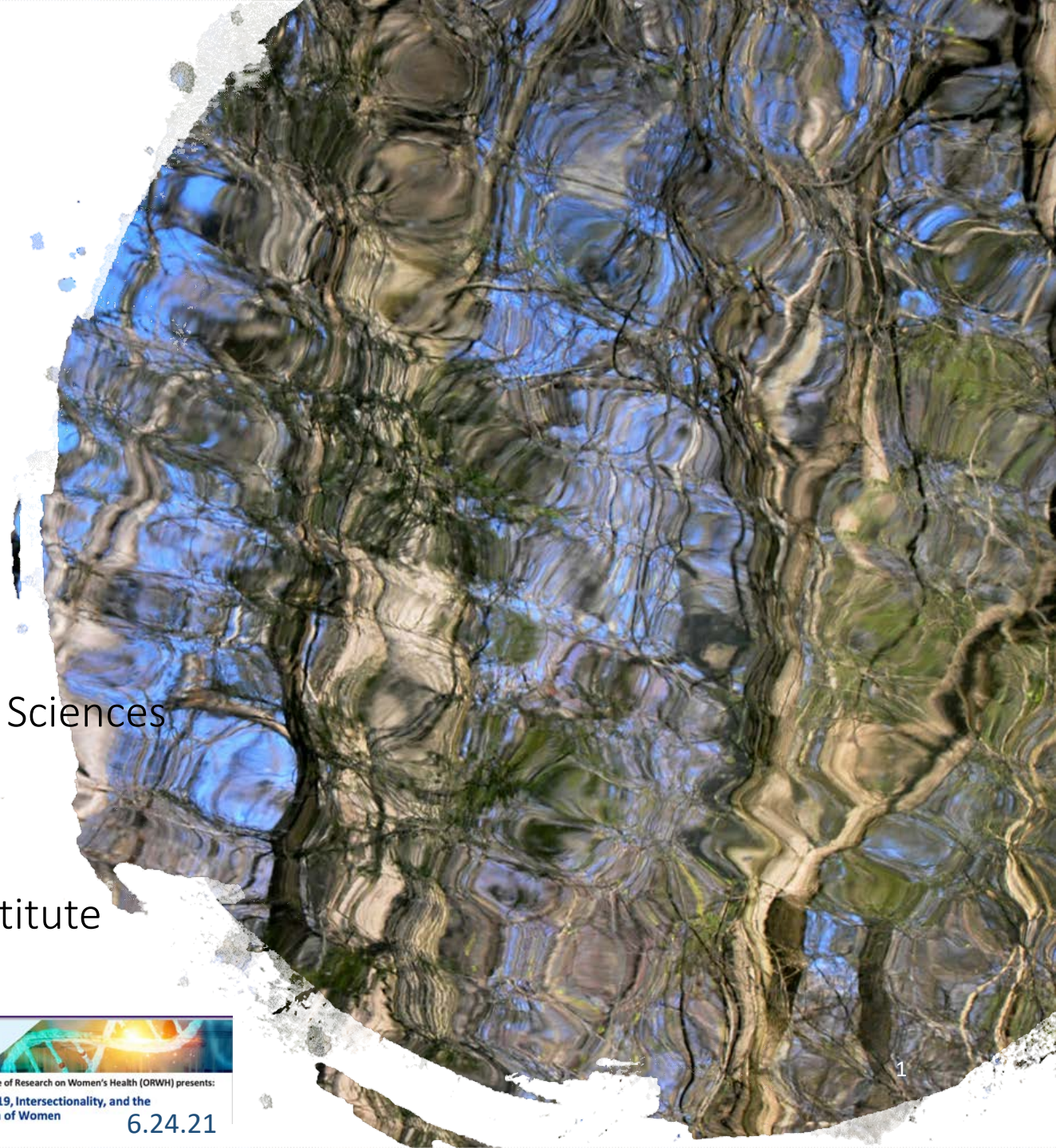
We're Not All In This Together: On COVID-19, Intersectionality, & Structural Inequality



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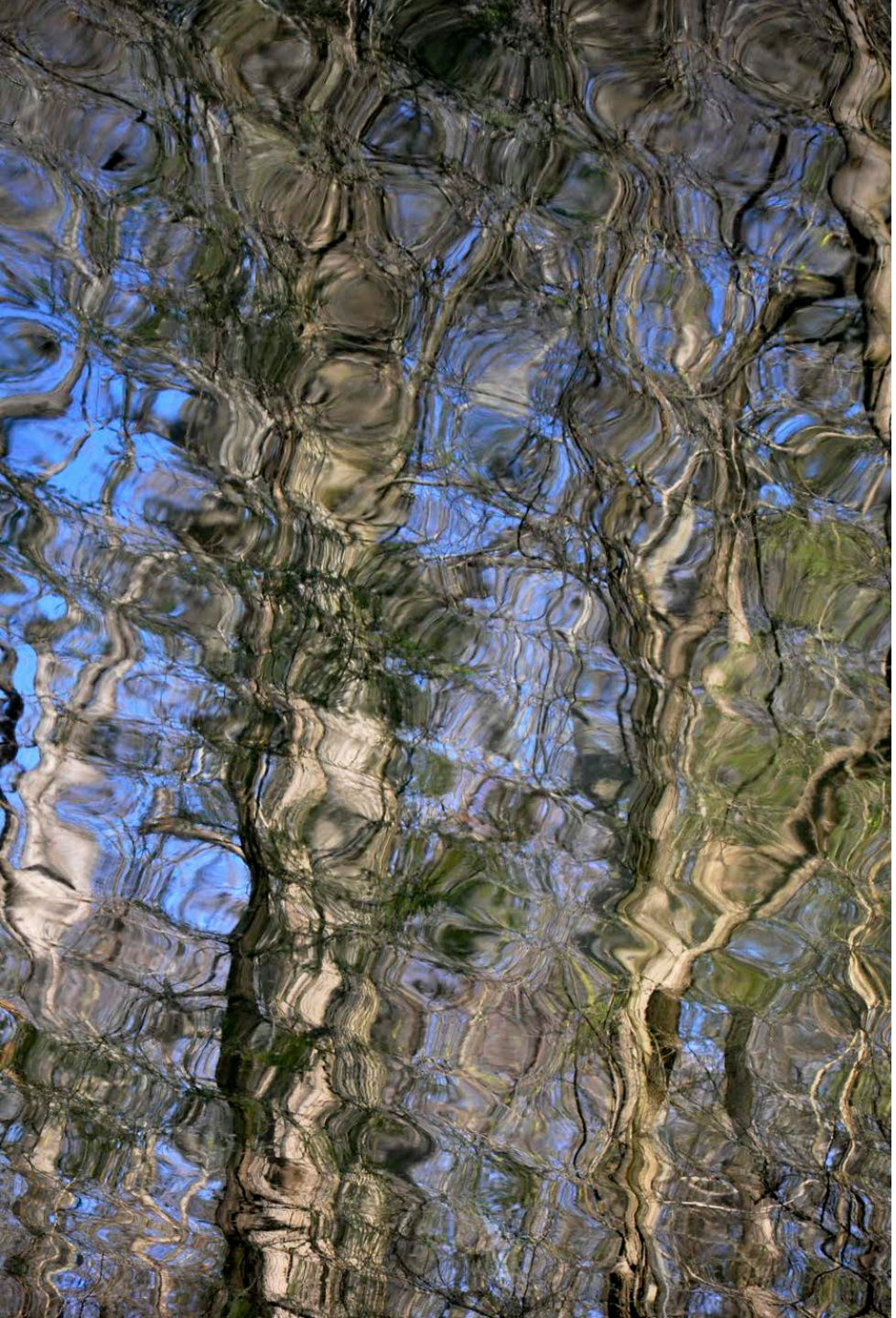
THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

intersectionality training institute

DC CFAR District of Columbia Center for AIDS Research



Overview

- Genesis of my article
- Traditional vs. critical conceptualizations of health
- Benefits of structural/critical approaches
- 6 Takeaways

EDITOR'S CHOICE

We're Not All in This Together: On COVID-19, Intersectionality, and Structural Inequality

We are not all in this together. My 32-year history with the HIV/AIDS epidemic in the United States—initially as an HIV/AIDS policy analyst and now as an HIV-prevention researcher—has provided the dubitable opportunity to witness how adroitly deadly viruses spotlight fissures of structural inequality. In the late 1980s, "changing face" was the term often used to describe the epidemic's transition from one that affected predominantly White and class-privileged gay and bisexual men to one that exacted a disproportionate toll on people at the most marginalized demographic intersections: Black and Latinx gay and bisexual men, cisgender and transgender women, injection drug users, and poor people.

The epidemic curve of HIV/AIDS in the United States has now flattened, to use the parlance of the day, but not for people marginalized by intersections of racism, sexism, classism, and transphobia. An HIV vaccine still eludes us, but biomedical interventions such as preexposure prophylaxis effectively reduce HIV transmission. Alas, not for all. Black people are still less likely to have access to preexposure prophylaxis than are their White counterparts. Thus, COVID-19's arrival made me dread what its "changing face" might portend. Newspaper headlines swiftly affirmed the disproportionate impact of COVID-19 in Black and Navajo communities and issued ominous warnings about the pandemic's future in poor White rural communities.

My irritation with the ubiquitous phrase "We're all in this together" quickly ensued. Although seemingly innocuous and often well intentioned, the phrase reflects an intersectional color and class blinding that functions to obscure the structural inequities that befall Black and other marginalized groups, who bear the harshest and most disproportionate brunt of anything negative or calamitous: HIV/AIDS, hypertension, poverty, diabetes, climate change disasters, unemployment, mass incarceration, and, now, COVID-19.

"We are all" socially distancing to flatten the curve, public health officials tell us. But cognitive, social, physical, and moral distancing from groups marginalized by structural inequality is perpetual. Intersectionality, a critical theoretical framework, provides an indispensable prism through which to examine the intersectional effects of COVID-19. Intersectionality highlights how power and inequality are structured differently for groups, particularly historically oppressed groups, based on their varied interlocking demographics (e.g., race, ethnicity, gender, class). Intersectionality troubles the notion of a collective "we" and "all" with the harsh and inconvenient truth that when social injustice and inequality are rife, as they were long before COVID-19, there are only what intersectionality scholar Kimberlé Crenshaw calls "specific and particular concerns."

