The Problem With the Phrase *Women and Minorities:* Intersectionality—an Important Theoretical Framework for Public Health

Lisa Bowleg, PhD

Intersectionality is a theoretical framework that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism). Public health's commitment to social justice makes it a natural fit with intersectionality's focus on multiple historically oppressed populations. Yet despite a plethora of research focused on these populations, public health studies that reflect intersectionality in their theoretical frameworks, designs, analyses, or interpretations are rare. Accordingly, I describe the history and central tenets of intersectionality, address some theoretical and methodological challenges, and highlight the benefits of intersectionality for public health theory, research, and policy. (*Am J Public Health.* 2012;102:1267–1273. doi:10.2105/AJPH.2012.300750)

The term *women and minorities* is ubiquitously wedded in public health discourse, policy, and research. Take, for example, the *NIH [National Institutes of Health] Policy and Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research.*[1] The 2001 amended guidelines provide guidance on including women and minorities as participants in research and reporting on sex/gender and racial/ethnic differences. The problem with the "women and minorities" statement or the "ampersand problem"[2(p22)] is the implied mutual exclusivity of these populations. Missing is the notion that these 2 categories could intersect, as they do in the lives of racial/ethnic minority women.

Further compounding the issue is that the word *minority* is multidefinitional. Although it typically modifies race/ethnicity in the United States, *minority* also can reference populations such as lesbian, gay, bisexual, and transgender (LGBT) people; people with physical and mental disabilities; or, depending on geographic context, White people. Thus, in addition to being vague, the term *minority* in conjunction with *women* obscures the existence of multiple intersecting categories as exemplified by, for instance, a low-income Latina lesbian with a physical disability.

The notion that social identities are multiple and interlocking is not limited to the women and minorities discourse. The introduction to the US Department of Health and Human Service's (DHHS's) recent *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* acknowledges that

> characteristics such as race or ethnicity, religion, SES [socioeconomic status], gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status.[3(p2)]

This acknowledgment illustrates another conjunction problem—that of the "or." Pursuant to this logic, one's sexual orientation or gender identity or race/ethnicity may have an adverse effect on health, but nowhere in the report is there any indication of how the intersection of being, for example, a low-income Black gay or bisexual man might influence health. Acknowledging the existence of multiple intersecting identities is an initial step in understanding the complexities of health disparities for populations from multiple historically oppressed groups. The other critical step is recognizing how systems of privilege and oppression that result in multiple social inequalities (e.g., racism, heterosexism, sexism, classism) intersect at the macro social-structural level to maintain health disparities.

Enter intersectionality. Intersectionality is 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 (i.e., racism, sexism, heterosexism, classism) at the macro social-structural level.[4–7] Far from being just an exercise in semantics, intersectionality provides the discipline of public health with a critical unifying interpretive and analytical framework for reframing how public health scholars conceptualize, investigate, analyze, and address disparities and social inequality in health. The aforementioned DHHS report on health disparities and the even newer *National Prevention Strategy*[8] assert that the reduction and elimination of health disparities are a top national public health priority. This priority is further reflected in public health and biomedical journals, which are replete with health disparities research. Yet a key omission from most policy and research is first and foremost the recognition of multiple intersecting social identities and next an acknowledgment of how the intersection of multiple interlocking identities at the micro level reflects multiple and interlocking structural-level inequality at the macro levels of society.

The need for intersectionality as a unifying public health framework is further underscored by the relative dearth of theory and research that specifically address the multiple and interlocking influence of systems of privilege and oppression such as racism, sexism, and heterosexism. Instead, most public health research typically examines each system independently, "thus impairing efforts to understand the health of people whose lives cut across these diverse realisms of experiences."[9(p99)] Accordingly, I advocate for a greater awareness of intersectionality within public health. Intersectionality, I assert, provides a critical,

insightful, and unifying theoretical framework for guiding public health theory, research, surveillance, and policy. Hereafter, I refer to intersectionality synonymously as a theoretical framework or perspective.

A BRIEF HISTORY OF INTERSECTIONALITY

Intersectionality is rooted in Black feminist scholarship. Although feminist legal scholar Kimberlé Crenshaw[6] coined the term *intersectionality* to describe the exclusion of Black women from White feminist discourse (which equated women with White) and antiracist discourse (which equated Black with men) in the 1990s, the intersectionality concept is hardly new. Freed slave Sojourner Truth's[10] interrogation of the intersections of race and gender in her famous "Ain't I a Woman?" speech at the 1851 Women's Convention in Akron, Ohio, is one of the earliest recorded accounts of the intersectionality perspective. In the speech, Truth challenged the notion that being a woman (i.e., gender) and Black (i.e., race) are mutually exclusive:

> That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman?

