

Health Inequities, Social Determinants, and Intersectionality

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ABSTRACT | In this essay, we focus on the potential and promise that intersectionality holds as a lens for studying the social determinants of health, reducing health disparities, and promoting health equity and social justice.

Research that engages intersectionality as a guiding conceptual, methodological, and praxis-oriented framework is focused on power dynamics, specifically the relationships between oppression and privilege that are intrinsic to societal practices. Intersectional knowledge projects aimed at studying this interplay within and across systems challenge the status quo. Whether reframing existing conceptualizations of power, implementing empirical research studies or working with community organizations and global social movements, intersectional inquiry and praxis are designed to excavate the ways in which a person's multiple identities and social positions are embedded within systems of inequality. Intersectionality also is attentive to the need to link individual, institutional, and structural levels of power in a given sociohistorical context for advancing health equity and social justice.

Health Disparities, Inequity, and Social Determinants: A Brief Context

The urgency to promote health, reduce health disparities, and address the social determinants of health is highlighted in countless reports (World Health Organization, 2006, 2015; Hankivsky and Christoffersen, 2008). In short, problems in health disrupt the human developmental process. They undermine the quality of life and opportunities for children, youth, and families, particularly those exposed to vulnerable circumstances. Despite incremental change within and across health-serving agencies and increased health education and scrutiny of patient care, we continue to see significant disparities in the quality of health and life options that children in racial and ethnic minority, low-income homes and neighborhoods experience (Bloche, 2001). Research has uncovered several interconnections between health and environmental and social factors (Chapman and Berggren, 2005; Thorpe and Kelley-Moore, 2013), but has not always shifted

paradigms sufficiently to either disentangle intersecting inequalities or tease apart the ways in which social factors and structural barriers at once interlock to prevent meaningful and sustainable change.

In this essay, we focus on the potential and promise that intersectionality holds as a lens for studying the social determinants of health, reducing health disparities, and promoting health equity and social justice. Collins and Blige (2016) describe intersectionality as

Intersectionality is a way of understanding and analyzing complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each

other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves...People use intersectionality as an analytic tool to solve problems that they or others around them face. (p. 2)

We ask: How do we engage in inquiry and praxis (action and reflection) that departs from the understanding that intersecting systems of oppression, including race/structural racism, class/capitalism, ethnicity/ethnocentrism, color/colorism, sex and gender/patriarchy, and sexual orientation/heterosexism, nationality and citizenship/nativism, disability/ableism and other systemic oppressions intersect and interact to produce major differences in embodied, lived race-gender that shape the social determinants of health? How can we as scholars, researchers, and practitioners concerned with child and family well-being take seriously the reality of intersecting systems of power intersecting to produce lived race-gender-class and other social locations of disadvantage and develop an intersectionality health equity lens for advancing health equity inquiry, knowledge projects and praxis?

We argue that the potential power of intersectionality as a transformational paradigm lies in two domains relevant to understanding social determinants. First, it is a critical knowledge project that questions the status quo and raises questions about the meaning and relationship between different social categories and intersecting systems of privilege and oppression (Collins, 2008, 2015; Collins & Bilge, 2016; Bowleg, 2008; Yuval-Davis, 2011). It also pushes against the idea of “blaming the victim”—that is, the simplicity of explaining health or educational outcomes by attributing problems to individuals’ genetics or cultural and social behaviors alone. Second, by focusing on power relations at the individual, institutional and global levels and the convergence of experiences in a given socio-historical context and situational landscape, it serves as an anchor to advance equity and social justice aims for marginalized communities that have experienced and continue to experience structural inequalities (Crenshaw, 1993; Collins, 2008, 2009, 2015; Weber, 2010). In both instances, researchers and practitioners cross traditional academic, sectoral and disciplinary boundaries to reconceptualize a problem and combine methods from different disciplines (e.g., in interdisciplinary research), or they apply conceptualizations and methods from one discipline to closely examine

issues in another (e.g., in transdisciplinary research, epistemologies and methodologies).

There is growing evidence and professional wisdom to suggest that health disparities do not exist in isolation, but are part of a reciprocal and complex web of problems associated with inequality and inequity in education, housing, and employment (Schultz and Mullings, 2006; Weber, 2010; LaVeist and Isaac, 2013; Williams and Mohammed, 2013). These disparities affect the unborn child through social-emotional challenges such as maternal stress and diagnosed and undiagnosed medical problems, including higher prevalence of gestational and preexisting diabetes in some pregnant populations. In other cases, they are observable at birth, particularly pronounced when prenatal care is unavailable, when the importance of care is not understood fully, and when young children are not exposed to the cognitive and social-emotional stimulation needed to thrive. These and other problems are manifested in parental stress, for example, in mother-headed and two-parent, low-income, and immigrant households alike. Parent and family adversity may reduce the number and quality of resources available and life experiences for children and families in the early years and throughout the life course. Such adversity is exacerbated by structural barriers that limit employment opportunities, increase housing instability, and contribute to homelessness, and that constrain efforts by families to effect positive change.