The current presidential administration's response to COVID-19 has unnecessarily exacerbated pain and suffering. But the pain and suffering have not been equally borne. COVID-19 reveals disproportionate risk and impact based on structured inequality at intersections of racial/ethnic minority status and class, as well as occupation. Many of the riskiest and most stressful frontline jobs now deemed essential offer low pay and are occupied by people at the most marginalized intersections: racial/ethnic minorities, women, and undocumented workers. These intersections contrast starkly with those of the predominantly White, middle-class, and rich people who hire, legislate, and direct the conditions under which the "essential"—or expendable, depending on your point of view—work and, in the COVID-19 era, live or die.

Now, and when COVID-19 ends, we—policymakers, public health officials, and all of us who care about public health—have a moral imperative to center and equitably address the health, economic, and social needs of those who bear the intersectional brunt of structural inequality. This could move us a bit closer to all being in this together. Or we could maintain the inequitable status quo and acknowledge "we're all in this together" for what it is: another hollow platitude of solidarity designed to placate the privileged and temporarily uncomfortable and inconvenienced. AJPH

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doi: 10.2105/AJPH.2020.305766

8 Years Ago

Vaccines and Their Alternatives in Influenza Pandemics

[V]accines have continued to remain the much sought-after magic bullet in the war against infectious diseases. In the specific context of pandemic influenza, the fixation on vaccines . . . has served to distort the existing governance arrangements, granting pharmaceutical manufacturers a disproportionate amount of political power and influence. . . . Accordingly, less attention has been given to building the evidence base for alternative measures such as the use of personal protective equipment, personal hygiene, and social distancing principles—measures that would arguably benefit a larger proportion of the world's population that currently do not have access to these essential medicines. Indeed, in the majority of pandemic plans, governments have only tended to consider these measures as a means to limit virus transmission until a vaccine becomes available.

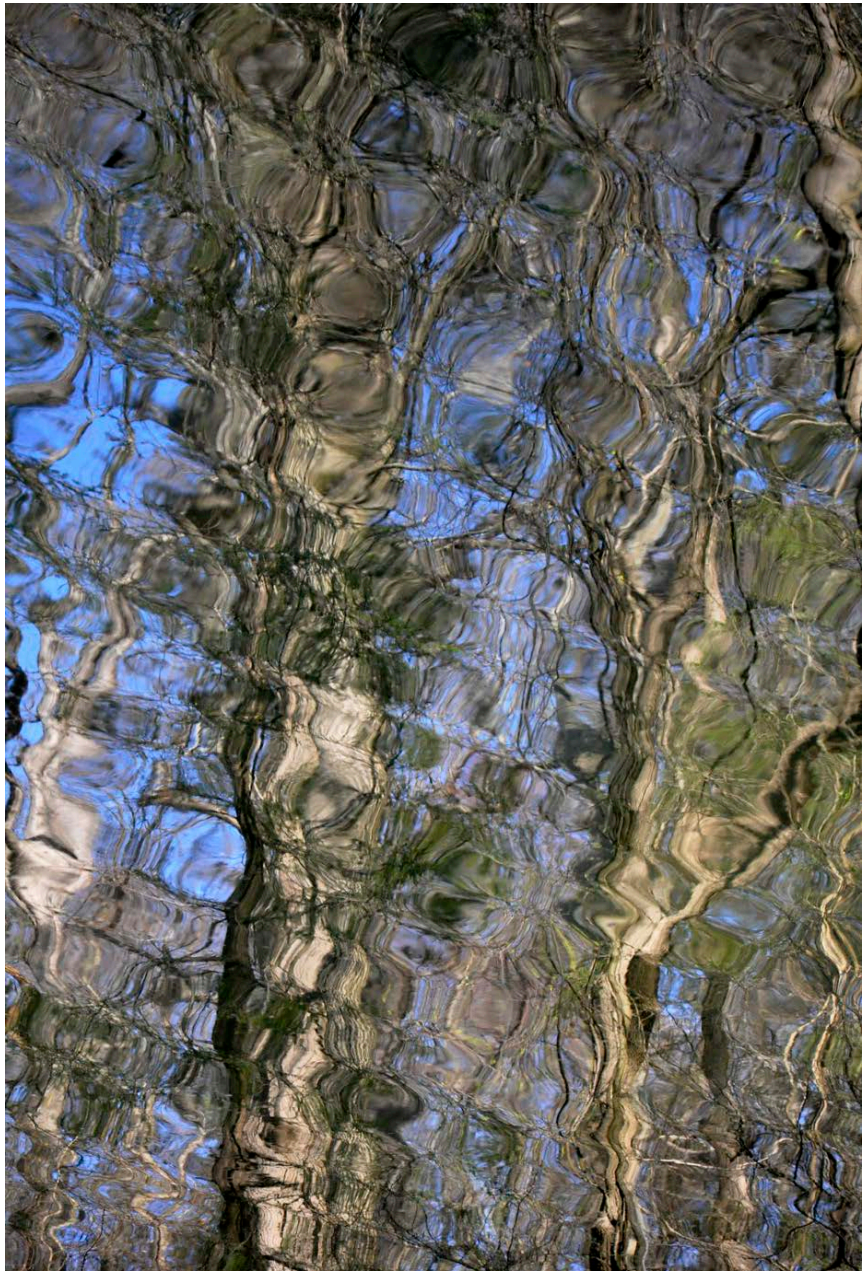
From AJPH, *January 2012, p. 96*

95 Years Ago

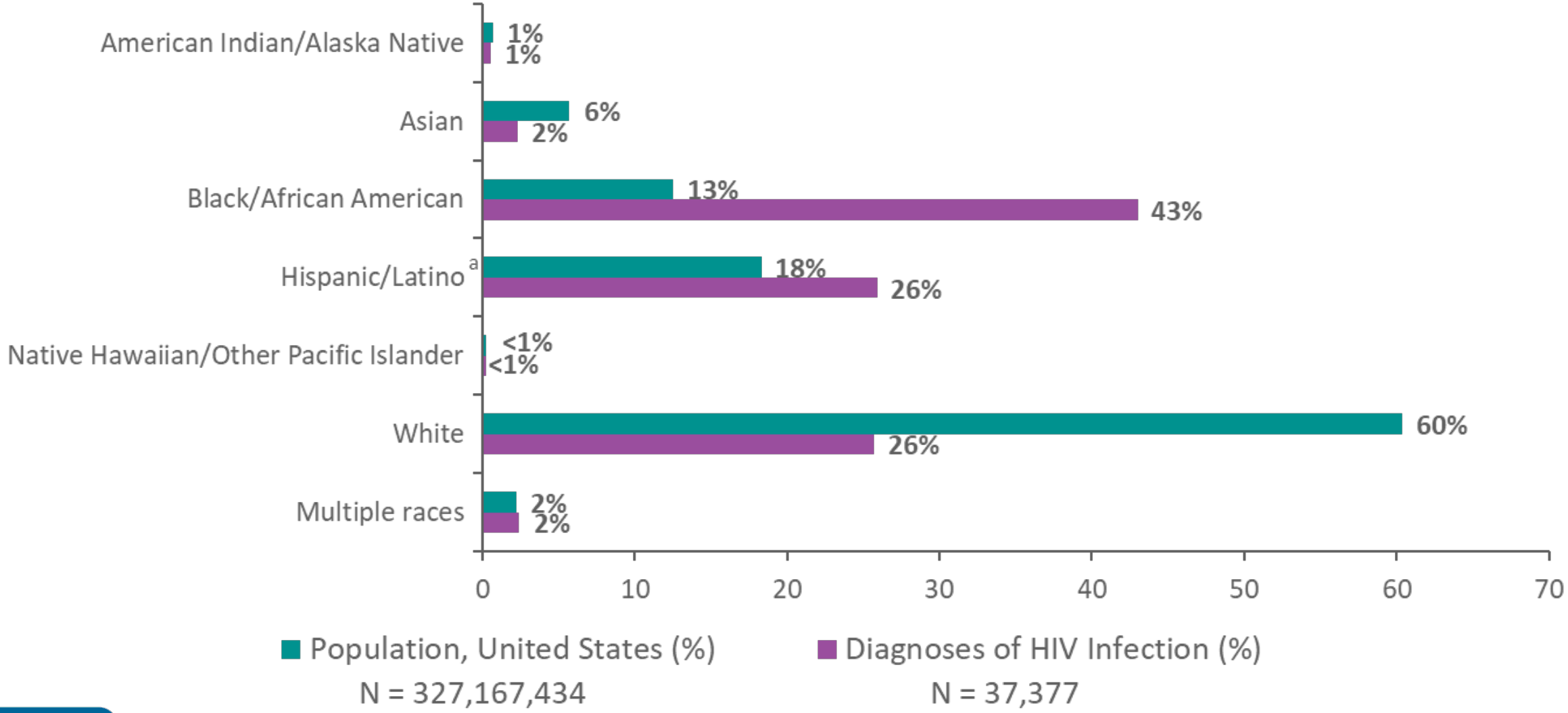
How the Influenza Problem Looked in 1925

No one can hope to prevent altogether another pandemic of influenza by methods of quarantine and isolation. It is believed, however, that something can be done to lower the attack rate in favorably situated small groups, to protect some individuals altogether and to lessen the exaltation of virulence on the part of the accessory microbes. Mortality may be lowered even if morbidity is not greatly affected. Difficult to apply and uncertain of success as it may be, the minimizing of contact seems at present to offer the best chance we have of controlling the ravages of influenza.

From AJPH, *November 1925, p. 947*



Diagnoses of HIV Infection and Population by Race/Ethnicity 2018—United States



Note. Data for the year 2018 are considered preliminary and based on 6 months reporting delay.
[a] Hispanics/Latinos can be of any race.

Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	1.6x	0.7x	1.1x	2.0x
Hospitalization[2]	3.5x	1.0x	2.8x	3.0x
Death[3]	2.4x	1.0x	1.9x	2.3x

Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., among frontline, essential, and critical infrastructure workers.