The topic of intersectionality is a staple of women's studies and feminist legal studies,[4] is nascent in psychology[11,12] and interdisciplinary gender studies, but remains relatively scarce within mainstream public health. A November 10, 2011, PubMed search of the keyword *intersectionality* yielded just 49 results; not a single one was in a mainstream public health journal. Even an insightful 2008 article on intersectionality published in *Critical Public Health*[13] did not make the list. A same-date keyword search for *intersectionality* within the *American Journal of Public Health* (*AJPH*) found 7 records dating back to 2005. Of these, 4 referred to citations in the reference list, not the main text. Another *AJPH* keyword search for *intersection** returned 267 results, most of which referred to intersections of streets or disciplines. Only 26 of the 267 (10%) were articles that used the term *intersection* to refer to the intersection of race, ethnicity, gender, sexual orientation, and SES. Thus, for mainstream public health, a focus on intersectionality is both timely and overdue. The Institute of Medicine's Committee on LGBT Health's[14] 2011 report provides another case in point. Recognizing the promise of intersectionality for advancing research on LGBT health, the committee included intersectionality as 1 of 4 conceptual perspectives that shaped its work. Alas, the glossary's definition of intersectionality as "a theory used to analyze how social and cultural categories intertwine"(p318) and attribution of this definition to a 2006 conference presentation rather than the scholarly or peer-reviewed literature on intersectionality underscore a critical need for greater awareness of intersectionality within public health.

CORE TENETS OF INTERSECTIONALITY RELEVANT TO PUBLIC HEALTH

Although scholars sometimes refer to intersectionality as a theory,[4] it is not the kind of theory with which most social scientists are familiar. That is, intersectionality has no core elements or variables to be operationalized and empirically tested. For this reason, I avoid the term *theory* in favor of terms such as *theoretical framework* or *perspective* that denote intersectionality as more of an analytical framework or paradigm than a traditional testable theory. Indeed, intersectionality departs from traditional biomedical, biobehavioral, and psychosocial paradigms that have shaped medicine, public health, and the other social sciences in several key ways. A comprehensive discussion of these differences is beyond the scope of this article. Instead, I refer readers to Weber and Parra-Medina's[15] excellent chapter on intersectionality and women's health in which they elucidate the differences between the traditional biomedical, biobehavioral, and psychosocial paradigms and intersectionality.

I consider the core tenets of intersectionality most relevant to public health to be as follows: (1) social identities are not independent and unidimensional but multiple and intersecting, (2) people from multiple historically oppressed and marginalized groups are the focal or starting point, and (3) multiple social identities at the micro level (i.e., intersections of race, gender, and SES) intersect with macrolevel structural factors (i.e., poverty, racism, and sexism) to illustrate or produce disparate health outcomes.

Multiple Intersecting Identities

The most elemental tenet of intersectionality is the notion that social categories (e.g., race, SES, gender, sexual orientation) are not independent and unidimensional but rather multiple, interdependent, and mutually constitutive.[6,16,17] Far from representing a simple addition of social identities such as race (e.g., Black) plus gender (e.g., woman), the intersectionality perspective asserts that race and gender constitute each other such that one identity alone (e.g., gender) cannot explain the unequal or disparate outcomes without the intersection of the other identity or identities. Thus, harkening back to Sojourner Truth's "Ain't I a Woman?" query, the notion of her gender as a woman did not sufficiently explain the inequitable treatment she experienced without its intersection with her race. Fast forward 160 years after Truth's speech, and the unrelenting hold of health disparities among racial and ethnic minorities in the United States provides ample cause and opportunities to examine how multiple identities intersect to adverse effect. From an intersectionality point of view, attempting to understand or address health disparities via a single analytical category (e.g., gender or race or sexual orientation), as the DHHS report on health disparities implies, elides the complex ways in which multiple social categories intersect with social discrimination based on those multiple intersecting categories to create disparity and social inequality in health.

Historically Oppressed and Marginalized Populations

Technically speaking, we all have multiple intersecting identities. Universal intersectionality is not the province of intersectionality, however. Rather, another core tenet of intersectionality is its focus on the intersecting identities of people from historically oppressed and marginalized groups such as racial/ethnic minorities, LGBT people, low-income people, and those with disabilities. Because people from multiple historically oppressed and marginalized populations are its starting point, intersectionality examines the health of these

populations in their own context and from their vantage point rather than their deviation from the norms of White middle-class people.[15] Turns out, this makes good sense practically, not just theoretically.

Examples from HIV prevention research and practice with Black individuals, who represented 52% of new HIV cases in 2009 despite representing just 13% of the US population,[18] accentuate why fashioning health policy and prevention messages exclusively from the perspective of White middle-class populations does not always equal good public health practice. Take the case of Black men who have sex with men (MSM) who in 2009 represented 42% of new HIV cases among MSM.[18] Early in the HIV/AIDS epidemic, the Centers for Disease Control and Prevention (CDC) learned that HIV prevention messages targeted to gay and bisexual men were failing to resonate with Black and Latino MSM who did not identify as gay or bisexual. This recognition prompted a policy change of using the MSM nomenclature in HIV/AIDS surveillance activities and reports that is now well established in HIV prevention theory, research, and practice. The solution is far from perfect. MSM is a behavioral category, not an identity category. Thus, some MSM do not identify as MSM. Nonetheless, this policy change confirms the importance of shaping health policy from the perspective of multiple historically oppressed populations.