Over the past 20 years, two major shifts in discussions of health disparities and inequity have spurred interest and research. One shift is the growth in and opportunities presented by interdisciplinary and transdisciplinary research (e.g., work extending from sociology and psychology to economics, among other fields) and cross-domain practice (e.g., medicine, education, and social work) (see LaVeist and Isaac, 2013; Gadsden et al., 2015b). The reach of interests in these issues can be found not only in the social and medical sciences but also in contemporary ethical, moral and political philosophy, such as Sen’s (2009) linking of health equity and agency, and his commentaries on the implications for social justice (Sen, et.al., 2009). A second shift has been the heightened attention to health determinants, more frequently called social determinants of health instead of a biomedical model that solely focuses on the individual level make-up and behaviors of patients as the source of health disparity. The report

of Commission on the Social Determinants of Health (CSDH, 2008) points to the importance of being attentive to the overlapping effects and simultaneity of intersecting inequalities and their implications for social determinants:

The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives—their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a "natural" phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries. (p. 1)

In emerging conceptualizations of these social determinants, racism and discrimination are overwhelmingly significant factors, but are not the only critical dimensions related to identity to be considered (Williams and Mohammed, 2013). They are tied inextricably to multiple identities and social locations that children, youth, and adults assume, and define a context for health (Bauer et al., 2016; Brown et al., 2016). One might argue that there is no issue more important than ensuring health. How a person understands this point and is able to act upon it is determined by more than her or his cognitive ability to engage the idea. It is influenced as well by a range of dynamic and situational identities and social positions that are biologic, cultural, and epigenetic, by social determinants (i.e., where people are born, grow up, work, and age, and interact with their changing environments), and by a person's social experiences and encounters than her or his self-agency across a variety of social settings. Even individuals with the strongest work ethic and sense of agency, when faced with daily problems associated with intersectionality across any combination of racial, class, gender, sexual orientation, language, or disability systemic oppressions and discrimination, may find fighting against these inequalities daunting.

Several researchers have advocated for a new way of combining the insights and perspectives used in intersectional knowledge projects in order to move away from decontextualized biomedical frameworks that often fetishize "cultural competence" as the panacea for structural intersecting inequalities (Viruell-Fuentes et al., 2012). Instead, getting distracted by the alleged "deficits" or "individual behaviors" of marginalized communities, they instead call for what Chapman and Berggren (2005) refer to as a "radical contextualization of the social determinants of health perspectives." Sen and colleagues (2009) acknowledge this shift:

In addition to the obvious benefit of deepening our insights into social inequalities and how they interact, the study of intersectionality . . . has the potential to provide critical guidance for policies and programmes. By giving precise insights into who is affected and how in different settings, it provides a scalpel for policies rather than the current hatchet. It enables policies and programmes to identify whom to focus on, whom to protect, what exactly to promote and why. It also provides a simple way to monitor and evaluate the impact of policies and programmes on different sub-groups from the most disadvantaged through the middle layers to those with particular advantages. (p. 412)

Our objective in the remainder of this essay is to provide a discussion of the possibilities for innovation in conceptualization, methodologies, and practices that can promote human development and health equity through an "intersectionality health equity lens." We employ Jones' (2016) definition of health equity. Jones defines health equity as "the [active] assurance of optimal conditions for all people." Dr. Jones explains that we can get there by "valuing everyone equally, rectifying historic inequities and distributing resources according to need." Jones invites us to think deeply and critically about equity as a never ending process that requires constant and on-going vigilance and not just an outcome that once accomplished can be forgotten. Building on Jones' (2016) and Collins and Bilge's (2016) ideas about equity and intersectionality we define an intersectionality health equity lens, as ongoing critical knowledge projects, inquiry and praxis that can include research, teaching, and practice approaches that are attentive to the ways in which systems of inequality interlock to create conditions for either health equity or health inequities (Collins & Bilge, 2016; Collins, 2008, 2015; Crenshaw, 1993).

