

SOCIO-CULTURAL INEQUITIES IN HEALTH RESEARCH: WHAT DOES THE INTERSECTIONALITY FRAMEWORK OFFER?

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The diversity turn in health care

The case for diversity-sensitive health care research and practice is relatively easy to make in current times. Access, safety and quality for all people are at the forefront of practice concerns, although pressures come from different directions such as the World Health Organization, the Dutch Council for Health Research, and the Canadian Institutes of Health Research. The current diversity literature focuses almost exclusively on difference, which paradoxically serves to produce more difference and exclusions, e.g., in calls for ‘culturally specific’ health care services and service providers. As a consequence, the possibilities enabled through the forging of alliances based on similarities are relatively unexplored. In addition, power relations are frequently ignored, so that research in this area often fails to take a critical perspective on problems. In contrast, the intersectionality approach attends to socio-cultural commonalities as well as inequities.

The origin of the intersectionality approach lies in Black Women’s Studies with the view that Black women’s lives could not adequately be understood from either a ‘race’ *or* a gender perspective. Kimberle Crenshaw (1991) first used the term in her analysis of the intersection of ‘race’ and gender in relation to discrimination against women of colour. She aimed to transcend the problem of identity politics within second wave feminism, whereby inequities other than gender differences were ignored or downplayed and multiple oppressions were treated as the sum of distinct, individual oppressions with varying import (Mann and Huffman, 2005). Thus, the intersectionality approach addresses many of the concerns raised within the fields of medical anthropology and feminist health care (Mullings, 2005). In this contribution, we explore the methodological challenges and possible solutions associated with adopting the intersectionality approach within health care research.

The intersectional approach

Although there are now several accounts of the intersectionality approach, they share three characteristics - the assumption that the effects of social categories are intertwined, a recognition that power is ubiquitous, and in the European context at least, a predominantly postmodern conceptualization of social categories and power. These commonalities constitute the framework for our application of intersectionality.

Social categories are intertwined

The inequities and commonalities associated with, for example, gender, 'race', class, and age are thought to occur together, being inseparable and intertwined. Consequently, they simultaneously affect everyday and professional life. For instance, the sexual interest imputed to men varies with skin colour, with Black men stereotyped as more sexually active than White men. Similarly, White women are stereotyped as less assertive than Black women, and people take for granted that senior men and women are heterosexual. One strength of an intersectional approach then is sensitivity to the complexity associated with categories of difference.

The ubiquity of power

Socio-cultural inequities and commonalities are understood to be produced by, and to produce, power relations. Thus, groups and communities acquire a minority position as the outcome of socio-historical and political processes, i.e., being a minority is not a status based on some inherent properties. Importantly, minority positions are never unequivocal as they usually consist of an intersection of various oppressions and privileges, vulnerabilities and resiliences. Examples of this contradictory mixing of membership within a disadvantaged group together with a privileged identity include middle- or upper-class Blacks, White women, gay men, and able-bodied seniors. Thus, another contribution of an intersectional approach is to highlight that social differences are always about power, and that power positions may be hybrid.

A postmodern conceptualization of social categories and power

Categories (or axes) of social difference are constructed through people's everyday activities: people 'do' differences in gender, ethnicity, class, and so on, while also being positioned by

others as women, White, middle class, and so on. Thus, attention is focused on an individual's social location at the intersection of a complex set of identities (e.g., Brah & Phoenix, 2004).

Importantly, constructing difference may create the problem of ignoring similarities. For example, an individual can be both different (female rather than male) from others and similar (same age) to them, depending on the context of comparison. Moreover, when and where particular differences matter is subject to variations of time and place.

Furthermore, social differences have multiple dimensions, including at least the symbolic (cultural), social (structural) and personal. When applied to health care, economic, political, interpersonal, and biological dimensions become relevant and useful. These dimensions are viewed as continua that may change over time, with histories related to the local context. Thus, the interaction of an individual's actions and their biology are assumed to shape and maintain the social categories and their cultural significance, frequently mediated by social interactions. Gender, for example, is built up by processes of identification, internalisation and imitation, socialisation, social representation, social positioning, and acculturation. Over time, these processes constitute 'spirals of difference' although they may also diminish each other and smooth over the differences. The particularities of how they are constructed depend on the specific historical moment and social context.

Power is conceptualised as a continuously circulating and dynamic force, impinging on all social relations. It encompasses discursive power; is inherent in the relations of social difference, such as sexism, racism, classism, ageism, and heterosexism; produces moral, economic, and social capital; and is implicated in mental and physical dominance as well as social, mental and physical vulnerabilities and strengths. Thus, power produces as well as constrains how we understand ourselves and our world, as well as what we do.