How to Slow the Spread of COVID-19

Wear a mask

Stay 6 feet apart

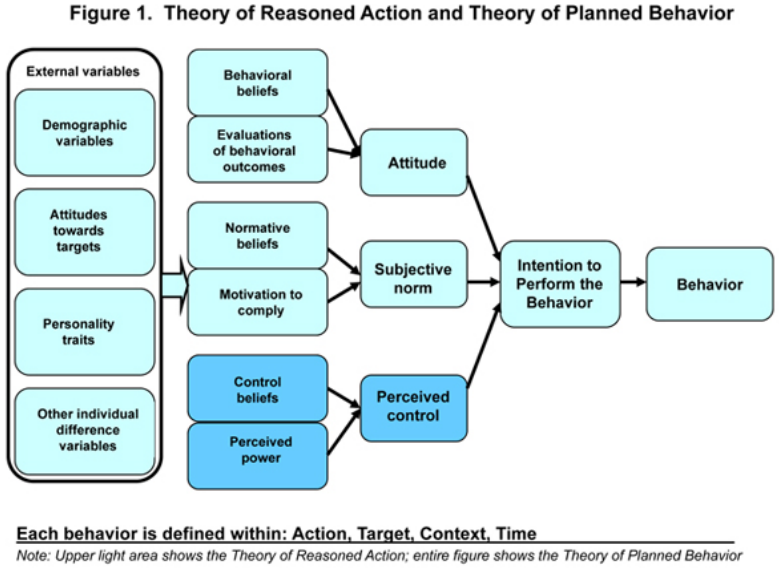
Avoid crowds and poorly ventilated spaces

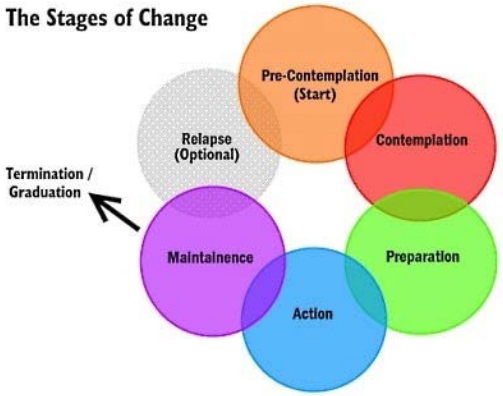
Wash your hands

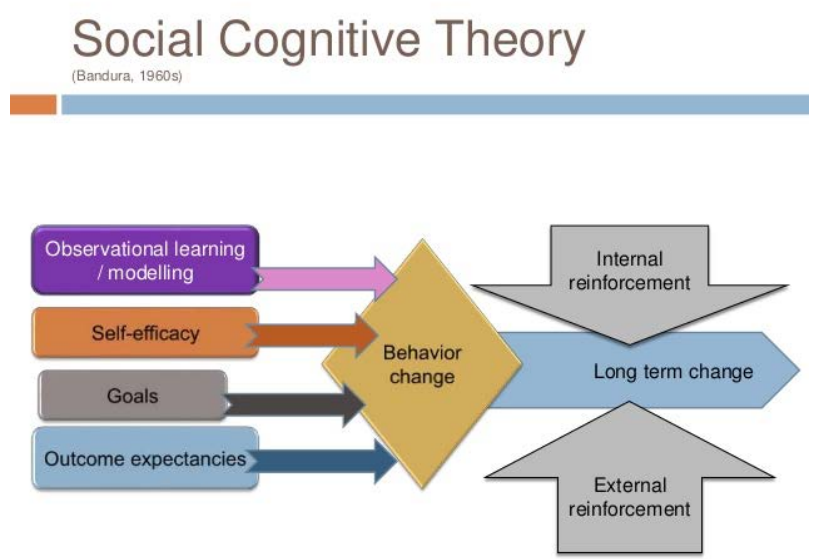
cdc.gov/coronavirus

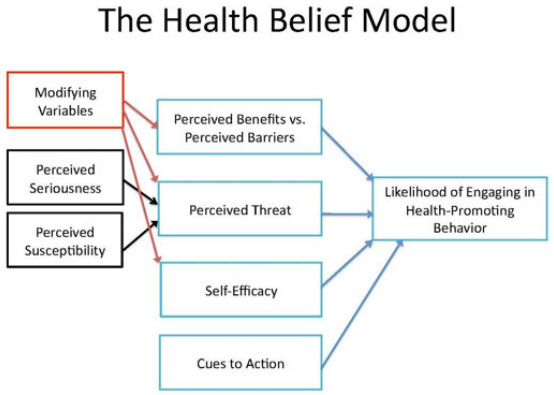
CS319360-A 04/15/2021

Conceptualizing Health & Risks

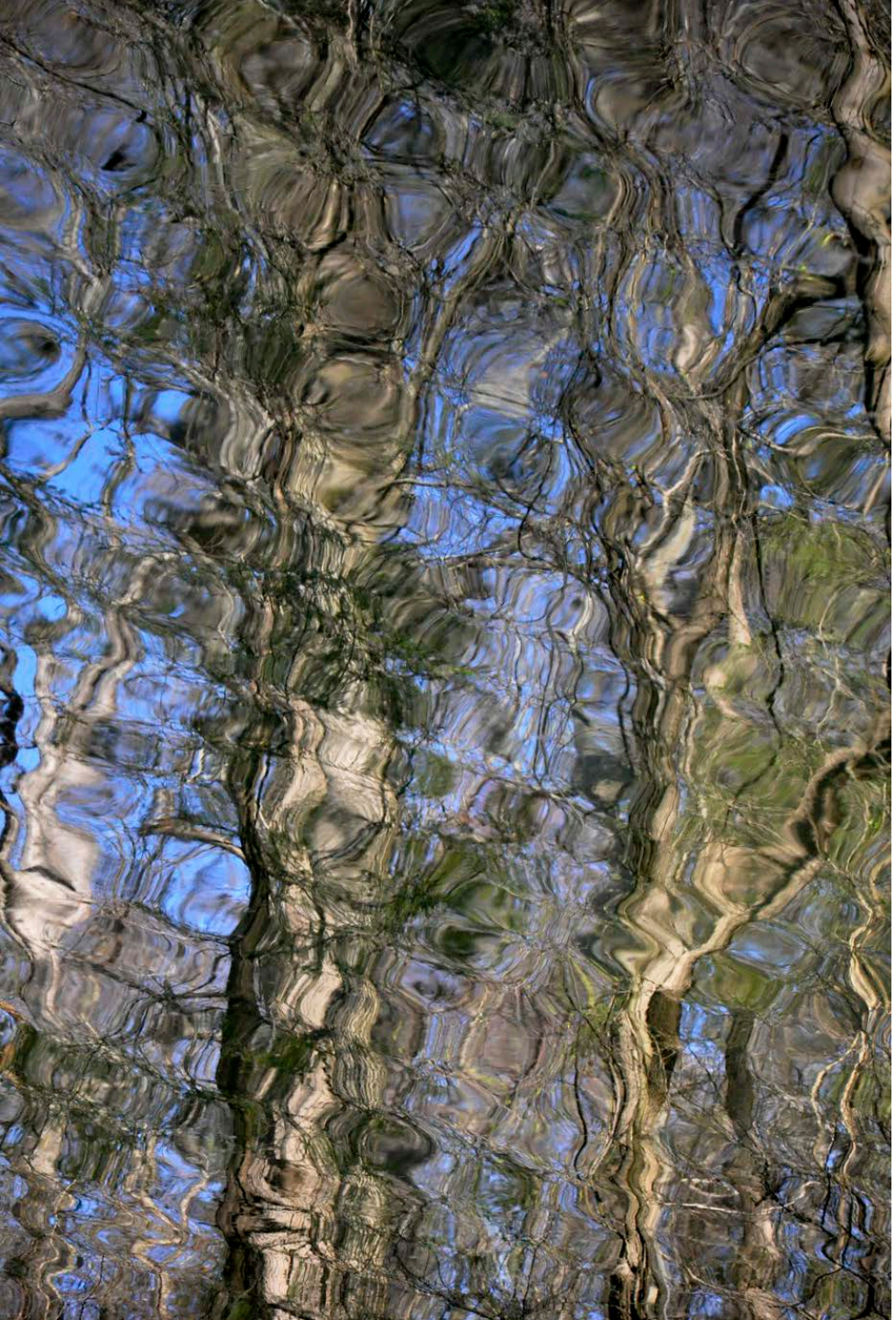








Traditional Theories of Health Behavior



LIMITATIONS

- Presume that people are primarily cognitive and rational;
- Conceptualize health primarily as a property of individuals and what they do/don't, or biomedical factors (e.g., viruses, bacteria)
- Center White middle-class people, and those who are WEIRD, as normative
- Ignore contextual factors (e.g., politics, relationships) and structural barriers (e.g., structural racism, homelessness, incarceration)

The Washington Post
Democracy Dies in Darkness

Morning Mix

Study: Men say they're less inclined to use condoms if a female partner is attractive

FILE - This Feb. 14, 2013 file photo shows a sample of condoms distributed freely by the AIDS Healthcare Foundation at the AHF headquarters in Los Angeles. Los Angeles County last year passed a law requiring porn actors to wear condoms during movie shoots. Ventura County is considering a similar ordinance at its May meeting. (AP Photo/Damian Dovarganes, file) (Damian Dovarganes/AP)

By Ben Guarino
Reporter

June 24, 2018 at 6:05 a.m. EDT

+ Add to list

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The Washington Post
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Health

Some Americans refuse to wear masks even as their hometowns become covid-19 hot spots

By Joel Achenbach and Lori Rozsa

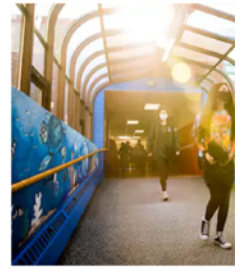
Oct. 27, 2020 at 8:21 p.m. EDT

+ Add to list

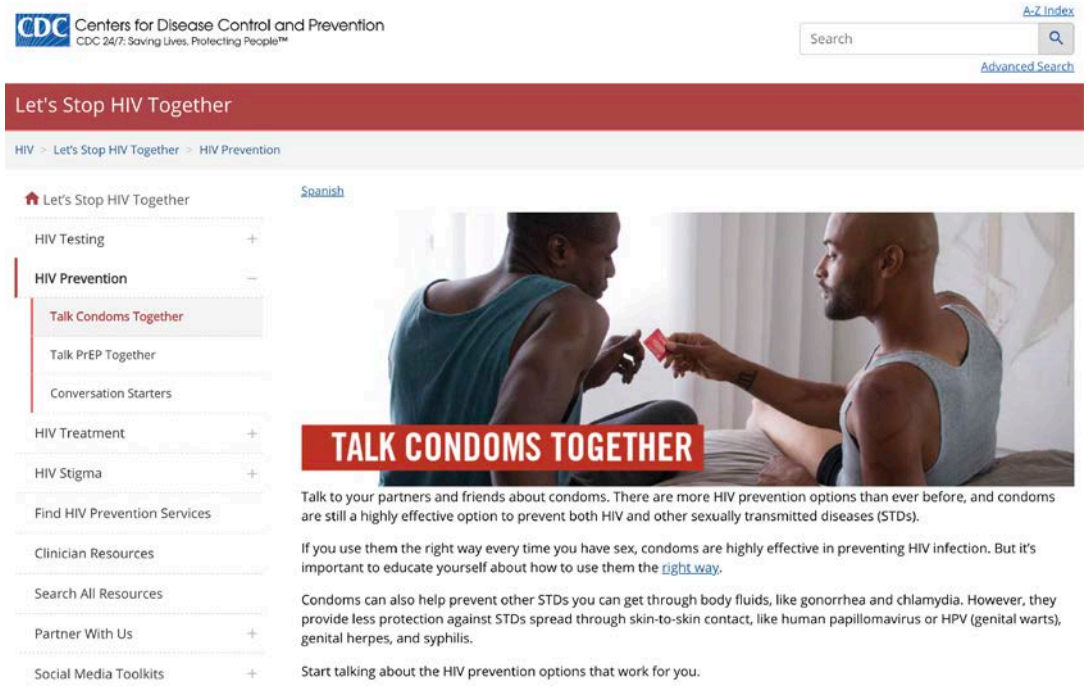
Resistance to mask-wearing and other efforts to control the spread of the coronavirus has hardened in the final days before the presidential election, demonstrating how the pandemic has been politicized and posing a daunting challenge to the nation's medical experts.