We also embrace Collins and Bilge (2016:25) core ideas of intersectionality, namely a focus on inequality, relationality and connectedness, power, social context, complexity and social justice. They use the analogy of “domains of power” to paint a picture of the way that power is visible at the “interpersonal” or individual level in terms of who is advantaged or disadvantaged at the level of social interactions. For example, individuals may experience privilege and or disadvantages when searching for a job, housing, interacting with law enforcement or even when accessing a voting booth. Collins and Bilge (2016:8) assert:

“Using intersectionality as an analytic lens highlights the multiple nature of individual identities and how varying combinations of class, gender, race, sexuality, and citizenship categories differentially position every individual.”

Collins and Bilge (2016) also underscore that we must always be attentive to the “disciplinary” level as a domain of power that organizes and regulates the lives of people in ways that echo our distinct social positions with regard to systems of oppression. For example, rules about who will or will not be seen at a medical office because of the ability to pay a co-pay, who will or will not be admitted to a domestic violence shelter based on their English Proficiency and who has access to gifted classroom, based on IQ test scores that are rooted in eugenicist origins, will inevitably impact the conditions for the advancement of health equity (see also Crenshaw, 1993; Zuberi, 2001).

Collins and Bilge also invite us to reflect on how power is also visible at the “cultural” level or in the realm of ideas, norms and narratives. For Collins and Bilge (2016) ideas matter and how messages are manufactured creates explanations, justifications or challenges to the status quo vis-à-vis inequalities. For instance, if the idea that racialized health inequalities are simply a matter of individual behavior, food ways and choice, and that we live in a meritocracy, where your station in life is simply a matter of individual effort, then we are subscribing to what Bonilla-Silva refers to as “colorblind” racism or the belief that present day realities of race-gaps in health only mirror individual deficits of individuals or defective cultures.

The last arena where Collins and Bilge interrogate the dynamic of power, include the “structural” level or at the level of institutional arrangements, which interrogates how intersecting systems of institutionalized

power, whether in the economy and labor market in terms of who’s labor is valued and who is exploited, or at the political level in who is granted substantive citizenship rights and privileges and who is not, as well as at the level of who has access to structures of political power and influence, shapes the institutionalization of the conditions for health equity. For example the struggle for sovereignty of indigenous people as evidenced in the Standing Rock movement to protect indigenous land and water for generations in South Dakota, provides a snapshot of the structural location of indigenous nations and capitalist neoliberal actors that are in a struggle to define the environmental context for current and future generations, which will have grave consequences for health justice for marginalized indigenous communities.

While an intersectionality health equity lens may inform or drive interdisciplinary or transdisciplinary research, it must also be considered as part of both the process of conceptualizing the problem and the product of research on the problem. Throughout this essay, readers should consider the potential applications of an intersectionality health equity lens, how its use enhances (or disrupts) our understanding of salient and longstanding issues, what might be learned from its use that will inform and deepen research and practice with children and families who are among the marginalized in society, and what types of intersectionality-focused approaches might lead to health access and equity. In the next section, we focus on the contributions of an intersectionality health equity lens for research and for promoting health equity.

An “Intersectionality Health Equity Lens” For Social Justice

When developing or applying an intersectionality health equity lens, the researcher engages in deep self-reflection that contextualizes and recognizes the ways in which race, gender, class, sexual orientation, disability, and other axes of inequality constitute intersecting systems of oppression. Such systems produce very different lived experiences for entire categories of people who are embedded within complex webs and social networks at different levels, for example family, neighborhood, and community as well as institutional and structural. These lived experiences can either enhance or challenge the developmental pathways of children through adulthood and the ability of parents and families to ensure a positive trajectory for their

children. They affect both the individual child and the networks and communities in which children live and grow and that define their access to resources.

An intersectionality health equity lens for the purposes of our discussion takes on the broader, philosophical meaning attached to praxis as process involving health, educational, and social service researchers and practitioners in not only self-reflection but also action. Critical self-reflection allows researchers and practitioners to continually and closely examine their own race, gender, class, sexual orientation, disability, language, nativity/citizenship and social position, and their relationship to systems of inequality as part of intersecting systems of oppression and privilege. It argues for researchers and practitioners to draw upon their own experiences with health inequities and discrimination and to understand and respond to new or subtle forms of inequities and discrimination. These subtle forms of inequity and discrimination are sometimes so deeply embedded in and accepted as societal practices that they may be difficult to uncover, yet render many children and families hopeless. The interplay between and among relevant systems and the statuses accompanying power attributed to different ethnic, racial, cultural, and socioeconomic groups affect both individuals and their social networks (e.g., family, neighborhood, and community). They are tied directly to and within institutional and structural hierarchies.