In 2009, Black women constituted 66% of women newly diagnosed with HIV despite representing just 13% of the female US population.[18] Many feminist HIV prevention scholars have chided the implicit White middle-class bias of many HIV/AIDS prevention messages targeted to racial/ethnic minority women. In an early critique of these messages, Mays and Cochran[19] derided as a "rather middle class notion"(p954) the public health directive that women should negotiate or communicate with their sexual partners about condom use and HIV risk. They explained that verbal communication about risk may be unrealistic and inapplicable to the lives of poor women who "may not bother to ask men about previous sexual or drug use behaviors because they know the men will lie or discount the risk"(p954) and cautioned developers of HIV prevention messages for low-income women of color to remember that "poor people do not always have the luxury of honesty, which is much easier when there is sufficient money and resources to guide one's choices."(p954)

Yet despite its emphasis on multiple socially disadvantaged statuses as a focal point, intersectionality does not presume that all interlocking identities are equally disadvantaged. Rather, intersectionality considers how low (e.g., racial minority, LGBT persons) and high (e.g., upper- or middle-class SES) status social identities intersect to yield disparity and advantage.[7,20] Accordingly, the intersectionality paradox is another of intersectionality's noteworthy, albeit underresearched, contributions to public health. The intersectionality paradox describes the result of adverse health outcomes at the intersection of a high status identity (i.e., middle-class SES) with race and gender for Black middle-class women and men.[21] An abundant empirical base documents the relation between higher SES and better health outcomes.[9,22–25] Paradoxically, this is not always the case for Black middle-class men and women as the disproportionate rates of infant mortality among highly educated Black women and homicide rates among Black middle-class men illustrate.[21] Infant mortality is a widely recognized indicator of a population's health.[26] Non-Latino Black people in the United States had an infant mortality rate 2.4 times that of non-Latino White people in 2006.[27] This disparity persists despite Black women's higher levels of education, a key measure of SES. The infant mortality rate for Black women with more than 13 years of education was almost 3 times higher than that for non-Latino White women in 2005.[27] Historically, the infant mortality rate of highly educated Black women has exceeded that of non-Latino White women with less education,[21] highlighting the paradox of the intersection of SES, race, and gender for Black women in the United States.

The paradox is also evident for Black men, for whom homicide is a critical public health issue. Homicide does not appear on the list of the 10 leading causes of death for men in the aggregate. In 2008, however, homicide was the fifth leading cause of death for Black men of all ages in the United States and the leading cause of death for Black males aged 15 to 44 years.[28] Lower homicide rates are often inversely associated with higher SES,[29,30] but the higher SES of Black men conveys no such advantage. In 1994, the homicide rate for Black men with some college education was 11 times that of White men with similar levels of education. Emphatically, Jackson and Williams[21] concluded, "strikingly, the homicide rate of Black males in the highest education category exceeds that of White males in the lowest education group!"(p148) Thus, intersectionality provides a more comprehensive insight into how multiple social identities intersect in complex ways to show social inequality. This notwithstanding, it is important to segue here and note that although updated homicide rate data by age, race, gender, and Hispanic origin are easily locatable at the CDC's National Vital Statistics System Web site, education data are not. The omission of education data (or at least easily retrievable data) shows how the absence of critical data such as SES obscures the more complex understanding of public health issues that an intersectionality analysis facilitates.

Social-Structural Context of Health

Whether using language such as "social determinants of health,"[31] "social discrimination or social inequality,"[9,32] "fundamental causes,"[33–35] "structural factors or influences,"[36] or "ecological or ecosocial influences,"[37,38] an ever-growing chorus of public health scholars have advocated for a greater focus on how social-structural factors beyond the level of the individual influence health. This too is a core tenet of intersectionality. Moreover, a central consideration of intersectionality is how multiple social identities at the individual level of experience (i.e., the micro level) intersect with multiple-level social inequalities at the macro structural level. From an intersectionality perspective, a middle-class Latina lesbian's negative experiences at her physician's office are linked to multiple and interlocking sexism, heterosexism, and racism at the macro level. Her microlevel experiences at the intersection of her race/ethnicity, sexual orientation, and gender correspond with empirically documented evidence of the heterosexism that lesbian and bisexual women often encounter when they seek health care services[39,40] and the intersection of racism and sexism well documented

in research on racial/ethnic minority women's health care experiences.[9,41,42] Alas, with the exception of a 1988 study focused on Black lesbian and bisexual women's experiences of disclosing their sexual identity to physicians,[43] much of the research on lesbian and bisexual women's experiences in health care settings stems from research with predominantly White middle-class lesbian and bisexual women. Similarly, much of the research on racial/ethnic minority women's experiences in health care settings does not include or report sexual orientation data or presumes heterosexuality, thereby limiting an in-depth understanding of women's experiences in health care settings beyond the intersections of gender and race.