The refusal to go along with expert health guidance has persisted even in parts of the country that are seeing soaring caseloads and hospitalizations. That was driven home this week when the coordinator of the White House coronavirus task force, Deborah Birx, toured North Dakota, which has had more coronavirus infections per capita than any other state and over the past month has experienced a stunning surge in hospitalizations and deaths.

Most Read Health



1 This state is shutting bars a… coronavirus surges — but n…


CDC Centers for Disease Control and Prevention
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Let's Stop HIV Together
HIV > Let's Stop HIV Together > HIV Prevention
Let's Stop HIV Together
HIV Testing
HIV Prevention
Talk Condoms Together
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Conversation Starters
HIV Treatment
HIV Stigma
Find HIV Prevention Services
Clinician Resources
Search All Resources
Partner With Us
Social Media Toolkits
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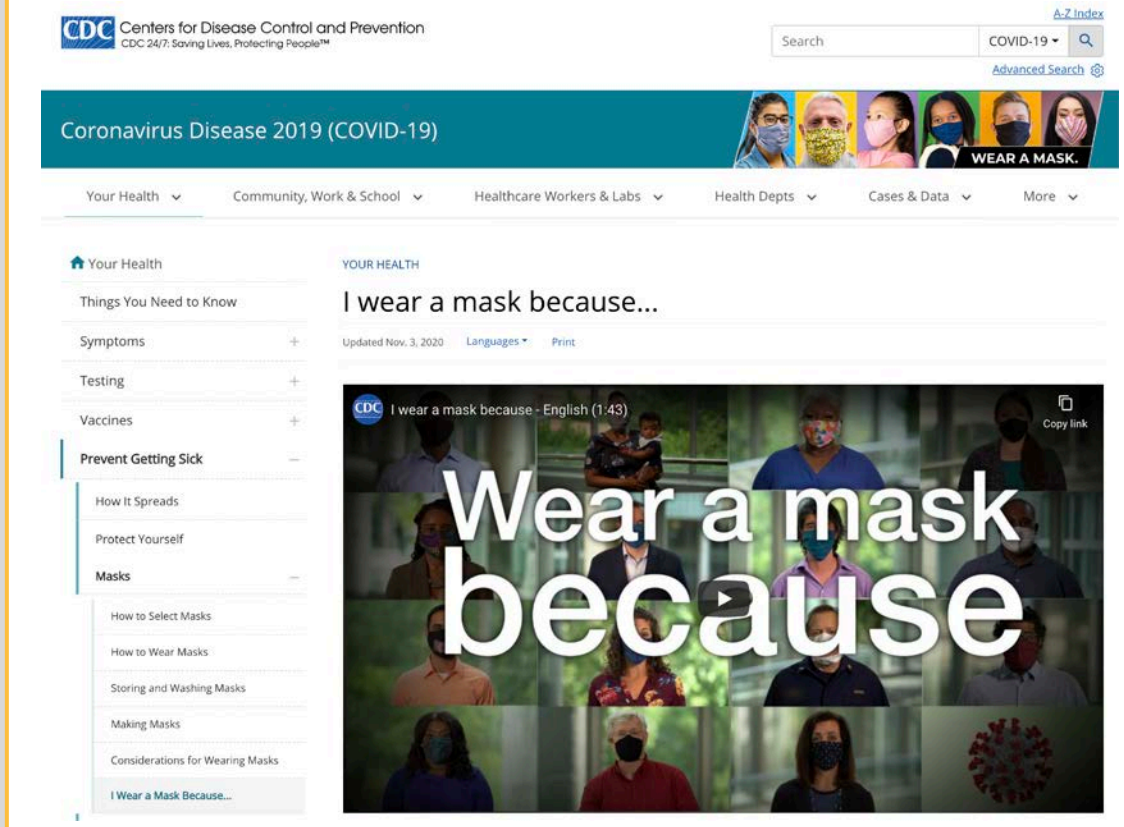
TALK CONDOMS TOGETHER
Talk to your partners and friends about condoms. There are more HIV prevention options than ever before, and condoms are still a highly effective option to prevent both HIV and other sexually transmitted diseases (STDs).
If you use them the right way every time you have sex, condoms are highly effective in preventing HIV infection. But it's important to educate yourself about how to use them the right way.
Condoms can also help prevent other STDs you can get through body fluids, like gonorrhea and chlamydia. However, they provide less protection against STDs spread through skin-to-skin contact, like human papillomavirus or HPV (genital warts), genital herpes, and syphilis.
Start talking about the HIV prevention options that work for you.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Protect Yourself
Masks
How to Select Masks
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I Wear a Mask Because...
YOUR HEALTH
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Updated Nov. 3, 2020
Languages
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BEHAVIORAL AND BRAIN SCIENCES (2010) **33**, 61–135
doi:10.1017/S0140525X0999152X

The weirdest people in the world?

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W esternized (typically the U.S.)
E ducated
I ndustrialized
R ich
D emocracies

HEALTH

The Problem That Psychology Can't Shake

Ten years after a seminal paper laid bare psychology's white, affluent, Western skew, not much has changed.

MICHAEL SCHULSON AND UNDARK JANUARY 25, 2020

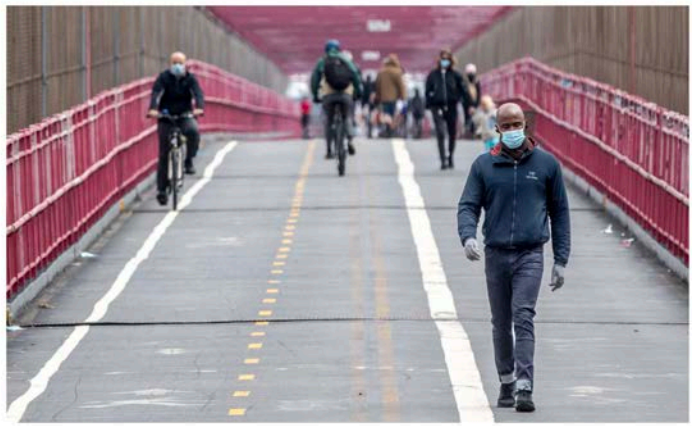
UTE GRABOWSKY / PHOTOTHEK VIA GETTY

The New York Times

The Coronavirus Outbreak › | LIVE Latest Updates | Maps and Tracker | States Reopening | Living at Home | Newsle

For Black Men, Fear That Masks Will Invite Racial Profiling

African-American men worry that following the C.D.C. recommendation to cover their faces in public could expose them to harassment from the police.



As the coronavirus spreads, black men face two concerns: the virus and those who see their covered faces as threatening. Brittainy Newman/The New York Times

By Derrick Bryson Taylor

April 14, 2020

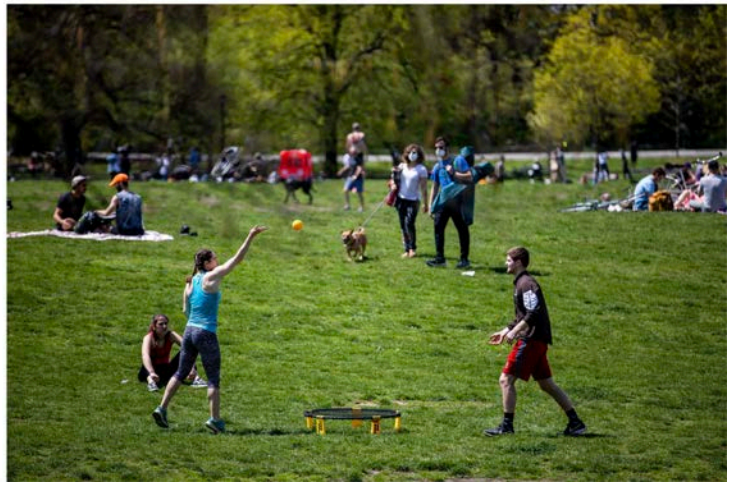
6

The New York Times

The Coronavirus Outbreak › | LIVE Latest Updates | Maps and Cases | Personalized Covid Tracker | Vaccine Tracker | FAQ: Thanksgiving and More

Masks Become a Flash Point in the Virus Culture Wars

As people resume going out in public in the middle of a pandemic, to wear or not to wear a face mask has become a personal statement and sometimes a political one.



The Washington Post

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Morning Mix

A birthday lunch left 15 Texas relatives battling covid-19: 'Please don't be like my family'

The Aragonez family of Arlington, Tex., shared a video on Nov. 19, warning viewers about the dangers of coronavirus after a family picnic led to 15 infections. (City of Arlington, Tex.)

By Andrea Salcedo

November 23, 2020 at 6:08 a.m. EST

Add to list

Eight members of the Aragonez family drove from Arlington to Fort Worth for the birthday lunch at her cousin's house, where four other relatives lived. The plan was never to gather indoors, Aragonez said, but as family members arrived, people congregated in the living room, where for a couple of hours, everyone sat around the couch without masks, sharing fajitas and chocolate cake.

"It really was: 'Hey, I'm coming in' and everyone started talking," Aragonez said. "They naturally gravitated to the living room. ... It was not like we were, 'Let's all hang out inside.' We fell back into our old habits."