By avoiding mono-dimensional categories and a priori dichotomies in analyzing social differences and power relations, previously unnoticed nuances and hybridity can be identified. Below, we address, firstly, what this multi-axis and power-conscious intersectionality lens contributes to the project of promoting equity in health care access, and secondly, how this lens can be translated into methodological principles for health (care) research.

Access to health care

An intersectional approach enables systematic exploration of within-group variation as well as commonalities and differences across groups. The focus on within-group variation enhances

the visibility of those who were hitherto not noticed within the health care system, because of their hybrid position on one or more categories. For example, heterosexual women with HIV/AIDS were invisible for a long period of time, because professional attention was exclusively oriented towards gay men. An intersectional approach would draw attention to gender *and* sexuality.

Commonalities across groups also become visible due to the multi-dimensional lens of intersectionality. When recognized, they provide opportunities for coalitions between patient groups. For example, two of the patient characteristics that are impediments for immigrants needing to access Dutch health care, linguistic skills and health illiteracy, are also a problem for autochthonous, working class patients. Thus, both groups have an interest in the simplification of health information and regulations. Similarly, the commonalities between older people and people with disabilities offer opportunities for alliances regarding the accessibility of buildings and the terms of health insurance.

The intersectional lens also illuminates the complex power positionings of minoritized people as well as the power relations between those seeking help and health care providers. Firstly, health care providers can identify clients' strengths associated with possible privileged positions in terms of education, income, physical abilities or social networks. This could enhance the quality of care by recognizing what clients can do for themselves and developing strategies for filling in the gaps (i.e., empowerment). Secondly, it makes clear how health care access and quality may suffer when health care professionals are unfamiliar with the stresses associated with their own positions (both minority and privileged) as well as those of their clients (Pheterson, 1986). Thirdly, it draws attention to the complex array of regulations and practices associated with hospitals and clinics that are designed to deliver benefits, but may also be oppressive or exclude some clients. Generally, clinical guidelines are tailored to a 'standard' person, who arguably does not exist, and clients rarely have the opportunity to choose a health care professional based on similarities or differences with respect to ethnicity gender, age, and sexual orientation. The health care provider also controls the linguistic domain by determining the language of communication and may (but likely not) invest in the services of interpreters. Similarly, the food provided and visitor restrictions may not meet the needs of all clients. Finally, policies and laws, e.g., regarding immigration and residency status, may result in the exclusion of "illegal" men and women from the health care system.

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A heuristic device for intersectional health care research

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There is no consensus on the appropriate research methods for an intersectional approach. Some researchers advocate complex designs involving prohibitively large heterogeneous samples or interdisciplinary teams that allow for triangulation; others simplify the intersectional approach to a set of demographic variables, e.g. race, gender, etc., and the interactions among these variables that are included in their statistical models; and some argue that only qualitative research methods, such as ethnography and depth interviews, guarantee that the analysis will focus on the effects of multiple, intertwined social differences (Mens-Verhulst and Radtke, 2006; 2008) .

Recently however, Elisabeth Cole (2009) has offered three questions that may serve as a heuristic device for incorporating an intersectional approach into one's research: (1) Who is included within this category? (2) Where are there similarities? (3) What role does inequality play? These questions must be answered at each stage of the research process from the development of hypotheses to data collection, analysis and interpretation. Below, we adapt them to a health care research context, using the experience of the first author in the pilot project "Aspiring to Healthy Living" (AtHL). This project explored the healthy living representations of Dutch and Moroccan seniors, who live in The Netherlands with low socio-economic status, as a first step in developing a preventive health care intervention (van Mens-Verhulst & van Bavel, 2005). When appropriate, we point out parallel applications to quantitative research.

Who is included within this category?

Sampling decisions need to be based on which categories influence the health condition or access to the health care service of interest. Expert opinion and members of the group to be studied are two sources that can be used to ascertain the relevant categories, and then, to develop hypotheses and sampling criteria. For example, in the AtHL-project, we included ethnicity and sex/gender in addition to age, because we assumed that these differences would influence senior's health representations. Consequently, we used purposive sampling to obtain groups of eight autochthonous, as well as immigrant, men and women, a strategy that is akin to stratified sampling in quantitative research.

The *operationalisation* of specific categories entails its own problems, due to the complexity of the possible dimensions involved. In our case, ethnicity was operationalized as autochthonous citizens and Muslim immigrants, more specifically first-generation Moroccans. This decision then influenced our definition of a 'senior', because the criterion of

chronological age was inadequate (i.e., 55-75 years of age). Moroccan men enter the senior stage of life almost ten years earlier than Dutch men in terms of leaving the labour force and having grandchildren; first-generation Moroccan wives are ten years younger than their husbands, thus entering the senior stage at an even earlier age. The 'life stage' approach was not completely satisfactory either however, due to cultural differences in parenting: In Moroccan families most children stay at home until they marry, while most Dutch young adults leave their parents' homes earlier. Finally, specifying class was a challenge, because income and education level did not always indicate the same, low status.