Crenshaw (1993) points to the entrenched nature of inequity, underscoring the need for a useful paradigm in which to locate the issues faced by African American women and other racially stigmatized, visible minority women of color. Credited with creating a systematic analysis of the concept of intersectionality, Crenshaw (1993) urged readers to “map the margins” by focusing on those social locations that remain invisible. She argues that such invisibility results from a reliance on a mythical universal “black experience” (e.g., when we assume that the default category is the “black male experience” and by the same token when we speak about “women’s experiences” and assume that all women’s experiences are represented in white women’s experience). In each of these dominant conceptualizations of the black [male] and [white] woman’s experience, heteronormativity is the invisible structure.

Crenshaw (1993) also illustrates how language, and potentially nativity and citizenship status, can serve as other axes of stratification that have received less

attention than race and class. To illustrate her point, Crenshaw flexes her intersectional lens to bring into sharp relief the effects of “good intentions” on the real lives of women. She demonstrates that despite their good intentions, some domestic violence shelters may operate in ways that ignore the plight of immigrant women with children who may not speak English and are unable to access domestic violence shelters. It goes without saying that this would structurally exclude immigrant (both documented and undocumented) women and their children who do not speak English. “Nativism, English Only” categories are the invisible, yet real, structural barriers to addressing domestic violence in the aforementioned situation. By the same token, members of lesbian, gay, bisexual, transgender, queer, and in-transition (LGBTQI) communities may not face explicit rules about being barred from these services because of their gender identity, but if counselors and other providers assume that their clients are in heterosexual, gender-conforming relationships, heteronormativity can operate as another type of an informal barrier.

One might well ask, given the complex relationships in addressing identity, whether it is possible to create intersectionality-grounded projects that integrate the issues of race, class, gender, disability, and other identities, statuses, and social locations in research on health and well-being for the range of issues facing marginalized children, youth, and families. Although we do not have a simple response, we highlight the need to address the real or perceived complexity of creating such projects and allowing time and resources for them to be developed well and to be refined. We similarly understand the limitations of relying on one-dimensional categories that are, at best, additive, for example, first race, then maybe class, then maybe gender, depending on the focus of the research. As the World Health Organization (WHO, 2015) and several health researchers before (e.g., LaVeist and Isaac, 2013; Williams and Mohammed, 2013) suggest, understanding the social determinants of health requires a broad reach to identify, and respond to, the embedded and entrenched inequities of policies that are situated in place and context.

Intersectionality health equity lenses help us understand that every person’s experience is fundamentally different than the experience of others, based on their unique identity and structural positions within systems of inequality and structural impediments (Feagin and

Sikes, 1994; Nakano Glenn, 2002; López, 2003, 2013a; Weber, 2010). More than just a theory or framework to be used selectively, it is a commitment to developing a relentlessly critical and self-reflective lens that begins with the premise that race, class, gender and other axes of social identities are intertwined and mutually constitutive, and that such a lens can help advance health disparities research, practice, and leadership by making the invisible visible.

Integrating Race, Gender, Class, and Sexuality as Lived Experiences: A Case Example

In considering intersectionality projects, we must be aware of the overwhelming inequities associated with longstanding problems of race and gender and the added problems of poverty and class, problems that have narrowed in some cases over time but where inequality persists. It should come as no surprise that an intersectionality-focused project might appear opaque or obscure initially, despite its potential to uncover the breadth of issues faced in ensuring health and well being.

Imagine the year 2050, and all institutional data on departed from the critical insight offered by Bowleg (2008:323):

"It is the analysis and interpretation of research findings within the sociohistorical context of structural inequality for groups positioned in social hierarchies of unequal power (Collins 1995; Crenshaw 1989, 1991; Cuadraz and Uttal 1999; Weber and Parra-Medina 2003) that best defines intersectionality research."

López (2013b) proposes the "racialized-gendered social determinant of health" as a heuristic device or framework for centering the lives of marginalized communities. This framework consists of two major concepts: (1) "lived race-gender" and (2) "racialized-gendered pathways of embodiment." López (2003) offers an example of the enactment of these concepts in the minds and experiences of both the observer and the observed. For example, she makes explicit the ways in which race-gender disparities are enacted and experienced in school and society by young Dominican and Caribbean men and women in what she calls "New York Immigration and Racialization." Consider Orfelia's narrative on the public's perceptions of blacks,

hispanics, and whites and the differential result of their identities on these perceptions:

If you put on the news, anyone who does anything bad, if he's not Black, he's Hispanic . . . You watch the news and you see that when any white guy does something, you won't see their face. They might just say it, and that's all. But if it's a Dominican, a Hispanic, a Black, they put him on for about two minutes, so that you can know him. (p. 23)

Orfelia points to the ways in which she has internalized race and gender stigma as dominant identity markers and their intersections with place (Queens in New York) and other intersectional identities such as immigrant and Spanish speaker. The mental health costs of feeling racially stigmatized may become embodied by many youth who also feel what sociologist W. E. B. DuBois coined in 1903 as the "double consciousness" experienced by blacks in the U.S. context or the sense of always being seen with contempt, pity, or disdain because of one's stigmatized status (DuBois, 1999; Vidal-Ortiz, 2005) (1).