THEORETICAL AND METHODOLOGICAL CHALLENGES

Feminist sociologist Leslie McCall[44] has heralded intersectionality as "the most important theoretical contribution that women's studies, in conjunction with related fields, has made so far."[(p1771)] Although many scholars concur with McCall's assessment, many continue to "grapple with intersectionality's theoretical, political, and methodological murkiness."[20(p1)] This murkiness may simultaneously be a strength because it provides seemingly endless opportunities for debate, theorizing, and research.[4]

Theoretical Challenges

At least 2 theoretical challenges relevant to the integration of intersectionality within public health exist: (1) determining which social categories intersectionality should include and (2) recognizing that intersectionality was not developed to predict behavior or mental processes[45] or health. First, as I have noted previously, Black women were the original subjects of intersectionality. Accordingly, the intersections of race and (female) gender in the lives of women of color[6,7,17,46] and women's health[11,15,47] have been the primary focus of intersectionality. Contemporary critiques of intersectionality's historic focus on race and gender have problematized the issue of treating Black women as a monolith, obscuring within-group differences such as sexual orientation and SES, for example.[20] Other critiques note that social identities are not "*trans*-historical constants"[20(p5)] but vary historically and by context.

Framed from a public health perspective, however, intersectionality's promise lies in its potential to elucidate and address health disparities across a diverse array of intersections including, but not limited to, race, ethnicity, gender, sexual orientation, SES, disability, and immigration and acculturation status. Thus, consistent with Collins's notion of an intersectional "matrix of domination,"[7(p225)] my view of intersectionality includes and transcends women of color to include all people whose microlevel and macrolevel experiences intersect at the nexus of multiple social inequalities and is broad enough to include populations who inhabit dimensions of social privilege and oppression simultaneously (e.g., Black heterosexual men; White low-income women). Hankivsky and Christoffersen[13] aptly sum up intersectionality's theoretical complexity: "Without doubt, this framework complicates everything."[(p279)]

Another challenge is how to transform a perspective that was designed primarily as an analytical framework into one that can empirically examine multiple intersecting social identities and resultant multiple macrolevel structural inequality. Predicting and testing the effect of intersectionality on health behavior outcomes and mental processes have never been the focus of intersectionality.[45] Thus, for public health and other social science researchers, the absence of theoretically validated constructs that can be empirically tested poses not only a major challenge but also tremendous opportunities for advancing the study of intersectionality from a public health perspective.

Methodological Challenges

As for methodological challenges, there is ample consensus that a paucity of knowledge about how to conduct intersectionality research exists.[12,13,20,44,48] Although qualitative methods or mixed methods appear to be ideally suited to intersectionality's implicit complexity and multiplicity,[13,16,48] the challenges of conducting intersectionality research quantitatively are especially daunting.[44,48] Among the many challenges are (1) the absence of guidelines for quantitative researchers who wish to conduct intersectionality research[12]; (2) the fact that the task of investigating "multiple social groups within and across analytical categories and not on complexities within single groups, single categories or both"[44(p1786)] is often complex and complicated, necessitating the use of interaction effects or multilevel or hierarchal modeling, which bring further "complexity in estimation and interpretation than the additive linear model" [44(p1788)]; and (3) the fact that many statistical methods often rely on assumptions of linearity, unidimensionality of measures, and uncorrelated error components[49] that are incongruent with the complex tenets of intersectionality. More quantitative methodologies are critically needed "to fully engage with the set of issues and topics falling broadly under the rubric of intersectionality."[44(p1774)]

Even so, public health scholars need not wait for the methodological challenges of intersectionality to be resolved to incorporate intersectionality into their theoretical frameworks, designs, analyses, and interpretations. Methodological revolution is simply not essential to the advancement of intersectionality. Instead, what is needed is an intersectionality-informed stance. This stance involves a natural curiosity and commitment to understanding how multiple social categories intersect to identify health disparity. It also involves the a priori development of questions and measures to facilitate analyses about intersectionality. At a minimum, this would involve collecting data on race, ethnicity, age, SES, gender (including gender categories relevant to transgender people), sexual identity, sexual behavior (see my earlier comments about MSM), and disability status. At the interpretation phase, the stance would include an interdisciplinary approach in which "the researcher locates the particular sample within historical and socioeconomic circumstances, regardless of the particular character of the sample."[16(p177)] How researchers interpret their data is as important as the methodological choices they make about sampling, sample sizes, or using qualitative or quantitative methods.[16] The definition of data can be expanded to include empirically collected data "AND other sources of information"[(p177)] such as historical materials, results from other studies, social theories, and the analysts' tacit knowledge. Cuadraz and Uttal[16] caution researchers not to "subsume

or privilege"[pp177–178] one social category over another but rather to

> strive to contextualize data within the multiple intersectionalities of historical structures, cultures, ideologies and policies. [This will result] in studies that more accurately reflect the social realities of inequality and power in society, yet at the same time not lose site [sic] of the individual experiences that reflect, shape, and construct those social structures.[p178]

