Are you scared of getting in trouble because of your legal status? Have you ever been arrested or incarcerated?
Next steps	If you answered yes to any of these questions, would you like to receive assistance with any of these needs?

Modified from Health Leads. Social needs screening toolkit. Health Leads; 2018. Accessed May 18, 2024. https://healthleadsusa.org/wpcontent/uploads/2023/05/Screening_Toolkit_2018.pdf

while also overlooking diversity within groups by equating individual beliefs with group beliefs (31). Categorizations such as race and class often are reduced to cultural positions rather than complex political, social, historical, and economic phenomena. Moreover, cultural competency overlooks the cultural dimensions of health care systems and health care professionals themselves. The emphasis on cultural beliefs tends to simplify patients' behavior into basic individual choices, which impedes a deeper understanding of complex interactions of the social, economic, political, and environmental circumstances of patients' lives.

Despite the limitations of a cultural competency approach, it is nonetheless critical for health care professionals to recognize that both patients and health care professionals hold their own set of values stemming from individual life experience and, in some cases, cultural backgrounds. It may be especially helpful, for instance, for a health care professional working in a locale with a large population of immigrants from a particular country to learn about cultural specificities of that group, recognize variations within that group, and understand the overlaying general experience of being an immigrant.

Instead of "competence," which mistakenly implies that culture is a skill that one can master, other ways to recognize that culture matters in certain clinical encounters include cultural humility, cultural awareness, cross-cultural care, and cultural respect (32–34). These approaches include health care professionals being humble about recognizing the limits of their knowledge of a patient's situation, avoiding generalizing assumptions, being aware of their own and their patients' biases, ensuring mutual understanding through patient-centered communication, respectfully asking open-ended questions about patients' circumstances and values when appropriate, and committing to a lifelong practice of self-reflection about power imbalances related to cultural differences (35).

Use of Language

The American College of Obstetricians and Gynecologists recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review ACOG's policy on inclusive language, see https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

RECOMMENDATIONS AND CONCLUSIONS

Health care professionals should be aware of and understand the social and structural drivers that affect health outcomes. They should acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health.

It is essential that ob-gyns be aware of the factors that may promote inequity in the clinic and hospital setting. To dismantle racist and discriminatory policies and practices, there must be an understanding of the historical context, as well as how such biases permeate contemporary medicine. Acknowledgement of one's individual implicit and explicit biases is important to best understand the true effects that social and structural determinants of health have on an individual's choices. That is, it is not simply "noncompliance" when a patient does not follow recommended clinical advice. Review of protocols and implementation of new policies should be scrutinized to ensure equitable access and outcomes and to reduce discriminatory practices. Certain practices, such as urine toxicology screening or referral to child protective services for clinical nonadherence, may be implemented with unintended racial bias but may result in substantial harm for Black and Brown patients.

To provide patient-centered care, each routine office visit should include appropriate questions about social and structural drivers of health that may influence a patient's health and use of the health care system. It is important to be cognizant that screening for social and structural drivers may not elicit open responses from all patients due to perceived stigma or fear of negative consequences (eg, social services involvement) or both.

Social and structural drivers of health should be included in patient-completed intake questionnaires and expanded medical history questions and integrated into electronic medical records prompts. At each routine office visit (eg, prenatal care, well-person visits, preoperative evaluations), health care professionals should inquire about and document social and structural determinants of health that may influence a patient's health and use of health care, such as access to stable housing, food, and safe drinking water, as well as utility needs, safety in the home and community, immigration status, employment conditions, social integration and support, and freedom from discrimination. Before initiating these screening questions, health care professionals should counsel patients that these data are being collected to help identify necessary services and that they will not be reported or used in ways that could harm them or their families. Patients should be aware of mandatory

reporting requirements before investigating such factors. Patients may be hesitant to give honest answers due to the fear of incarceration or involvement of the judicial system, depending on answers given. Health care professionals should be aware that questioning regarding social and structural determinants and social service referrals can be stigmatizing; a patient–doctor relationship of respect and trust is needed to ensure that patients feel safe. When purchasing or customizing electronic medical records for the office, ob-gyns and other health care professionals should request structured fields that capture information on social and behavioral determinants (15, 27, 36, 37).

An individual health care professional's biases (whether overt or unconscious) affect delivery of care and may exacerbate and reinforce health disparities through inequitable treatment.

Obstetrician–gynecologists and other health care professionals should seek to understand patients' health care decision making not simply as patients' cultural beliefs or individual-level behavior, which at times may appear unexpected or irrational to health care professionals, but rather as the result of intersecting socio-political conditions, structural inequities, and social needs that create and maintain inequalities in health and health care. Recognizing the importance of social and structural determinants on individual and community health can help obstetrician–gynecologists and other health care professionals to better understand patients, overcome biases, and effectively communicate about health-related conditions and behavior. This contributes to improved health outcomes, including patients' experience of care and their trust in the healthcare system.

