Health Inequalities and Intersectionality

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Briefing Note

For up-to-date knowledge relating to healthy public policy

Intersectionality is a way to think about and act upon social inequality and discrimination. It offers a promising approach to these issues within public policy and within public health. This briefing note briefly explains intersectionality and explores the potential of an intersectional approach to reducing health inequalities.[1]

Work in the field of public health has recognized for some time that the social location[2] of groups and individuals has a significant impact on health. When health outcomes are compared by income, gender, race or education, to name just a few, a picture emerges that clearly shows that these factors play key roles in determining health and well-being. People living in poverty, for example, have higher rates of many diseases and die younger than those in higher-income groups. Racialized groups in Canada also have poorer health outcomes than white Canadians and women often have disadvantaged health outcomes when compared to men. Lesbian, gay, bisexual and transgender (LGBT) individuals often face significant barriers in access to health care and LGBT youth in particular have significantly higher rates of homelessness and suicide (Mulé et al., 2009). For those working in the field of public health, none of the above statements will come as a surprise. Along with factors such as housing, income and education, among others, these are commonly referred to as the **social determinants of health** (SDOH).[3] While most discussions of the social determinants of health include what are sometimes referred to as the structural determinants (macro-level social, fiscal and economic policies and general cultural and social values) (Commission on Social Determinants of Health, 2007), the mandates of public health organizations have sometimes made it difficult to see how they can integrate action on these into their practices. Into this quandary, the ideas and approaches which have emerged from intersectionality studies can contribute on two significant fronts: understanding the interaction between two or more disadvantaged social locations, and understanding how these are related to social structures that contribute to their formation and maintenance.

Intersectionality – What is it?

Intersectionality as an approach and as a practice has emerged as one of the promising ways to address structural forms of inequality in recent years. Originally conceived to address the complex and multifaceted forms of discrimination faced by women of colour, its ability to help understand and intervene in the policy domain is even broader in scope and its "fit" with public health is particularly appropriate. Bowleg defines intersectionality as: "a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression" (Bowleg, 2012, p. 1267).

[1] The Government of Canada defines health inequalities as "differences in health status experienced by various individuals or groups in society. These can be the result of genetic and biological factors, choices made or by chance, but often they are because of unequal access to key factors that influence health like income, education, employment and social supports" (Government of Canada, 2008, p. 5). While the term *health inequities* is often used in the literature on intersectionality, we use *health inequalities* here as in other NCCHPP documents. (Note: all of our documents are produced in both French and English and there has not yet been a widely agreed-upon translation of *health inequities* into French [the WHO Commission reports on the social determinants of health, for example, use *health inequities* in English and *inégalités de santé* in French]). For clarity and consistency, we use *health inequalities* in English and *inégalités de santé* in French.

[2] The expression *social location* (or *social position*) is used to capture the idea that while each of us occupies a specific and individual place in the world, it is produced by our relationship to the social settings in which live. That is, our social locations are relational, shifting and shaped by our positions in the social structures we inhabit. While largely determined by structures of inequality inherent in a social system, social location is also often lived as a deeply felt identity by individuals as they negotiate their position in a social setting.

[3] The Canadian Public Health Association defines the social determinants of health as: "the social and economic factors that influence people's health" (Canadian Public Health Association. (N.d.).

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The term *intersectionality* was first used by Kimberlé Crenshaw as she set out to analyze and explain workplace discrimination rulings in the United States as they related to cases brought before the courts by Black women (Crenshaw, 1989). In one of these rulings, a group of Black women brought suit against General Motors after they felt they had been unfairly dismissed from their jobs specifically because they were Black women. The courts ruled that under current legislation, they could not file such a suit; they were either discriminated against because they were women, or they were discriminated against because they were Black. There was no legal position from which they could be both Black *and* women at the same time. This example served as a stark reminder of the precarious and specific position of African-American women. Indeed, the first collection of Black feminist writing pointed to this problem in its title, *All the Women are White, All the Blacks are Men, But Some of Us Are Brave* (Hull, Bell-Scott, & Smith, 1982). It was in the midst of these realizations, that both the Black and feminist movements marginalized the voices of Black women, that the concept (and some would argue, the movement) of intersectionality was born – though it is worth reiterating that the ideas behind intersectionality were not at this point new. In the decades following the early work by Crenshaw (1989; 1991), Hooks (1990) and Hill-Collins (1990), notably, the approach has been widely picked up in the social sciences.