INTERSECTIONALITY'S BENEFITS FOR PUBLIC HEALTH

Intersectionality is ideally suited to join the ranks of other critical theories such as critical race theory[50–52] and various feminist[53] and gender[54–56] theories applied to public health issues. Intersectionality is an especially close ally of critical race theory. Indeed, key intersectionality theorists such as Kimberlé Crenshaw[57] and Patricia Hill Collins[7] are also critical race theorists. Developed in the 1970s by legal scholars, lawyers, and activists, critical race theory asserts at least 5 key tenets.[58] First, racism in the United States is not aberrant but an ordinary and immutable characteristic of everyday life for people of color. Second, critical race theory asserts that White supremacy manifests in 2 features that serve psychic and material purposes: ordinariness and interest convergence. Ordinariness highlights the mundane and seemingly incurable nature of racism. That is, because racism is so commonplace and ordinary, "color-blind" legal remedies that tout meritocracy mainly serve the material interests of White elite individuals and the psychic interests of White working class people. *Interest convergence,* a term coined by Derrick Bell,[59] one of the pioneers of critical race theory, posits that White people will support and encourage policies and initiatives that advance the interests of Black people only to the extent that these policies and initiatives serve the interests of White people. This was the crux of Bell's provocative argument that *Brown v. Board of Education,*[60] the landmark 1954 US Supreme Court civil rights public school desegregation case, was more motivated by White people's self-interest than by interest in advancing the legal rights of Black people. Third, critical race theory focuses on the social construction of race. The notion that race is not a biological reality but a socially constructed one is well documented in the scientific literature.[61,62] The fact that society routinely ignores scientific evidence about the socially constructed nature of race bolsters critical race theory's assertions about the salience and permanence of racism as a defining and enduring characteristic of everyday life for people of color in the United States. Moreover, because race is socially constructed, many contemporary critical race theorists emphasize how dominant groups have historically racialized different minority groups to respond to the varying needs of the labor market. Critical race theory's focus on the socially constructed nature of race dovetails with contemporary intersectionality theorists' emphasis on the socially constructed nature of social identities.[20,63] That is, critical race theory recognizes that race and racism intersect with other social identities such as gender, sexual orientation, and SES and interlocking systems of oppression such as sexism, heterosexism, and classism. Fourth, critical race theory emphasizes the importance of narratives or "storytelling" from people of color to counter White supremacy and privilege the voices of people of color. In this way, critical race theory's focus on the centrality of the experiences and voices of people of color parallels intersectionality's emphasis on historically marginalized people as its focal point.[15] Last, but hardly least, critical race theorists, like intersectionality theorists, share a commitment to social justice and advocacy. Although critical race theory has had its debut in the mainstream public health literature,[50–52] intersectionality has not.

One of intersectionality's greatest strengths is its broad embrace of multiple intersecting identities and multiple interlocking privilege and oppression. No social category or form of social inequality is more salient than another from an intersectionality perspective. Social categories are not additive and thus cannot be ranked. As such, intersectionality is a substantially useful but woefully underused critical theoretical framework for public health.

Although intersectionality provides no methodological panacea for the myriad and complex health issues and problems that are the province of public health, the advantages of intersectionality for public health theory and research far outweigh the challenges. Intersectionality stands to benefit public health in at least 5 noteworthy ways. First, intersectionality provides a unifying language and theoretical framework for public health scholars who are already engaged in investigating intersections of race, ethnicity, gender, sexual orientation, SES, and disability to reduce and eliminate health disparities. Having scholars from diverse disciplines incorporate the intersectionality framework as an analytical perspective regardless of methodological approach[16] and explicitly use the word intersectionality in their titles, keywords, abstracts, or articles would facilitate a cohesive body of theoretical and empirical knowledge about multiple intersecting social categories and social inequality that could inform health policy, practice, and interventions and further theoretical and methodological advancement and refinement of intersectionality.

Second, intersectionality prompts public health scholars to conceptualize and analyze disparities and social inequalities in health in the complex and multidimensional ways that mirror the experiences of the populations for whom adverse health outcomes are most disproportionate. From intersectionality's perspective, single or dual analytical categories such as race and gender offer limited explanatory power. Intersectionality also provides a theoretical lens for interpreting novel or unanticipated findings. This was the conclusion that Kertzner et al.[64] reached when they determined that their additive social stress model showed no diminished well-being among racial/ethnic minority lesbians or gay men: "Studying identity intersection (Black poor women) will be more informative than studying Blacks, women and poor individuals separately."[p508]

Third, intersectionality's focus on the importance of macrolevel social-structural factors aligns well with contemporary advocacy to consider the substantial effect of factors beyond the level of the individual on health. SES, for example, is one of the best predictors of health status.[65] Furthermore, intersectionality expands this focus to consider the intersection of multiple-level social-structural factors as well as the intersection between multiple microlevel and macrolevel factors. Privileging a focus on structural-level factors rather than an exclusive focus on the individual is likely to facilitate the development of structural-level

interventions more likely to affect the "fundamental causes" (e.g., poverty, social discrimination) of social inequalities in health in the United States.[15,21,33–35,66]