Critical Perspectives

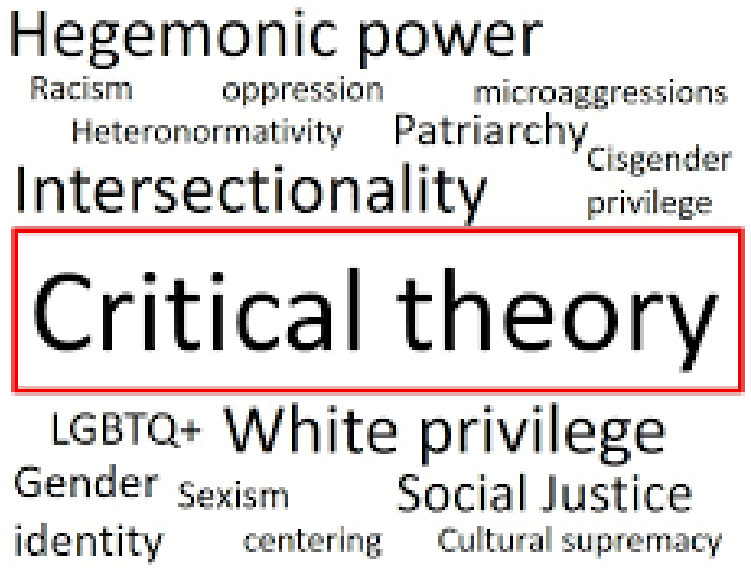
Structural Approaches

Critical Race Theory

Intersectionality

Critical theories interrogate, expose, and challenge assumptions about power and privilege that function to:

- Conceal power relations
- Define or justify knowledge
- Conceal how dominant groups construct knowledge, facts and problems
- Maintain the racialized and economic status quo



Structural Approaches

"… locate the source of public health problems in factors in the social, economic and political environments that shape and constrain individual, community and societal health outcomes"
(Blankenship, Bray, & Merson, 2000, p. S11)

Structural interventions in public health

Kim M. Blankenship, Sarah J. Bray and Michael H. Merson

Objective: To review structural interventions in public health, identify distinct approaches to structural interventions, and assess their implications for HIV-prevention interventions.

Method: The MEDLINE, HealthStar, PsychInfo and Sociofile databases were searched on specific health issues, types of public health interventions, and conceptual topics (e.g. empowerment, social structure, and inequality) to compile a list of public health interventions in the United States. We excluded interventions focused on testing and surveillance unless they specifically facilitated prevention, and educational or media campaigns focused on increasing individuals' level of knowledge about a particular health problem.

Results: The term 'structural' is used to refer to interventions that work by altering the context within which health is produced or reproduced. Structural interventions locate the source of public-health problems in factors in the social, economic and political environments that shape and constrain individual, community, and societal health outcomes. We identified two dimensions along which structural interventions can vary. They may locate the source of health problems in factors relating to availability, acceptability, or accessibility; and they may be targeted at the individual, organizational, or environmental levels. All together, this framework suggests nine kinds of structural interventions, and it is possible to identify examples of each kind of intervention across a range of public health issues.

Conclusions: The relevance of this framework for developing HIV prevention interventions is considered.

AIDS 2000, **14 (suppl 1)**:S11–S21

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The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities

Zinzi D. Bailey, Sc.D., M.S.P.H., Justin M. Feldman, Sc.D., and Mary T. Bassett, M.D., M.P.H.

In the 5 years since one of us published "#Black LivesMatter — A Challenge to the Medical and Public Health Communities" in the *Journal*,[1] we have seen a sea change in the recognition of racism as a durable feature of U.S. society and of its high cost in Black lives. Elected officials, corporate leaders, and academics alike use the slogan "Black Lives Matter," which has also been widely adopted by members of the public, who by the millions protested the extrajudicial killing of George Floyd.[2] With this change comes growing recognition that racism has a structural basis and is embedded in long-standing social policy. This framing is captured by the term "structural racism."

There is no "official" definition of structural racism — or of the closely related concepts of systemic and institutional racism — although multiple definitions have been offered.[3-7] All definitions make clear that racism is not simply the result of private prejudices held by individuals,[8] but is also produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic system as well as in cultural and societal norms.[3,8] Confronting racism, therefore, requires not only changing individual attitudes, but also transforming and dismantling the policies and institutions that undergird the U.S. racial hierarchy.

As a legacy of African enslavement, structural racism affects both population and individual health in three interrelated domains: redlining and racialized residential segregation, mass incarceration and police violence, and unequal medical care. These examples, among others, share certain cardinal features: harms are historically grounded, involve multiple institutions, and rely on racist cultural tropes.

REDLINING AND RACIALIZED RESIDENTIAL SEGREGATION

In 1933, the federal government established the Home Owners' Loan Corporation (HOLC) to expand homeownership as a part of recovery from the Great Depression.[8] To guide determinations of mortgage-worthiness, HOLC created maps of at least 239 U.S. cities. Using racial composition as part of its assessment, HOLC staff literally drew red lines (hence "redlining") around communities with large Black populations, flagging them as hazardous investment areas whose residents would not receive HOLC loans. Redlining made mortgages less accessible, rendering prospective Black homebuyers vulnerable to predatory terms, thereby increasing lender profits, reducing access to home ownership, and depriving these communities of an asset that is central to intergenerational wealth transfer. Federal mortgages were declined regardless of home loan officers' racial views; it was not personal.

This government-sanctioned practice validated other racist maneuvers, such as restrictive covenants that barred Blacks from home ownership by means of legal agreements set up by previous owners, undervaluing of real estate in Black neighborhoods, and mob violence against Blacks who moved into White neighborhoods. Although redlining officially ended with the Fair Housing Act of 1968, its impact is seen today in the social geography of cities. Residential segregation formed a platform for broad social disinvestment, especially in neighborhood infrastructure (e.g., green space, housing stock, and roads), services (e.g., transport, schools, and garbage collection), and employment.

Residential racial segregation remains a powerful predictor of Black disadvantage.[3,5,9] There is

768 N ENGL J MED 384;8 NEJM.ORG FEBRUARY 25, 2021

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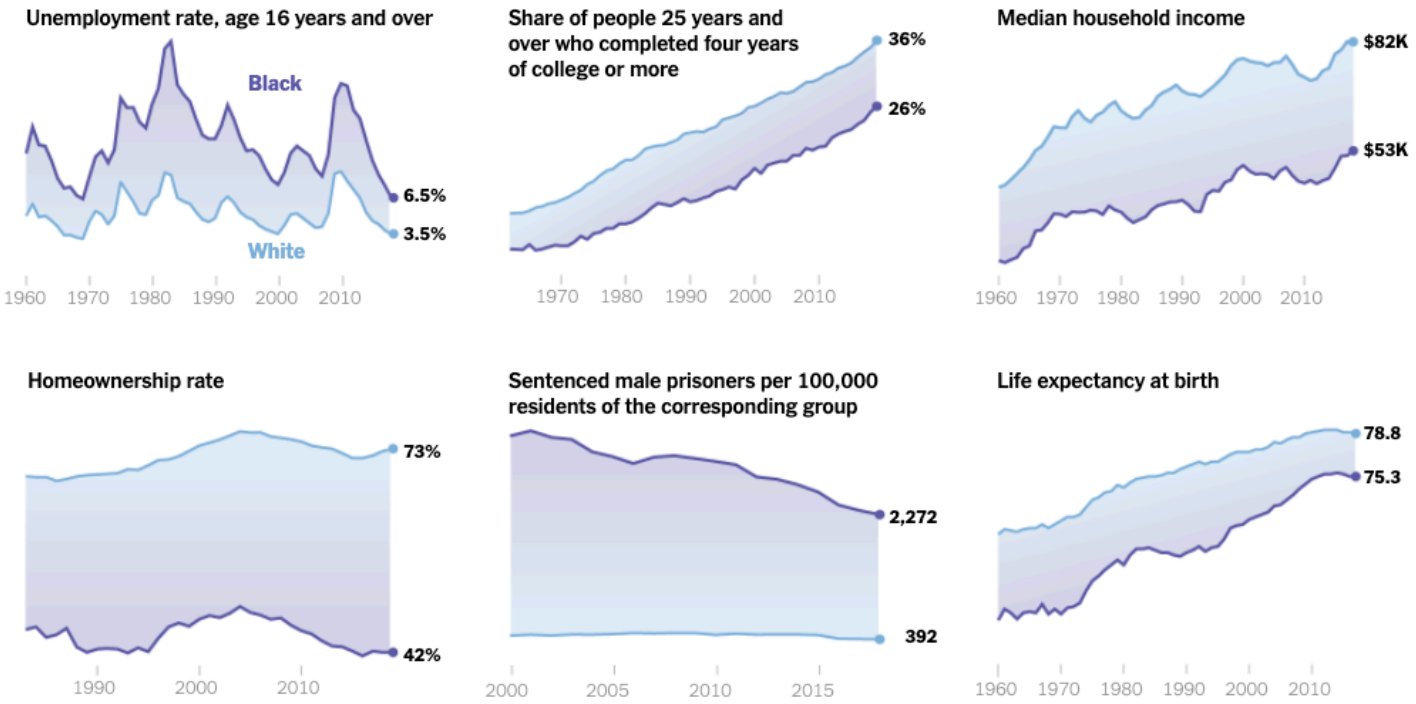
The New York Times

Opinion

The Gaps Between White and Black America, in Charts

By Patrick Sharkey, Keeanga-Yamahtta Taylor and Yaryna Serkez June 19, 2020



Critical Race Theory

Racism is not anomalous or aberrant, but instead a routine, ordinary and seemingly fixed fact of everyday life for Black and other people of color in the U.S. (Bell, 1979)

COMMENTARIES

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Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis

Racial scholars argue that racism produces rates of morbidity, mortality, and overall well-being that vary depending on socially assigned race. Eliminating racism is therefore central to achieving health equity, but this requires new paradigms that are responsive to structural racism's contemporary influence on health, health inequities, and research.

Critical Race Theory is an emerging transdisciplinary, race-equity methodology that originated in legal studies and is grounded in social justice. Critical Race Theory's tools for conducting research and practice are intended to elucidate contemporary racial phenomena, expand the vocabulary with which to discuss complex racial concepts, and challenge racial hierarchies.