López also underscores the dominance of race and gender identities, along with other identities (e.g., social class, sexual orientation, age, ethnicity and nativity, and legal status) that form the basis for education and health frameworks. She draws upon a personal example to demonstrate connections among race, gender, sexuality, and social class and the significance attached to heteronormativity (see Box 1).

While race, gender, and class were overriding identities in the short narrative in Box 1, heteronormativity was the silent but overpowering lens for López and her cousin (3). As López notes, the nature and type of her cousin's experiences in and out of school, within family and community contexts, and with stressors that were unnamed distinguished the two cousins. As she suggests through this anecdote, sexuality played only a small though apparently significant part in the everyday encounters that her cousin faced. What remains unanswered are questions about the ways race and gender (male and Dominican) played in her cousin's schooling, and the ways that gender nonconformance (what we now refer to as transgendered identity) produced barriers to health access, care, prevention, and maintenance; to employment; to housing; and to the daily acceptances that allow individuals to maintain

BOX 1

Contextualizing Lived Race-Gender & the Racialized-Gendered Social Determinants of Health

As the U.S.-born daughter of Spanish-speaking immigrants from the Dominican Republic, I grew up as the eldest of five children in public housing in the Lower East Side of Manhattan in New York City during the 1970s and 1980s. I also graduated from a de facto segregated public high school, one of the last large vocational schools for girls in New York City. My cousin, labeled a boy, was born in the Dominican Republic but came to New York at the age of 5; they (2) also grew up in New York City public housing in the 1970s and 1980s. Yet, we faced quite different life course contexts that shaped our health status and health outcomes. While we are both Afro Latinos and would be described as racially black, my cousin was darker-skinned than I, and thus colorism operated to shape his experiences in ways that highlight the effects of colorism even within communities that would be racialized as black (Gómez, 2000; Hunter, 2007; Monk, 2015). My cousin often confided in me, sharing many of the experiences he had with police harassment connected to the criminalization of many black and Latin@ neighborhoods, and race-gender profiling policies and practices that created real fear among boys of color and particularly who are visibly racialized as black or brown. Later, as a visibly transgendered AfroLatinx (e.g., dark-skinned, black Dominican gender-nonconforming adult), my cousin faced the additional challenge of being gender-nonconforming. For example, at their twenty-first birthday, while dancing with their Latinx partner, my cousin donned silver sequined sportswear with a matching baseball cap. I often wondered about how my cousin's racialized-gendered-gender-nonconforming and sexual identity and social positions shaped their lived experiences while walking down the street, while attending school, while seeking an apartment, while seeking employment, or even when seeking health care, and of course while interacting with law enforcement. The constellation of social determinants of health that my cousin faced were starkly different than my own and could account for the fact that while I am in my late forties, married, and the mother of two children, my cousin passed in New York City due to a chronic liver disease before reaching the age of 45 (Ortiz, Duncan, Blosnich, Salloum, & Battle, 2015).

not just a healthy personal racial, gendered, class, ethnic, or sexual identity but also an identity that can be embraced in full in all social domains and situations that López's cousin traversed throughout their short life.

Focusing on López's cousin's experiences from a health equity perspective, several additional questions are raised: Did the health system fail her cousin, or was it the larger social system that did not accept their intersectional identities? To what degree do our current systems of data collection make her cousin's intersecting lived oppressions vis-à-vis race, national origin, class, sexuality, gender identity, and nativity invisible? If we collect data only on gender identity and not class, nativity, citizenship, ethnicity, language, and/or national origin, do we make some social locations invisible? Do we ignore the temporal element of identities across the life course? How would López's cousin's life experiences have been different if her cousin had been from an LGBTQI middle class, Dominican immigrant family that was light skinned, white-looking Latinx and not a visible minority? All of these data challenges are opportunities for establishing communities of practice committed to intersectionality praxis (action and reflection) (4). Bowleg (2008:312) provides

us with critical epistemological, ontological and methodological insights on advancing intersectional inquiry and praxis:

"I argue that a key dilemma for intersectionality researchers is that the additive (e.g., Black + Lesbian + Woman) versus intersectional (e.g., Black Lesbian Woman) assumption inherent in measurement and qualitative and quantitative data analyses contradicts the central tenet of intersectionality: social identities and inequality are interdependent for groups such as Black lesbians, not mutually exclusive. In light of this, interpretation becomes one of the most substantial tools in the intersectionality researcher's methodological toolbox."