Fourth, because intersectionality takes the experiences of historically oppressed or marginalized populations as its vantage point, it can facilitate and inform the development of well-targeted and cost-effective health promotion messages, interventions, and policies. Indeed, this was one of the rationales that Dr. Garth Graham,[67] the DHHS Director of Minority Health, advanced in response to the DHHS new draft standards for health data collection:

> These new data standards, once finalized, will help us target our research and tailor stronger solutions for underserved and minority communities. To fully understand and meet the needs of our communities, we must thoroughly understand who we are serving.[p1]

Finally, the intersectionality perspective naturally summons and supports the collection, analysis, and presentation of surveillance and health data that allow examination of multiple interlocking social identities across several categories beyond race and gender. A critical need exists, for example, for more health data on SES at the individual, household, and neighborhood level[65] to advance knowledge about how SES intersects with other social identities to influence disparities and social inequality in health. The DHHS's[67] June 29, 2011, announcement of its draft guidelines to improve how the nation's health data are collected and reported by race, ethnicity, sex, primary language, and disability status and of its plans to collect LGBT health data is noteworthy. Collection of these data can facilitate greater understanding of the effect of multiple intersecting identities on social inequalities in health. Yet the absence of any mention of SES is a curious and critical omission from the list of data essential to understanding and addressing health disparities and social inequality.

TOWARD AN INTERSECTIONALITY-INFORMED PUBLIC HEALTH

Intersectionality is critical to public health because it "embraces rather than avoids the complexities that are essential to understanding social inequities, which in turn manifest in health inequities."[13(p279)] This makes the relative invisibility of intersectionality within the discipline of public health all the more puzzling. The discipline of public health, like intersectionality, is interdisciplinary. More importantly, public health's commitment, as the American Public Health Association's[68] mission statement affirms, to "working to improve the public's health and to achieve equity in health status for all"[p1] is an ideal mesh with intersectionality's social justice bent.[13] Complex multidimensional issues such as entrenched health disparities and social inequality among people from multiple historically oppressed and marginalized populations beg novel and complex multidimensional approaches. Intersectionality is the critical, unifying, and long overdue theoretical framework for which public health has been waiting. ■

About the Author

Lisa Bowleg is with the Department of Community Health and Prevention, School of Public Health, Drexel University, Philadelphia, PA.

Correspondence should be sent to Lisa Bowleg, PhD, Department of Community Health and Prevention, School of Public Health, Drexel University, 1505 Race St, 11th Floor (Mailstop 1032), Philadelphia, PA 19102 (e-mail: iab26@drexel.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted February 20, 2012.

Acknowledgments

I am grateful to the graduate students in my Spring 2011 Intersectionality and Public Health course for their intellectual and passionate engagement with the course's materials. Their enthusiasm for learning about intersectionality and stated desire to have intersectionality infused throughout the graduate public health curriculum served as the catalyst for this article. I also appreciate the assistance of my project director, Jenné Massie, MHS, and Brogan Piecara, an undergraduate summer intern who provided research assistance for this article.

Human Participant Protection

Institutional review board approval was not needed because no human participants were involved.

References

1. Office of Extramural Research, National Institutes of Health. *NIH Policy and Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research – Amended, October, 2001*. 2001. Available at: http://grants.nih.gov/grants/funding/women_min/guidelines_amended_10_2001.htm. Accessed April 27, 2011.

2. Spelman EV. Gender and race: the ampersand problem in feminist thought. In: Ruth S, ed. *Issues in Feminism: An Introduction to Women's Studies*. 4th ed. Mountain View, CA: Mayfield; 1998:22–34.

3. US Dept of Health and Human Services. *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*. 2011. Available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. Accessed June 1, 2011.

4. Davis K. Intersectionality as buzzword: a sociology of science perspective on what makes a feminist theory successful. *Feminist Theory*. 2008;9(1):67–85.

5. Crenshaw KW. The intersection of race and gender. In: Crenshaw KW, Gotanda N, Peller G, Thomas K, eds. *Critical Race Theory: The Key Writings That Formed the Movement*. New York, NY: The New Press; 1995: 357–383.

6. Crenshaw KW. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev*. 1991;43(6):1241–1299.

7. Collins PH. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York, NY: Routledge; 1991.

8. National Prevention Council. *National Prevention Strategy: American's Plan for Better Health and Wellness*. Washington, DC: US Dept of Health and Human Services, Office of the Surgeon General; 2011. Available at: http://www.healthcare.gov/center/councils/nphpphc/strategy/report.pdf. Accessed June 16, 2011.

9. Krieger N, Rowley DL, Herman AA, Avery B, Phillips MT. Racism, sexism, and social class: implications for studies of health, disease, and well-being. *Am J Prev Med*. 1993;9(6):82–122.