Intersectional *analysis* involves attention to the variation within groups, e.g., by analyzing the gender categories separately. Doing so in the AtHL-project, we learned that for Dutch women healthy living involves adding up separate aspects (i.e., physical, mental, social), whereas Moroccan women offered a unified narrative of their life experiences. Furthermore, Dutch women mentioned life style issues (e.g., smoking, fatty food, exercise) more frequently than their Moroccan sisters. Such analysis by subgroup is also appropriate for quantitative analyses, for example, by applying regression analyses to each group independently.

The results should be *interpreted* in light of the participants' historical and current, social context. In our AtHL-project, we kept in mind that the Moroccan women arrived in The Netherlands in the 1970s or 1980s, because of family reunification policies, and still live in relatively isolated situations, where they have limited access to messages concerning health prevention. The Dutch women, on the other hand, are socialized in the Dutch culture, with its western public health beliefs, emancipatory developments, and women's high participation in volunteer work.

The question of inclusion is also relevant in the *reporting* of results. Here, one should beware of generalizations beyond the sample. In our case, we did not assume that our results would also apply to higher class men and women, or to immigrants other than those of Moroccan origin.

Where are there similarities?

In order to analyse the commonalities across categories that are commonly viewed as deeply different, the *inclusion criteria* must be *carefully operationalized* (as we saw above with the multi-dimensional definition of 'the senior'), and this also applies to the choice of *interview topics*. In *interpreting* similarities, the various dimensions associated with social category membership should be utilized as well as the processes by which they interact (such

as acculturation, socialization, identification, and internalization).

In the AtHL-project, we deliberately developed an interview guide that topicalized the socio-cultural and existential dimensions of health representations in addition to the physical and psychological ones that are more commonly studied. Subsequently, we were able to establish that family was an important topic for both groups, in addition to mind-body interaction. We did not ask directly about gender roles, but through analyzing the participants' discourse, we determined that both Moroccan and Dutch women complied with the generalized feminine role 'you must care for others'. Further analysis, however, indicated that for Moroccan women 'the others' were mainly family members, whereas Dutch women referred to a broader social network. We explained these commonalities and differences as related to the women's culture and historical developments and their psychological effects.

In quantitative research, similarities are established only indirectly, when the null hypothesis of no difference is not disproved. From a difference perspective, a lower confidence level is also informative (Favreau, 1997).

What role does inequality play?

A starting point is to *conceptualize the social categories as hierarchies of privilege and power*, which aids in their operationalization. Subsequently, *both positions (advantaged and disadvantaged)* should be included *in the sample, and in the topic list*. While the AtHL-project focused on the disadvantaged (qua class) only, attention to the participants' moral and social capital might have added to the analysis. In our list of topics to be covered in the interviews, we included experiences with (minority) stress and discrimination but no specific, power-sensitive probes or questions related to strengths, resiliency, or pride. For studying the healthy living context, these omissions were not problematic, but in studying health problems or health care access, these topics ought to be included.

The interview relationship inevitably involves power differences: interviewers are paid employees and goal-oriented, interviewees are rewarded with a modest gift at most and have a less clear agenda. Matching research participants with interviewers of the same ethnicity and gender may reduce the inequities, but cultural similarity may also reduce the complexity of the data when shared cultural knowledge is taken for granted and remains unexplored in the interview. In the AtHL-project, a matching strategy enabled participants to speak their preferred language, and the interviewer then translated any non-Dutch responses afterwards. In the interpretation stage, however, this attempt at leveling the linguistic playing field became a problem, when we had to question whose perspectives were actually represented in

the translation, and if cultural biases were inadvertently reinforced.

In the *analysis, the advantaged and the disadvantaged should be compared* to reveal the impact of history, circumstances, and resources, but especially the possibilities for relief, recovery, and accessibility. In our AtHL-project, for instance, we identified instances of discrimination, badly built environments, air quality problems, and inaccessibility of services as parts of unhealthy living. Power inequities were not subjected to further separate analyses, but served, on the one hand, as background information for interpretation of the results, and on the other, to provide direction for the development of interventions.

Conclusion

An intersectionality approach holds considerable promise in allowing health researchers to better incorporate social differences into their research programs. In the absence of clear guidelines for its implementation, however, researchers may turn away to more familiar research paradigms. The diversity problem will not go away however, and as we have attempted to show in this article, it is possible to integrate intersectionality with familiar methodology. In doing this, researchers gain in their capacity to contribute to important knowledge domains through extending (or reducing) the social categories under consideration, gaining insight into how power works, and identifying inequities and the possibilities for alliances.

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