We introduce Critical Race Theory to the public health community, highlight key Critical Race Theory characteristics (race consciousness, emphases on contemporary societal dynamics and socially marginalized groups, and praxis between research and practice) and describe Critical Race Theory's contribution to a study on racism and HIV testing among African Americans. (*Am J Public Health.* 2010;100: S30–S35. doi:10.2105/AJPH.2009.171058)

Chandra L. Ford, PhD, and Collins O. Airhihenbuwa, PhD

ALTHOUGH RACE REMAINS salient to public health in a variety of ways, the field's theoretical and methodological conventions inadequately address the complexity with which structural racism influences both health and the production of knowledge about populations, health, and health disparities. Many projects lack clarity about the nature of racial stratification. They conceptualize, measure, and analyze race- and racism-related factors using tools better suited for studying other risk factors. Although structural forces drive inequities, research and interventions disproportionately emphasize individual and interpersonal mechanisms. Additionally, overconfidence in the objectivity of research can blind investigators to the inadvertent influence of a priori assumptions on research.

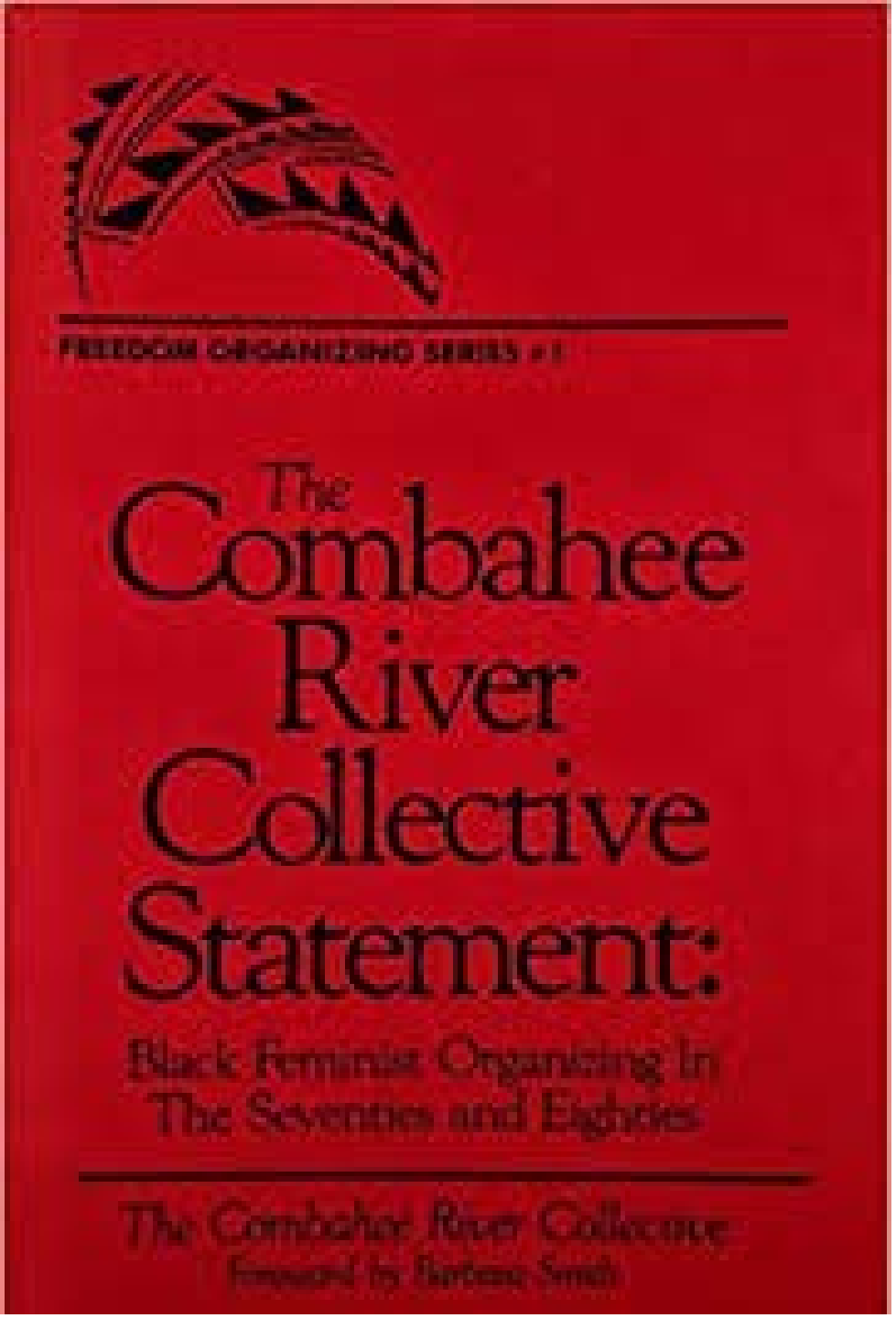
Race as a category denoting skin color was first used to classify human bodies by Francois Bernier, a French physician.[1] The notion of racial groupings was introduced in Carolus Linnaeus's *Natural History* in 1735 and subsequently advanced by many others.[1] Both Linnaeus's concept of race and the subsequent racial groupings devalued and degraded those classified as non-European.[2] Linnaeus's classification became the foundation on which many countries, including the United States, based their racial policies. Later, racialized policies gained "scientific" affirmation in the work of scholars such as Josiah Nott, whose publications reinforcing White supremacy appeared in 1843 in such respected journals as the *American Journal of the Medical Sciences.*

Prevailing notions about race shaped early scientific research, but because investigators were not critical about their relationships to their racialized social contexts, they were unable to perceive the insidious influence of racism in their work. The contributions of minorities who might have challenged underlying assumptions were largely excluded. Their exclusion buttressed artificially high levels of confidence among researchers about the import and validity of racial findings. Against this backdrop, progressive scholars, many of them racial or ethnic minorities, began to scrutinize knowledge production processes and the implications for minority communities. By the late 20th century, they had begun developing new frameworks such as Critical Race Theory to explicitly account for the influences of racism on both outcomes and research processes.

Gilmore defines racism as "the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death."[3(p247)] This definition suggests that health for all cannot be achieved if structural racism persists. Eliminating racism, therefore, is part and parcel to achieving the objectives of public health. Table 1 provides definitions of public health and of the Critical Race Theory concepts discussed in this commentary.

Critical Race Theory offers the field of public health a new paradigm for investigating the root causes of health disparities. Based on race equity and social justice principles, Critical Race Theory encourages the development of solutions that bridge gaps in health, housing, employment, and other factors that condition living.

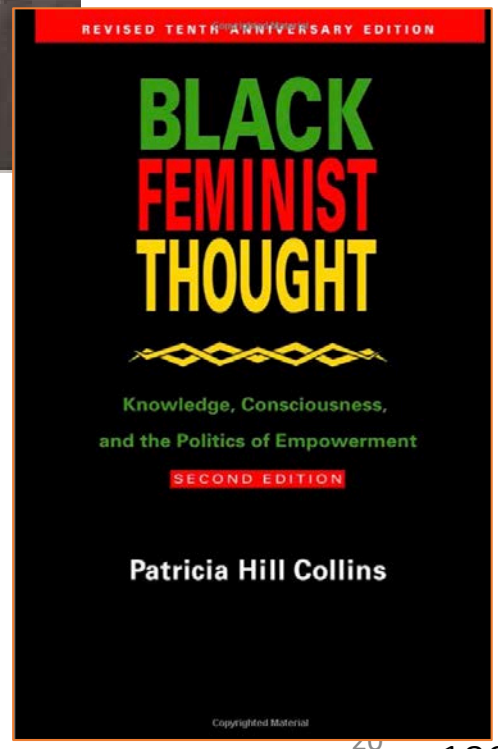
The newly developed Public Health Critical Race Framework adapts Critical Race Theory for public health research and practice (Ford CL and Airhihenbuwa CO, unpublished paper, 2009). Our aim here, however, is to introduce Critical Race Theory to the multidisciplinary field of public health and, more specifically, to researchers of health disparities and health equity. We also



We are a collective of Black feminists who have been meeting together since 1974. … The most general statement of our politics at the present time would be that we are actively committed to struggling against racial, sexual, heterosexual, and class oppression, and see as our particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking. The synthesis of these oppressions creates the conditions of our lives… (Combahee River Collective, 1977, p. 272)

Kimberlé Crenshaw
Professor of Law, UCLA Law &
Columbia University Law School

Patricia Hill Collins, Ph.D.
Distinguished University
Professor Emerita
Department of Sociology
University of Maryland, College
Park



Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color

Kimberle Crenshaw* 1988

University of Chicago Legal Forum

Volume 1989 | Issue 1 Article 8

Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics

Kimberle Crenshaw
Kimberle.Crenshaw@chicagounbound.edu

1991

A critical theoretical or analytical framework that posits that multiple social categories (e.g., race, gender, sexual identity) 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) (Bowleg, 2012, p. 1267).

FRAMING HEALTH MATTERS

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.