In studying these and other questions related to health access and equity, drawing upon broad conceptualizations and nuanced analyses is important as is drawing upon conceptually complementary methodological approaches. The efficacy of rigorous quasi-experimental studies and of large, integrated datasets, including administrative data, in identifying and addressing multiple problems facing differing communities is clear. For example, Brown and colleagues (2016) examine the influence of the intersecting

consequences of race-ethnicity, gender, socioeconomic status (SES), and age on health inequality with almost 13,000 (n = 12,976) whites, blacks, and Mexican Americans, based on panel data from the Health and Retirement Study. Drawing upon multiple-hierarchy stratification and life-course perspectives, they focus on (1) the variation of racial/ethnic stratification of health by gender and/or SES and (2) the decrease, stability, or increase of combined inequality in health between middle and late life. Analyses of the data indicated that the effects of racial/ethnic, gender, and SES stratification were interactive, resulting in the greatest racial/ethnic inequalities in health among women and those with higher SES.

Although improving our quantitative data infrastructure is of paramount importance, Chapman and Berggren (2005) also call upon health disparities researchers to take advantage of the benefits of qualitative data methods that “radically contextualize” the sociohistoric contexts that fuel the social determinants of health. They argue that qualitative methodologies such as participant observation, ethnography, and interviews can serve to demystify the link between structural, institutional, community, and individual processes that contribute to health inequities by shedding light on the social practices, interactions, policies, mechanisms, and processes that undergird manufactured health inequities. Rather than committing to one or the other, this focus on intersectionality will require the use of multiple methods, strategically layered to identify the problem and provide responsive interventions and equitable policies (Minkler and Wallerstein, 2011).

An intersectional paradigm or conceptual universe takes identity categories embedded within systems of inequality as a starting point to understanding the interactions between individuals and systems and among individual identities, systems, and social locations across the life course. The categories are fluid and must be examined in combination with each other. Metzler and Hansen’s (2014) concept of “structural competency” offers a useful example. It begins with the assumption that “inequalities in health [education, employment, housing, voting, law enforcement, nativity, etc. must] be conceptualized in relation to the institutions and social conditions that determine ... resources” (p. 127). Discussions of intersectionality address Metzler and Hansen’s concerns, described earlier, and

emphasize the importance of examining the simultaneity of racism, sexism, heterosexism, classism, and other axes of inequality for mapping and interrupting the sedimentation of health inequities in health care access and the social determinants of health. This perspective is moving slowly into mainstream health disparities research, as health focuses more directly on the social bases for health determinants (WHO, 2015). Intersectionality considers the multiplicity of policies and practices constructed for different groups. At the same time, it acknowledges the ways in which these historically situated policies and practices reinscribe positions of power, dominance, and oppression that contribute to the social determinants of health, education, and well-being.

Developing an Intersectionality Health Equity Lens: Changing the Narrative for Social Justice

What happens when health research takes an intersectional stance in producing and using knowledge to effect positive practice and social change and advance equity? In what ways do our personal and professional positionalities contribute to this intersectional stance, our research, and the opportunities afforded by our ways of seeing and knowing the world? How do we address the health inequalities and inequities that reduce these opportunities for children, youth, and families and redirect them to promote social justice?

We are aware that the answers to these questions require time, depth of inquiry, and breadth of analysis, and that they contribute to, rather than outline, a social justice framework. Throughout this essay, we argue that critical, self-reflexive intersectionality health equity lens and praxis depend upon a visceral commitment to uncovering the workings of the multiple systems of inequality in unpacking the social determinants of health. Such a lens might be expanded to become an “intersectionality equity” lens that questions further how our research, teaching, and practice can enact Crenshaw’s (1993) idea of “mapping the margins.” To achieve this, Crenshaw argues, we must center the lives of groups that remain often invisible when we talk about the generic working class “women” or “men” or “Latinos” or “LGBTQ” communities.

In moving forward, we also must be committed to enlarging and diversifying the pool of research scientists who study the issues. By diversity within an

intersectionality health equity lens, we are referring to research scientists whose own awareness of their intersectional identities—that is, ethnicity, race, gender, class, sexuality, nativity, and disability—pushes them to design research that produces greater knowledge and clarity about the conceptualization of sound intersectionality-grounded studies and the range of methods to ensure new knowledge, better applications of knowledge, and effective uses of knowledge to guide our understanding of human development and health.