Obstetrician–gynecologist practices that are part of a community health care clinic or larger networks should encourage their facilities to establish medical–legal partnerships. These partnerships involve co-locating legal services in the same site as the clinic, which enables patients to receive assistance with problems such as toxic environmental exposures in their homes, access to stable housing, legal aid for immigration challenges, and other legal matters that directly affect an individual's health. Medical–legal partnerships are available in many federally funded health care clinics and have been shown to positively affect health outcomes, including adverse pregnancy outcomes such as low birth weight (9, 38). Individual ob-gyn practices may not be able to have such services on location, but relationships can be developed with existing medical–legal partnerships to provide necessary services. Obstetrician–gynecologists should advocate for support navigators and care managers who can liaise with health care professionals to address needs identified by screening for social determinants. Larger health care systems, hospitals, and state agencies should work to provide support for legislative policy change to improve resources to address social and structural determinants of health.

Health care professionals should maximize referrals to appropriate services to help improve patients' abilities to fulfill needs identified by screening for social and structural determinants of health.

Obstetrician–gynecologists and other health care professionals should develop partnerships with social workers and local community advocates who provide assistance with basic resources such as food pantries and home utility bills. Patients in need may feel less inhibited from using assistance programs when the ob-gyn frames the referral letter to the community assistance program as a prescription, for example, to promote a healthy pregnancy. For more details on methods linking physicians to community social services, see the Health Leads website at www.healthleadsusa.org.

Health care professionals should be aware of and make allowances for transportation and other logistical difficulties and differences.

Historically and intentionally excluded populations often have difficulties obtaining transportation to health care facilities. Therefore, access to public transportation should be considered when planning office locations. Obstetrician–gynecologists should, whenever possible, accommodate patients who may arrive late due to unpredictable public transportation. In addition, patients from disinvested communities often must bring family members to an office visit. To facilitate attendance at health care appointments, ob-gyns and other health care professionals should avoid making arbitrary rules that prevent children and other family members from attending office visits.

Health care professionals should advocate for policy changes that promote safe and healthy living environments.

Obstetrician–gynecologists should promote hospital and clinical policies that combat discriminatory practices. Advocacy also can be external, including working with professional organizations such as ACOG, advocacy groups, and governmental bodies to identify inequities and enact change. Legislation and governmental policies, including those that address mass incarceration, immigration, housing, and access to reproductive health care, including abortion, have the potential to combat or exacerbate disparities. Obstetrician–gynecologists should use their collective and individual voices to promote patient well-being.

CONCLUSION

Social and structural determinants of health affect health outcomes as much as biological and individual-level factors. Although cultural competency is advocated to improve patient–health care professional communication, with the ultimate goal of reducing racial and ethnic inequities in health outcomes, the model has significant limitations. Obstetrician–gynecologists and other health care professionals should be aware of these limitations and, rather than solely explain health inequities by cultural differences, recognize that inequities are largely the result of forces that influence health at a point upstream from individual behavior. By understanding these inequities as manifestations of larger social pathologies, health care professionals may begin to address patient needs in a deeper and more effective way. Obstetrician–gynecologists and other health care professionals may address social determinants of health by implementing key practices such as employing multilingual staff, ensuring adequate interpreter services, partnering with medical–legal organizations, and engaging with community resources. These small steps can have an important effect on health outcomes at the individual level and can help reduce health inequities at a population level, resulting in an improvement in patient experiences.