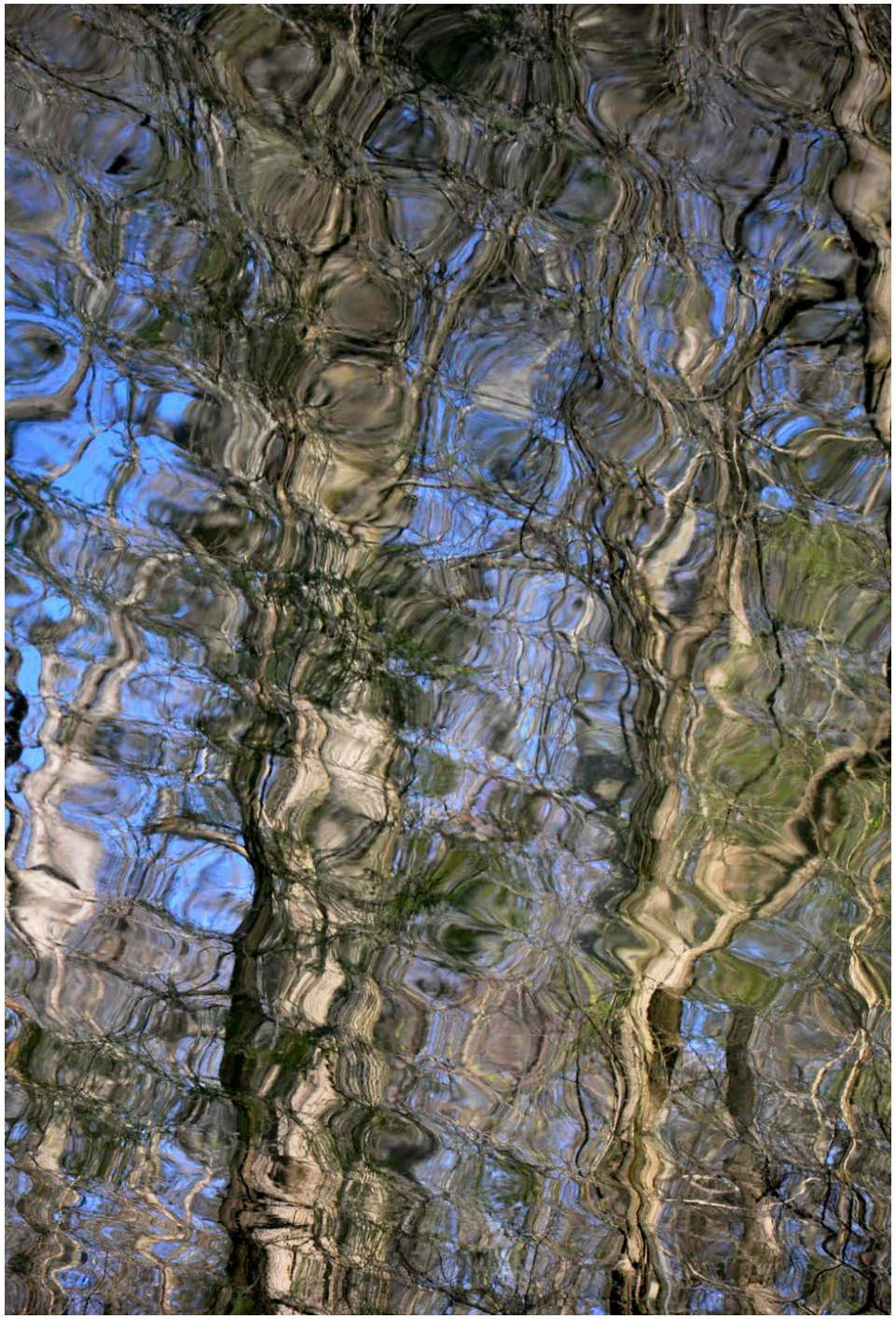
The notion that social identities are multiple and interlocking is not limited to the women and minorities discourse. The introduction to the US Department of Health and Human Service's (DHHS's) recent *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* acknowledges that

> 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,



(Some) Core Intersectionality Tenets

- Rejects "single-axis" (and/or) thinking in favor of matrix (both/and) perspectives (Crenshaw, 1989)
- Social positions interlock & thus can't be separated, added or ranked (Collins, 1991; Crenshaw, 1989; May, 2015)
- Power, privilege and social inequality are differently structured based on intersectional positions (Collins, 1991; Crenshaw, 1989; May, 2015)
- Intersectionality is not just about identities

POLICY & COMPLIANCE

Policy Topics

Inclusion Policies

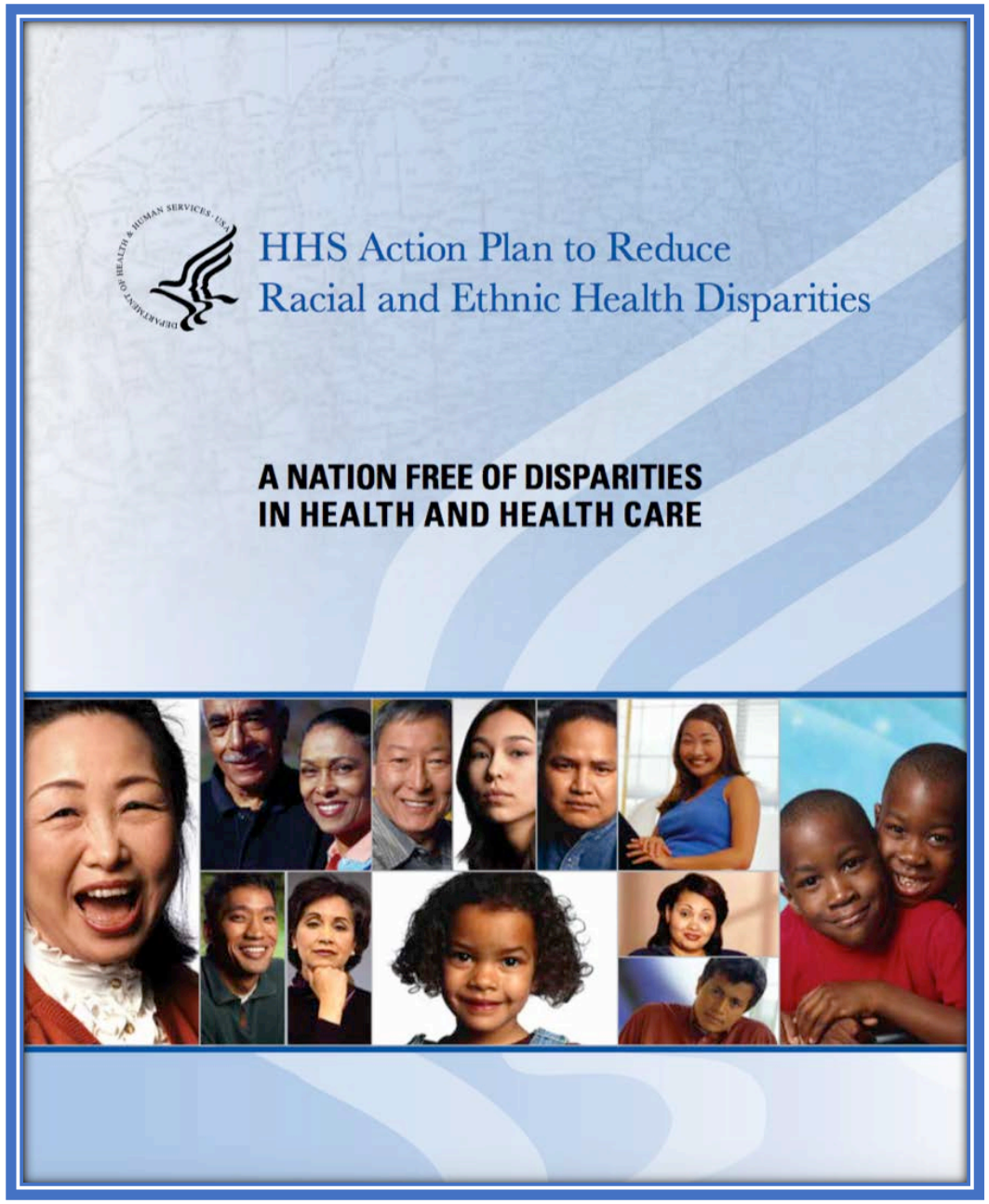
Inclusion of Women and Minorities

Inclusion Across the Lifespan

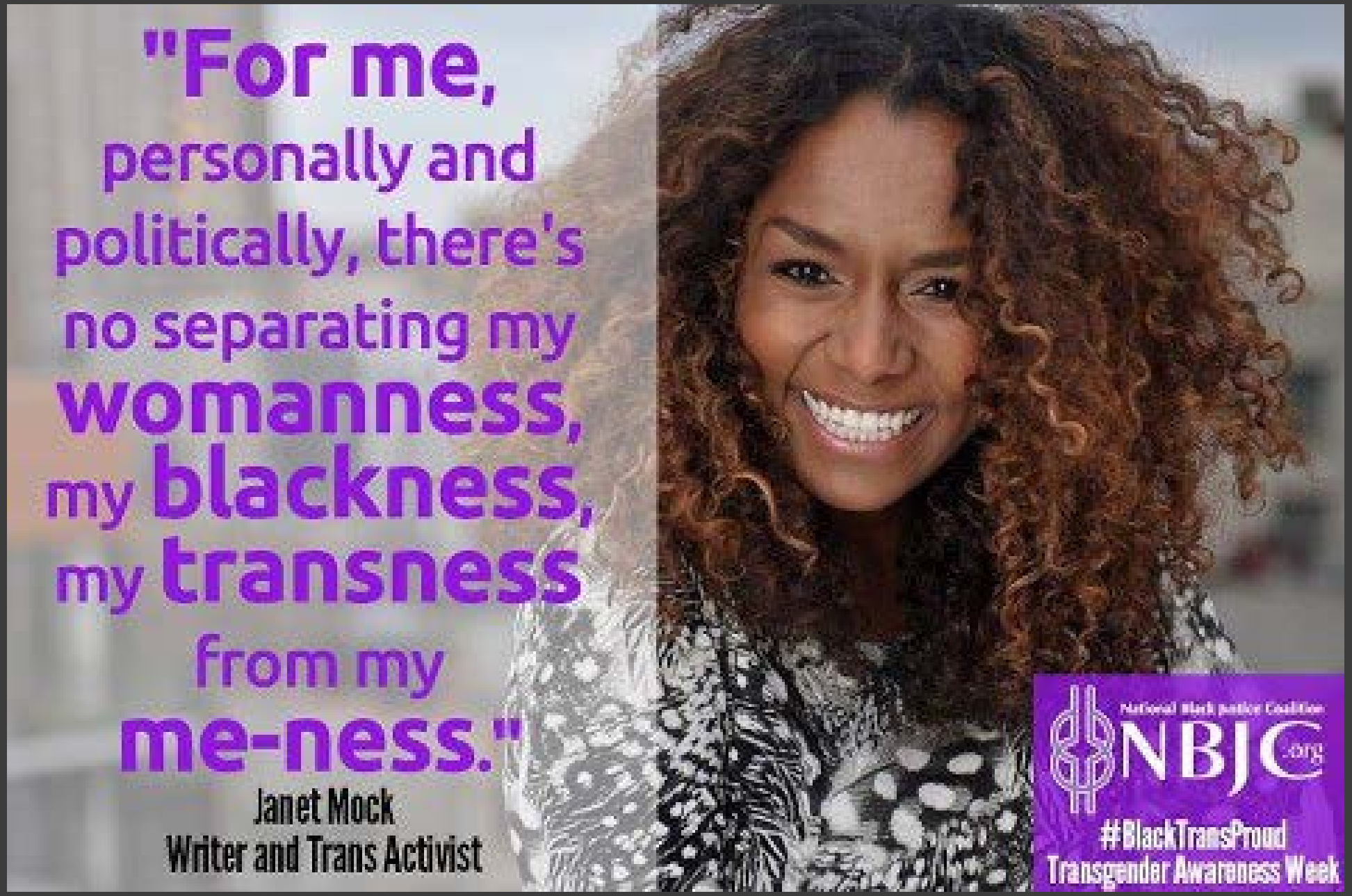
NIH Policy and Guidelines on The Inclusion of Women and Minorities as Subjects in Clinical Research

NOTE: The policy below is displayed as announced on October 9, 2001 in NOT-OD-02-001, and does not reflect the amendment NOT-OD-18-014, issued November 28, 2017. Additional information concerning the NIH Policy on Inclusion of Women and Minorities as Subjects in Clinical Research is available at https://grants.nih.gov/grants/funding/women_min/women_min.htm.