Initiatives focused on advancing social cohesion through intentional efforts to increase the diversity and number of research scientists with lived experiences that reflect multiple intersecting systems of oppression may take different forms. For example, in April 2011, the Institute for the Study of “Race” & Social Justice at the University of New Mexico, with support from a National Institutes of Health workshop grant, convened a group of scholars from the health and biological sciences and social sciences who embodied the intersecting race, gender, sexual orientation, class, age, disability status, religious, ethnic,

citizenship and national origin backgrounds that form the rich tapestry of our diverse union (**Figure 1**).

Other activities may include opportunities for interdisciplinary conferences and collaborative research, teaching, and writing. For example, at the University of Pennsylvania, one health disparities course is co-facilitated with tenure-track and clinical faculty within education and across the social sciences, medicine, and nursing. Bringing together all of the insights from Health Sciences, Psychology, Anthropology, Art History, American Studies and Law can actually generate new knowledge and new ways of doing research and developing equity based policy. It’s tremendously powerful to build on interdisciplinary knowledge. It’s not the case that any one discipline has all the answers. We need all of us working together, harmoniously, to continue to make advancements and these insights should be reflected in what is considered required coursework for all disciplines interested in health equity.

An intersectionality health equity lens offers enormous possibilities for research projects that take seriously the multiple identities of children, youth, and



Figure 1 | National Institutes of Health (NIH) R21 Workshop. This gathering convened diverse multi-disciplinary scholars for a workshop entitled, “Mapping ‘Race’ & Inequality: Best Practices For Conceptualizing And Operationalizing ‘Race’ in Health Policy Research Workshop,” April 29-30, 2011. The Institute for the Study Of “Race” & Social Justice, RWJF Center For Health Policy, University of New Mexico, Albuquerque, NM convened the workshop. Papers from this workshop were published in *Mapping “Race”: Critical Approaches to Health Disparities Research*. Laura Gómez and Nancy López, editors. New Brunswick, NJ: Rutgers University Press, 2013.

families in the study of health and human development. One might argue that a relationship exists between social ecological models of human development and health that highlight the intersections and interactions between and across contexts and discussions of intersectionality that consider social statuses.

In supporting an “intersectionality health equity lens” for research, we accept the limitations of implementation and of ways of looking at problems that children, youth, and families face. In our examples, drawn from our personal and research experiences, we suggest that there is little to no likelihood that one clean, one-size-fits-all approach exists to uncover the multiple intersectional identities in a given situation or sociopolitical and historical context. We also argue that to reveal the full expanse of complex intersecting factors that create social determinants of health and well-being, the discomforts associated with linking the different identities, the tendency to focus on one over another, and the difficulty of determining and building appropriate methodologies will have to be addressed (see Gadsden et al., 2014, 2015a). Palència and colleagues (2014), referring to their research and practice in Barcelona, remind us that “the development of research designs and methods that capture effectively all of the tenets of intersectionality theory remains underexplored” (p. 8). While intersectional analyses have relied heavily on ethnographic approaches, the authors note that “quantitative researchers have acknowledged the tensions between conventional research designs, intended to test for independent effects, and intersectionality principles” (p. 8).

The social sciences and health sciences are making progress toward considering the range of factors outside of simple genetics and social environments that affect health and health interventions. Intersectionality knowledge projects draw upon and have the potential to create innovative research and policy paradigms that can lead to practical measures and solutions for advancing health equity. Such measures map and interrupt inequality among racially stigmatized and other marginalized communities in local, municipal, state, and national contexts. At a minimum, they suggest a revisioning of policies that cut across relevant areas of health, education, social services, and law.

In developing our focus on intersectionality and social determinants of health, we attach our analysis

to the goals of advancing social justice, where commitments to equality and equity reside and power is shared. A list of resources focused on intersectionality appears in **Box 2** and demonstrates the range of efforts. As these efforts suggest, for all health and health policy researchers, scholars, practitioners, and community leaders who embrace a social justice framework, an intersectionality health equity lens could help to illuminate the often stifled issues that affect the health, development, and well-being of children and families in marginalized communities. This would mean that they would take seriously the ways in which institutional rights and duties allow people to participate and receive resources such as health, education, and social services in ways that are fundamentally shaped by intersecting inequalities. That would also mean promoting equal access to the fair distribution of wealth, equal opportunity, and equality of outcome by making the invisible visible through interrogating how race and class systems of oppression work together in shaping the social determinants of health.