Though coined by Crenshaw, the tenets of intersectionality pre-date the term itself in many practices and writings within and outside of North America, including in much Indigenous scholarship and in the writings and practices of many activists. Sojourner Truth's powerful poem, *Ain't I a Woman*, is often cited as proof of the long tradition of intersectionality-without-the-word in Black feminism. The essence of an intersectional approach can be seen at its most basic level in the phrase, *Black woman*. That is, being a Black woman is not the same thing as being Black plus being a woman (see text box below). The social, political and economic forces that create the social position of being Black and those that contribute to that of being woman cannot simply be added to one another, they intersect to become something new and they do so with various other social locations to create specific and conjunctural locations of disadvantage.[4] Hill-Collins refers to the intersections of these categories as constituting a "matrix of domination" (Hill-Collins, 1990). Again, we can see how this might contribute to understanding and reducing health inequalities by noting the importance of the interaction between different social locations. That is, intersectional analysis specifically seeks to understand and address the intersections of various locations of social disadvantage and not their accumulation. In other words, it is not a matter of adding up social disadvantages (woman + Black + low income + recent immigrant, etc.) but of seeing how these intersect in various situations and at various times. A woman may, for example, experience inequality on the basis of being a woman, on the basis of being Aboriginal, on the basis of living in a remote location or on the basis of living in poverty. Each of these individual locations tends, in contemporary Canadian society, to put these people at a significant disadvantage compared to others: men, Canadians of white European descent, urban dwellers, and those in higher socio-economic groups. But crucially, they may also combine in a variety of ways to produce specific configurations or intersections of inequality which can be shifting and mutable but which are almost always present in one combination or another. When viewed this way, we can begin to approach these factors as interacting forces that co-constitute one another rather than isolating each one in turn and attempting to address them that way.

Intersectionality also offers a way of conceiving of how structural factors interact to produce specific health outcomes in individuals. Though the final report of the World Health Organization's Commission on the Social Determinants of Health (2008) emphasizes the importance of the structural determinants, it has been, and continues to be difficult for the field to find purchase in areas where these causes originate. As is commonly the case in work which seeks to reduce health inequalities, and perhaps in public health institutions more generally, intersectionality is based on several principles which promote equity and social justice. Further, "far from being just an exercise in semantics, intersectionality provides the discipline of public health with a critical unifying interpretive and analytical framework for

[4] It is important to note that the same processes that create disadvantage also produce locations of privilege. Being white, male, wealthy and educated is also more than the addition of its parts; we can only understand how these positions often equate to advantage where they intersect.

reframing how public health scholars conceptualize, investigate, analyze, and address disparities and social inequality in health" (Bowleg, 2012, p. 1267). The second main potential contribution of intersectionality discussed here relates to the way in which structural determinants and their relationship to power are placed in the foreground. The locations of social disadvantage are not arbitrary. They are the result of structural, institutional and systemic relations which put some social locations or identities in positions of advantage and others in positions of disadvantage.

Intersectionality and public policy

A number of tools designed to mitigate or eliminate health inequalities have been developed in recent years (see, for example, Mendell, Dyck, Ndumbe-Eyoh, & Morrison, 2012). These are designed and used variously to aid in policy planning and to analyze the effects of existing policies. The primary examples of these include: (Sex and) Gender Based Analysis; Gender Based Analysis + (includes social locations besides gender but maintains gender's primacy); Health Impact Assessment; and various types of Impact Assessments that explicitly include an equity focus. Intersectionality seeks to offer an improvement on all of these.[5] As indicated earlier, intersectionality explicitly focuses on how different social locations interact with each other to create specific conditions as well as on how these interact with the structural forces that produce categories of advantage and disadvantage. While the tools listed above have contributed to furthering work on reducing health inequalities, they focus on single categories (how might this policy affect women *or* those living in poverty, for example) whereas intersectionality "focuses on interactions of different social locations, systems and processes, investigates rather than assumes the significance of any specific combination of factors" (Hankivsky, 2014, p. 13).

Three Canadian Approaches

The following section describes three of the main applications of intersectionality-inspired approaches currently in use and being developed in the Canadian context. All three of these use intersectionality as a promising approach to reducing inequality at the level of policy (state and institutional) and all are specifically connected to increasing health equity.

The Canadian Research Institute for the Advancement of Women (CRIAW)

The Canadian Research Institute for the Advancement of Women (CRIAW) adopted what they call Intersectional Feminist Frameworks (IFFs) in their work in the early 2000s after a lengthy internal examination of their practices (Lee, 2011). Part of their move to do so was the realization that adopting Gender Based Analysis (GBA), a common framework used in Canadian government and other organizations to examine how policy impacts men and women differently and tends to disadvantage women specifically, meant that those in the most disadvantaged social groups were left out of the analysis if other social locations were not part of the equation. "Aboriginal, immigrant, disabled, poor, and elderly women remain disproportionately represented in those groups demonstrating the greatest health disparities" (Lee, 2011, p. 359). For CRIAW, GBA, as it is meant to address the disparities between men and women where it is adopted as part of a public health approach, is ill-equipped to deal with the intersectional realities faced by women (or men) in these groups. This reflection led to the CRIAW to adopt IFFs which are described as, "fluid, specific, diverse, and interconnected both locally and globally" (CRIAW-ICREF, 2006, p. 8). For them, IFFs offer a way forward for dealing with the multitude of ways that people are disadvantaged with gender being one, but not the only, location where they intersect.