10. Truth S. Ain't I a woman? [account by Gage F] 1851. Available at: http://womenshistory.about.com/od/sojournertruth/a/aint_i_a_woman.htm. Accessed January 15, 2007.

11. Weber L. A conceptual framework for understanding race, class, gender, and sexuality. *Psychol Women Q*. 1998;22(1):13–32.

12. Cole ER. Intersectionality and research in psychology. *Am Psychol*. 2009;64:170–180.

13. Hankivsky O, Christoffersen A. Intersectionality and the determinants of health: a Canadian perspective. *Crit Public Health*. 2008;18(3):271–283.

14. Committee on Lesbian Gay, Bisexual and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011.

15. Weber L, Parra-Medina D. Intersectionality and women's health: charting a path to eliminating health disparities. In: Segal MT, Demos V, Kronenfeld, eds. *Gender Perspectives on Health and Medicine (Advances in Gender Research, Volume 7)*. Bingley, UK: Emerald Group Publishing; 2003:181–230.

16. Cuadraz GH, Uttal L. Intersectionality and in-depth interviews: methodological strategies for analyzing race, class, and gender. *Race Gender Class*. 1999;6:156–181.

17. Collins PH. Symposium: On West and Fenstermaker's "Doing Difference." *Gend Soc*. 1995;9(4): 491–494.

18. Centers for Disease Control and Prevention. HIV Surveillance Report, 2009. Vol 21. February 2011. Available at: http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf. Accessed February 28, 2011.

19. Mays VM, Cochran SD. Issues in the perception of AIDS risk and risk reduction activities by Black and

Hispanic/Latina women. *Am Psychol.* 1988;43(11): 949–957.

20. Nash JC. Re-thinking intersectionality. *Fem Rev.* 2008;89:1–15.

21. Jackson PB, Williams DR. The intersection of race, gender and SES: health paradoxes. In: Schulz AJ, Mullings L, eds. *Gender, Race, Class, & Health: Intersectional Approaches.* San Francisco, CA: Jossey-Bass; 2006:131–162.

22. Adler NE, Boyce WT, Chesney MA, Folkman S, Syme SL. Socioeconomic inequalities in health: no easy solution. *JAMA.* 1993;269(24):3140–3145.

23. Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. *Health Aff (Millwood).* 2002;21(2):60–76.

24. Adler NE, Ostrove JM. Socioeconomic status and health: what we know and what we don't. *Ann N Y Acad Sci.* 1999;896:3–15.

25. Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: what the patterns tell us. *Am J Public Health.* 2010;100(suppl 1):S186–S196.

26. Reidpath DD, Allotey P. Infant mortality rate as an indicator of population health. *J Epidemiol Community Health.* 2003;57(5):344–346.

27. Mathews TJ, MacDorman MF. Infant mortality statistics from the 2006 period linked birth/infant death data set. *Natl Vital Stat Rep.* 2010;58(17):1–31.

28. Centers for Disease Control and Prevention. LCWK3. Deaths, percent of total deaths, and death rates for the 15 leading causes of death in selected age groups, by race, and sex: United States, 2008. 2011. Available at: http://www.cdc.gov/nchs/data/dvs/LCWK3_2008.pdf. Accessed April 28, 2012.

29. Cubbin C, Smith GS. Socioeconomic inequalities in injury: critical issues in design and analysis. *Annu Rev Public Health.* 2002;23:349–375.

30. Cubbin C, LeClere FB, Smith GS. Socioeconomic status and the occurrence of fatal and nonfatal injury in the United States. *Am J Public Health.* 2000;90(1):70–77.

31. Wilkinson R, Marmot M, eds. *Social Determinants of Health: The Solid Facts.* 2nd ed. Copenhagen, Denmark: WHO Regional Office for Europe; 2003. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf. Accessed April 1, 2011.

32. Krieger N. Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. *Int J Health Serv.* 1999; 29(2):295–352.

33. Link BG, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav.* 1995;Spec No:80–94.

34. Link BG, Phelan JC. Understanding sociodemographic differences in health: the role of fundamental social causes. *Am J Public Health.* 1996;86(4):471–473.

35. Link BG, Phelan JC. Evaluating the fundamental cause explanation for social disparities in health. In: Bird C, Conrad P, Fremont AM, eds. *Handbook of Medical Sociology.* 5th ed. Upper Saddle River, NJ: Prentice-Hall; 2000:33–46.

36. Geronimus AT. To mitigate, resist, or undo: addressing structural influences on the health of urban populations. *Am J Public Health.* 2000;90(6):867–872.

37. Buffardi AL, Thomas KK, Holmes KK, Manhart LE. Moving upstream: ecosocial and psychosocial correlates of sexually transmitted infections among young adults in the United States. *Am J Public Health.* 2008;98(6): 1128–1136.

38. Hobfoll SE. Ecology, community, and AIDS prevention. *Am J Community Psychol.* 1998;26(1):133–144.

39. Diamant AL, Wold C, Spritzer K, Gelberg L. Health behaviors, health status, and access to and use of health care: a population-based study of lesbian, bisexual, and heterosexual women. *Arch Fam Med.* 2000;9(10): 1043–1051.