Organizations such as the National Academy of Medicine can serve as convergence spaces where intersectionality knowledge projects centering on the lives of multiple and diverse marginalized groups in a given sociohistorical context can be incubated and developed to advance health justice. How specialists see, treat, and understand the human experiences of children and families and the potential for their well-being will be revised. As a result, we begin to address the multiplicity of identities, social positions, and systems of intersecting inequalities that contribute to the social determinants of health for diverse populations of children, youth, and families and move closer to effecting sustainable change and equity.

BOX 2 Partial List of Intersectionality Focused Resources

Columbia University

Center for Intersectionality and Social Policy Studies, established in 2011
Professor Kimberlè Crenshaw, Executive Director and Founder
<http://www.law.columbia.edu/centers/intersectionality/about-the-center>

University of Maryland

Consortium on Race, Gender and Ethnicity (CRGE), established in 2001
Dr. Ruth Zambrana, Director
<http://crge.umd.edu>

Matrix Center for the Advancement of Social Equity and Inclusion, established 2005

University of Colorado, Colorado Springs
Dr. Abby Ferber
<http://www.uccs.edu/~matrix/>

University of New Mexico

New Mexico Race, Gender Class Data Policy Consortium, established 2014
Institute for the Study of "Race" & Social Justice, established 2009
Dr. Nancy López, Director & Cofounder
<http://race.unm.edu>

University of New Orleans

Race, Gender and Class Journal, established 1996
Dr. Jean Ait Belkhir, Director and Founder
<http://rgc.uno.edu/journal/>

Research Institute for the Study of Intersectionality and Social Transformation, established 2016

University of Southern California
Dr. Ange Marie Hancock, Executive Director and Founder
<http://www.ange-mariehancock.com>

Simon Fraser University

Institute for Intersectionality Research and Policy, established 2005
Dr. Olena Hankivsky, Director
<http://www.sfu.ca/iirp/>

Anna Julia Cooper Center

Advancing Justice Through Intersectional Scholarship
Wake Forest University
Dr. Melissa Harris Perry, Director
<http://ajccenter.wfu.edu>

Notes

1. See also Gravlee (2009) on when race becomes embodied).
2. "They" or "their" is used to denote the gender history of the transgender person.
3. For more information on providing equitable health care services for diverse LGBTQI communities, see Vidal-Ortiz (2005); NBER (2012); Chyn (2016) and Johnson, Rivera and López, under review for information the difference between ethical accuracy for civil rights and aesthetic accuracy for compliance only and the value added by having separate question on Hispanic origin and race for the 2020 Census.
4. For more on the AfroLatin@ experience in the United States. See JRoman and Flores (2010); for more information on providing equitable health care services for diverse LGBTQI communities, see Ortiz (in press); for more on segregation, see Vidal-Ortiz (2005); NBER (2012); Saenz and Morales (2015) Chyn (2016).

Background

This discussion paper was stimulated by conversations at a meeting on May 11, 2015, convened by the Board on Children, Youth, and Families of the National Academies of Sciences, Engineering, and Medicine. A number of discussion papers arose from this meeting and will be published as NAM Perspectives throughout 2016. You can access the papers at nam.edu/Perspectives and sign up to the Perspectives listserv at nam.edu/ListservSignUp. To watch the full recording of the May 11, 2015 meeting, please visit nam.edu/SocialJustice. A group of external peer reviewers reviewed the papers. They included: **Brigadier General Clara L. Adams-Ender**, United States Army Nurse Corps (retired), **David Brent, MD**, University of Pittsburgh, **David Britt, MPA**, Sesame Workshop (retired), **Hernan Cervante, BS**, Vera Institute of Justice, **Mark Courtney, PhD**, University of Chicago, **Elena Fuentes Afflick, MD**, University of California, San Francisco, **Amy Griffin**, National Institute of Justice, **Harry Holzer, PhD**, Georgetown University, **Larke Huang, PhD**, Substance Abuse and Mental Health Services Administration, **Jeff Hutchinson, MD**, Uniformed Services University of the Health Sciences, **Ann Masten, PhD**, University of Minnesota, **Christine Ramey, MBA, BSN, RN**, Health Resources and Services Administration, and member of the Academies' Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, **Martin Sepulveda, MD, MPH**, IBM, **Melissa Simon, MD**, Northwestern University Feinberg School of Medicine, and member of the Academies' Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, **Belinda Sims, PhD**, National Institute on Drug Abuse, and **Mildred Thompson, MSW**, PolicyLink Center for Health Equity and Place, and former member of the Academies' Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

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