Institute for Intersectionality Research and Policy

The Institute for Intersectionality Research and Policy at Simon Fraser University has become the hub around which intersectionality studies in Canada, particularly those related to health and social policies, have gravitated in recent years. The work here continues on the commitment to considering the multiple social locations that intersect to produce complex matrices of inequality. The Institute has produced a number of analyses and publications of varied scope and has developed a framework particularly focused on the analysis of health inequalities. When applied to health and health-related policies, the Intersectionality-Based Policy Analysis Framework (IBPA) is explicitly

[5] For a detailed discussion of how intersectionality differs from other approaches and what it adds to them, see Hankivsky, 2014, pp. 12-18.

intended to expand and improve upon both Gender Based Analysis and Health Impact Assessment (HIA - including those HIAs that employ an equity lens). "The IBPA can be used across all areas of policy, including but not limited to a broad range of health and health-related policies and programs. It can be used prospectively or retrospectively to consider questions of equity across all stages of the policy process" (Hankivsky et al., 2012, p. 7).

IBPA – Key Questions

Descriptive:

1. What knowledge, values and experiences do you bring to this area of policy analysis?
2. What is the policy "problem" under consideration?
3. How have representations of the "problem" come about?
4. How are groups differentially affected by this representation of the "problem"?
5. What are the current policy responses to the "problem"?

Transformative:

6. What inequities actually exist in relation to the problem?
7. Where and how can interventions be made to improve the problem?
8. What are feasible short-, medium- and long-term solutions?
9. How will proposed policy responses reduce inequities?
10. How will implementation and uptake be assured?
11. How will you know if inequities have been reduced?
12. How has the process of engaging in an intersectionality-based policy analysis transformed the following:
    - Your thinking about relations and structures of power and inequity?
    - The ways in which you and others engage in the work of policy development, implementation and evaluation?
    - Broader conceptualizations, relations and effects of power asymmetry in the everyday world?

(Cited from Hankivsky et al., 2012, pp. 39-42)

The IBPA framework revolves around a set of guiding principles (intersecting categories, multi-level analysis, power, reflexivity, time and space, diverse knowledges, social justice and equity) and 12 key questions, both descriptive and normative/transformative to be used either in considering policy/program options, or in evaluating those already in place.

IPBA combines a theoretical and conceptual approach to intersectionality with a practice-based framework that makes it particularly useful for those working in the area of health inequalities and public policy. It is meant to be adapted and applied as a tool for analyzing and formulating policies which promote greater equity. This new policy assessment tool can serve as a guide to understanding the ways that policies can and do impact groups and individuals differently depending on their social locations.

Intersectionality and the Social Determinants of Health

Recent work by Elizabeth McGibbon and colleagues also explicitly integrates an intersectionality-based approach with work on the social determinants of health and specifically with the consideration of oppression as a social determinant of health (McGibbon, 2012). McGibbon's approach thus fits with the approaches described above in putting power and power relations at the core of her considerations. McGibbon and McPherson further use intersectionality in combination with the social determinants of health and a specific attention to geography to describe what they call "synergies of oppression" (McGibbon & McPherson, 2011, p. 65). That is, this particular use of intersectionality attempts to tease out how intersections of the social determinants of health, those of identity categories (the "isms" as they are called) and those of geographies, create particular configurations of oppression where they intersect, which all impact on health and produce health inequalities. McGibbon's unique contributions include adopting an explicit position on how oppression operates as a social determinant of health as well as attending to the role played by geography and location.

All three of the approaches briefly described above have the potential to contribute to the attempts to reduce health inequalities in Canada by concentrating of relations of power and oppression as they impact the health of groups and individuals.

By looking specifically at the myriad ways that social locations intersect and produce advantage for some and disadvantage for others, intersectional approaches have the potential to contribute in important ways to understanding the production of disadvantage and how it may be countered.

Conclusion

Reducing health inequalities has become a focus of public health in recent years, both in the literature and in practice. These inequalities are related to broader social inequalities that are felt at every level of Canadian society. While some gains have been made over several decades, there is still a need to focus on the best ways to approach inequality. Intersectionality is an approach which draws our attention to the ways that social locations interact to produce advantage and disadvantage for groups and for individuals. It also helps us to consider how these positions interact with, and constituted by, social policy and social structures. Carrying this work forward in public health will add to our critical understanding of social inequalities in particular, as well as give us some help in addressing them.

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Related resources

Canadian Research Institute for the Advancement of Women: http://www.criaw-icref.ca/

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