**Author’s reply re: The Dangers of Biological Essentialism in Addressing Birth Equity: letter to the editor**

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We thank the authors for their interest in our article. We agree that viewing ethnic and racial categories as biological determinants of health is inherently racist and runs the risks of perpetuating the very health inequalities that we are trying to address. However, we respectfully disagree that utilisation of the FMF algorithm in fact invokes biological essentialism. Ethnicity in the FMF pre-eclampsia screening algorithm is not the sole determinant of an individual woman’s risk status, but is rather part of a set of multiple indices that help determine her risk. The algorithm incorporates maternal characteristics (such as age, height and weight), medical risk factors, blood pressure, uterine artery Dopplers, and biochemical placental markers1. Therefore, a normotensive Black woman with an absence of the aforementioned risk factors would not be categorised as high risk. This approach permits a more nuanced approach to individualised care and is concretely different from the over-simplified checklist approach adopted by the NICE induction of labour guideline that the authors cite2.

The authors’ assertion of women being wrongly assigned as high-risk, resulting in unnecessary medical intervention without improving care also fails to take into consideration the improved access to care and the tailored package of care provided for such women. Women in this high-risk group, regardless of their ethnicity, are offered Aspirin prophylaxis, monitored with serial growth scans, and elective birth at term. These interventions act to not only improve outcomes for both mother and fetus, but also successfully address the ethnic health disparity in pregnancy outcomes3-5.

Our view is that in the UK population, the relationship of ethnicity with various health outcomes is principally driven by socio-economic deprivation as well as individual experiences of both systemic and individual racism. This assertion is borne out in the recent ethnic health inequalities report from the NHS Race and Health Observatory (NHS RHO)6. We fully acknowledge that the incorporation of ethnicity into a screening algorithm has limitations, but that does not negate its use in the identification of women at risk of suffering the health consequences of socio-economic deprivation, to target interventions to prevent adverse perinatal outcomes. We eagerly look forward to the development of a tool, which will be able to address the complex factors associated with racial and ethnic inequalities, but until it exists, discounting ethnicity in its entirety will continue to perpetuate the stark health disparities that currently exist in our National Health Service. Whilst we wholeheartedly concur with the ambition of the authors to tackle racism at its core, we do not underestimate the effort and time this will take to achieve in medicine, let alone in wider society. Whilst we take on this considerable challenge, we cannot let the perfect be the enemy of the good when such stark health inequalities in pregnancy outcome persist.

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**DISCLOSURE OF INTERESTS**

None declared. Completed disclosure of interest forms are available to view online as supporting information.

**AUTHOR CONTRIBUTIONS**

All authors contributed to the writing of this correspondence.

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