REFERENCES

1. Magnan S. Social determinants of health 101 for health care: five plus five. Accessed May 10, 2024. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five
2. Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. Am J Prev Med 2016;50:129–35. doi: 10.1016/j.amepre.2015.08.024
3. World Health Organization. Rio political declaration on social determinants of health. Accessed May 18, 2024. https://www.who.int/publications/m/item/rio-political-declaration-on-social-determinants-of-health
4. Satcher Health Leadership Institute, Morehouse School of Medicine. What are political determinants of health & do they differ from SDOH? Accessed July 5, 2024. https://satcherinstitute.org/what-are-political-determinants-of-health-do-they-differ-from-sdoh
5. Pridan D. Rudolf Virchow and social medicine in historical perspective. Med Hist 1964;8:274–8. doi: 10.1017/s002572730002963x
6. Kleinman A. Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry. University of California Press; 1981.
7. Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Behav 1995;Spec No:80–94. doi: 10.2307/2626958
8. Artiga S, Hinton E. Beyond health care: the role of social determinants in promoting health and health equity. Accessed May 18, 2024. https://files.kff.org/attachment/issue-brief-beyond-health-care
9. Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med 2014;103:126–33. doi: 10.1016/j.socscimed.2013.06.032
10. Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. Am J Public Health 2011;101:1456–65. doi: 10.2105/AJPH.2010.300086
11. Blumenshine P, Egerter S, Barclay CJ, Cubbin C, Braveman PA. Socioeconomic disparities in adverse birth outcomes: a systematic review. Am J Prev Med 2010;39:263–72. doi: 10.1016/j.amepre.2010.05.012
12. Berkowitz SA, Hulberg AC, Standish S, Reznor G, Atlas SJ. Addressing unmet basic resource needs as part of chronic cardiometabolic disease management. JAMA Intern Med 2017;177:244–52. doi: 10.1001/jamainternmed.2016.7691
13. Kim D, Saada A. The social determinants of infant mortality and birth outcomes in Western developed nations: a cross-country systematic review. Int J Environ Res Public Health 2013;10:2296–335. doi: 10.3390/ijerph10062296
14. National Academies of Sciences, Engineering, and Medicine. A framework for educating health professionals to address the social determinants of health. Accessed May 22, 2024. https://nap.nationalacademies.org/catalog/21923/a-framework-for-educating-health-professionals-to-address-the-social-determinants-of-health
15. Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. Acad Med 2017;92:299–307. doi: 10.1097/ACM.0000000000001294
16. Bailey ZD, Krieger N, Ag nor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. Lancet 2017;389:1453–63. doi: 10.1016/S0140-6736(17)30569-X
17. Racial and ethnic inequities in obstetrics and gynecology. Committee Statement No. 10. American College of Obstetricians and Gynecologists. Obstet Gynecol 2024;144:e62–74.
18. SisterSong. Reproductive justice. Accessed February 24, 2024. https://www.sistersong.net/reproductive-justice
19. Gilliam ML, Neustadt A, Gordon R. A call to incorporate a reproductive justice agenda into reproductive health clinical practice and policy. Contraception 2009;79:243–6. doi: 10.1016/j.contraception.2008.12.004
20. Premkumar A, Nseyo O, Jackson AV. Connecting police violence with reproductive health. Obstet Gynecol 2017;129:153–6. doi: 10.1097/AOG.0000000000001731
21. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. American College of Obstetricians and Gynecologists. Obstet Gynecol 2021;137:e75–88. doi: 10.1097/AOG.0000000000004294
22. World Health Organization. Disability. Accessed July 5, 2024. https://www.who.int/news-room/fact-sheets/detail/disability-and-health
23. Health care for immigrants. ACOG Committee Statement No. 4. American College of Obstetricians and Gynecologists. Obstet Gynecol 2023;141:e427–33. doi: 10.1097/AOG.0000000000005061
24. Quesada J, Hart LK, Bourgois P. Structural vulnerability and health: Latino migrant laborers in the United States. Med Anthropol 2011;30:339–62. doi: 10.1080/01459740.2011.576725

25. Gottlieb L, Sandel M, Adler NE. Collecting and applying data on social determinants of health in health care settings. JAMA Intern Med 2013;173:1017–20. doi: 10.1001/jamainternmed.2013.560

26. Goldstein G, Holmes J. Physicians' daily life report. http://www.rwjf.org/content/dam/web-assets/2011/11/2011-physicians–daily-life-report

27. Estabrooks PA, Boyle M, Emmons KM, Glasgow RE, Hesse BW, Kaplan RM, et al. Harmonized patient-reported data elements in the electronic health record: supporting meaningful use by primary care action on health behaviors and key psychosocial factors. J Am Med Inform Assoc 2012;19:575–82. doi: 10.1136/amiajnl-2011-000576

28. Husk K, Blockley K, Lovell R, Bethel A, Lang I, Byng R, et al. What approaches to social prescribing work, for whom, and in what circumstances? A realist review. Health Soc Care Community 2020;28:309–24. doi: 10.1111/hsc.12839

29. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. J Natl Med Assoc 2008;100:1275–85. doi: 10.1016/s0027-9684(15)31505-4

30. U.S. Department of Health and Human Services. Limited English proficiency (LEP). Accessed May 10, 2024. https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html

31. Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS Med 2006;3:e294. doi: 10.1371/journal.pmed.0030294

32. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved 1998;9:117–25. doi: 10.1353/hpu.2010.0233

33. Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. Ann Intern Med 1999;130:829–34. doi: 10.7326/0003-4819-130-10-199905180-00017

34. National Institutes of Health. Cultural respect. Accessed May 18, 2024. https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect

35. DasGupta S. Narrative humility. Lancet 2008;371:980–1. doi: 10.1016/s0140-6736(08)60440-7

36. Adler NE, Stead WW. Patients in context–EHR capture of social and behavioral determinants of health. N Engl J Med 2015;372:698–701. doi: 10.1056/NEJMp1413945

37. Health Leads. Social needs screening toolkit. Accessed May 18, 2024. https://healthleadsusa.org/wp-content/uploads/2023/05/Screening_Toolkit_2018.pdf

38. Teufel J, Heller SM, Dausey DJ. Medical-legal partnerships as a strategy to improve social causes of stress and disease. Am J Public Health 2014;104:e6–7. doi: 10.2105/AJPH.2014.302268

CONFLICT OF INTEREST STATEMENT

All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG's Conflict of Interest Disclosure Policy. The ACOG policies can be found on acog.org. For products jointly developed with other organizations, conflict of interest disclosures by representatives of the other organizations are addressed by those organizations. The American College of Obstetricians and Gynecologists has neither solicited nor accepted any commercial involvement in the development of the content of this published product.

Published online on October 17, 2024.

American College of Obstetricians and Gynecologists
409 12th Street SW, Washington, DC 20024-2188

Addressing social and structural determinants of health in the delivery of reproductive health care. Committee Statement No. 11. American College of Obstetricians and Gynecologists. Obstet Gynecol 2024;144:e113–e20.