40. Aaron DJ, Markovic N, Danielson ME, Honnold JA, Janosky JE, Schmidt NJ. Behavioral risk factors for disease and preventive health practices among lesbians. *Am J Public Health.* 2001;91(6):972–975.

41. van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. *Soc Sci Med.* 2000;50(6):813–828.

42. Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340(8):618–626.

43. Cochran SD, Mays VM. Disclosure of sexual preference to physicians by Black lesbian and bisexual women. *West J Med.* 1988;149:616–619.

44. McCall L. The complexity of intersectionality. *Signs.* 2005;30(3):1771–1800.

45. Syed M. Disciplinarity and methodology in intersectionality theory and research. *Am Psychol.* 2010; 65(1):61–62.

46. Crenshaw KW. Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *Univ Chic Leg Forum.* 1989;139:139–167.

47. Ruzek S, Olesen V, Clarke A, eds. *Women's Health: Complexities and Differences.* Columbus: Ohio State University Press; 1997.

48. Bowleg L. When Black + lesbian + woman ≠ Black lesbian woman: the methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles.* 2008;59(5-6):312–325.

49. McGrath JE, Johnson BA. Methodology makes meaning: how both qualitative and quantitative paradigms shape evidence and its interpretation. In: Camic PM, Rhodes JE, Yardley L, eds. *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design.* Washington, DC: American Psychological Association; 2003:31–48.

50. Ford CL, Airhihenbuwa CO. Critical race theory, race equity, and public health: toward antiracism praxis. *Am J Public Health.* 2010;100(suppl 1):S30–S35.

51. Ford CL, Airhihenbuwa CO. The public health critical race methodology: praxis for antiracism research. *Soc Sci Med.* 2010;71(8):1390–1398.

52. Graham L, Brown-Jeffy S, Aronson R, Stephens C. Critical race theory as theoretical framework and analysis tool for population health research. *Crit Public Health.* 2011;21(1):81–93.

53. Amaro H, Raj A, Reed E. Women's sexual health: the need for feminist analyses in public health in the Decade of Behavior. *Psychol Women Q.* 2001;25(4):324–334.

54. Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Soc Sci Med.* 2000;50(10):1385–1401.

55. Wingood GM, DiClemente RJ. Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Educ Behav.* 2000;27(5):539–565.

56. Amaro H. Love, sex, and power: considering women's realities in HIV prevention. *Am Psychol.* 1995;50:437–447.

57. Crenshaw K. *Critical Race Theory: The Key Writings That Formed the Movement.* New York, NY: New Press; 1995.

58. Delgado R, Stefancic J. *Critical Race Theory: An Introduction.* New York New York University Press; 2001.

59. Bell DA Jr. *Brown v. Board of Education* and the interest-convergence dilemma. *Harv Law Rev.* 1979;93: 518–533.

60. *Brown v Board of Education,* 347 U.S. 483 (1954).

61. Krieger N. Stormy weather: race, gene expression, and the science of health disparities. *Am J Public Health.* 2005;95(12):2155–2160.

62. Yudell M. A short history of the race concept. In: Krimsky S, Sloan K, eds. *Race and the Genetic Revolution: Science, Myth and Culture.* New York, NY: Columbia University Press; 2011:13–30.

63. Brah A, Phoenix A. Ain't I a woman? Revisiting intersectionality. *J Int Womens Stud.* 2004;5:75–91.

64. Kertzner RM, Meyer IH, Frost DM, Stirratt MJ. Social and psychological well-being in lesbians, gay men, and bisexuals: the effects of race, gender, age, and sexual identity. *Am J Orthopsychiatry.* 2009;79(4):500–510.

65. Krieger N, Williams DR, Moss NE. Measuring social class in U.S. public health research: concepts, methodologies, and guidelines. *Annu Rev Public Health.* 1997; 18:341–378.

66. Weber L, Fore ME. Race, ethnicity, and health: an intersectional approach. In: Vera H, Feagin JR, eds. *Handbooks of the Sociology of Racial and Ethnic Relations.* New York, NY: Springer; 2007:191–218.

67. US Dept of Health and Human Services. Affordable Care Act to improve data collection, reduce health disparities [news release]. 2011. Available at: http://www.hhs.gov/news/press/2011pres/06/20110629a.html. Accessed June 29, 2011.

68. American Public Health Association. Vision/Mission. 2011. Available at: http://www.apha.org/about/gov/execboard/executiveboardvisionmission.htm. Accessed July 21, 2011.

This article has been cited by:

1. Gniesha Y. Dinwiddie, Ruth Enid Zambrana, Mary A. Garza. Exploring Risk Factors in Latino Cardiovascular Disease: The Role of Education, Nativity, and Gender. *American Journal of Public Health*, ahead of printe1-e9. [Abstract] [PDF] [PDF Plus]