SUMMARY: This notice updates the NIH policy on the inclusion of women and minorities as subjects in clinical research. It supercedes the 1994 Federal Register notice (https://grants.nih.gov/grants/guide/notice-files/not94-100.html) and the August 2000 notice in the NIH Guide to Grants and Contracts (https://grants.nih.gov/grants/guide/notice-files/NOT-OD-00-048.html). It incorporates the definition of clinical research as reported in the 1997 Report of the NIH Director's Panel on Clinical research. Also, this notice provides additional guidance on reporting analyses of sex/gender and racial/ethnic differences in intervention effects for NIH-defined Phase III clinical trials. The guidelines ensure that all NIH-funded clinical research will be carried out in a manner sufficient to elicit information about individuals of both sexes/genders and diverse racial and ethnic groups and, particularly in NIH-defined Phase III clinical trials, to examine differential effects on such groups. Since a primary aim of research is to provide scientific evidence leading to a change in health policy or standard of care, it is imperative to determine whether the intervention or therapy being studied affects women or men or members of minority groups and their subpopulations differently.



"Characteristics such as such as race or ethnicity, religion, SES, 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" (HHS, 2011, p.2).


"For me,
personally and
politically, there's
no separating my
womanness,
my blackness,
my transness
from my
me-ness."
Janet Mock
Writer and Trans Activist
National Black Justice Coalition
NBJC.org
#BlackTransProud
Transgender Awareness Week

"… What makes an analysis intersectional —whatever terms it deploys, whatever its iteration, whatever its field or discipline — is its adoption of an intersectional way of thinking about the problem of sameness and difference and its relation to power."
(Cho, Crenshaw, & McCall, 2013, p. 795)

Prof. Kimberlé Crenshaw
Columbia University

Prof. Sumi Cho,
DePaul University

Prof. Leslie McCall
Graduate Center, CUNY

Sumi Cho
Kimberlé Williams Crenshaw
Leslie McCall

Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis

Focusing primarily on social identities/positions “runs the risk of continuing to reinforce the intractability of inequity, albeit in a more detailed or nuanced way”
(Bauer, 2014, p. 12)

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Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity

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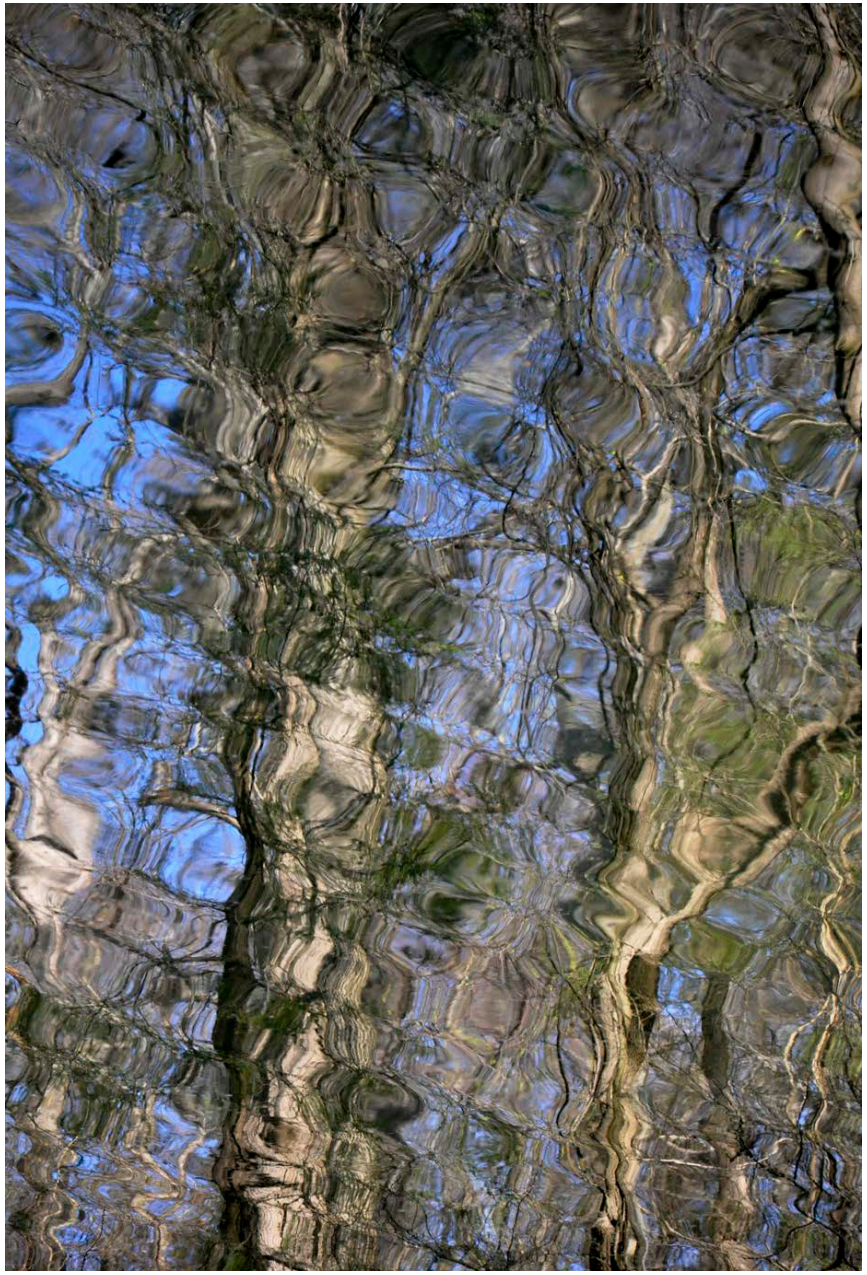
Summing Up: 6 Takeaways

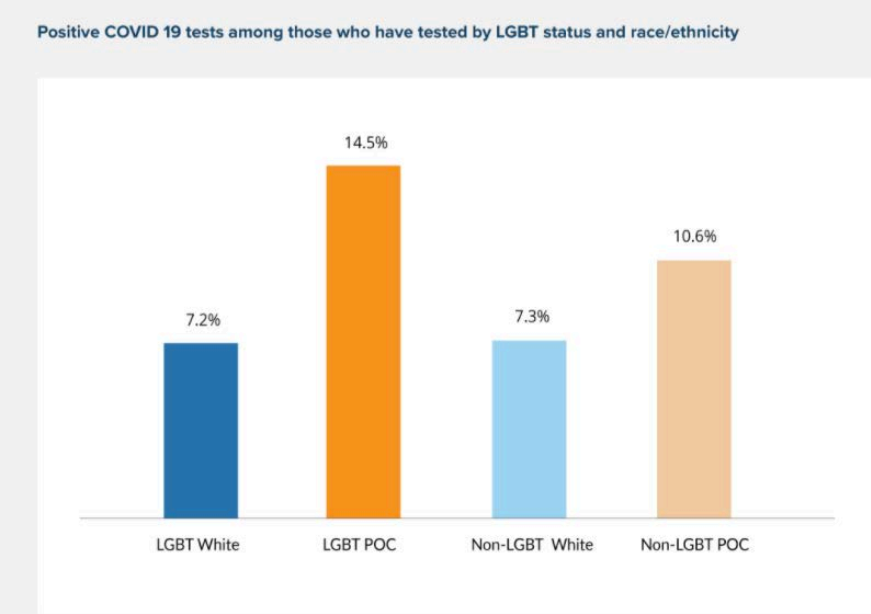


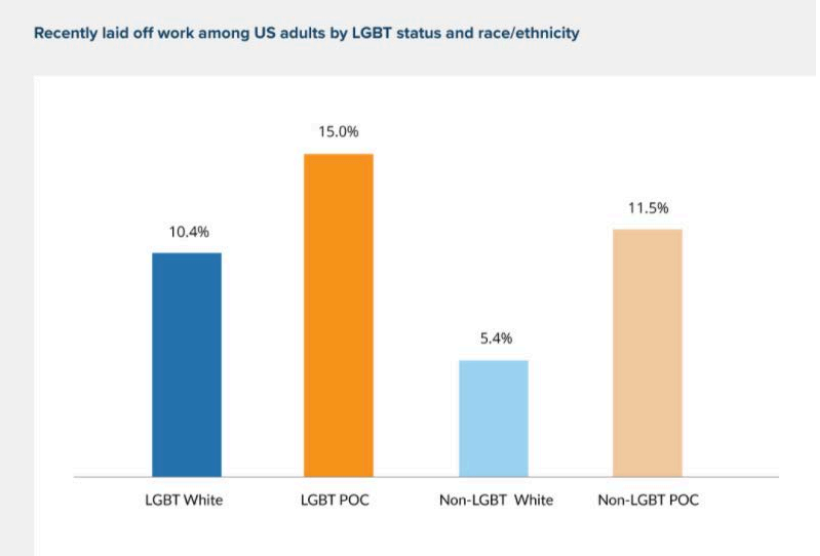
6 Takeaways

1. Center marginalized intersectional groups to highlight/address their "specific and particular concerns" (Crenshaw, 1989, p. 166)

2. Avoid demographics as sole explanations for health inequities;

3. Reconceptualize health as a function of structural/policy decisions, choices, and practices; not just individual "choices"





Source: https://williamsinstitute.law.ucla.edu/publications/covid-surge-lgbt/

"Although genetic risk factors may contribute to the severity of COVID-19, race is a poor proxy to understand the population distribution of such risk factors. Compelling evidence shows that racism, not race, is the most relevant risk factor" (Yudell, Roberts, DeSalle, Tishkoff et al., 2020, p. 1313)

LETTERS

Edited by **Jennifer Sills**

NIH must confront the use of race in science

Recent protests across the United States and the world have called attention to anti-Black racism in policing, employment, housing, and education. Science and medicine also have long histories of racism (*1*, *2*). This unfortunate yet persistent aspect of science and medicine includes the use of obsolete concepts of race to measure human biological difference and the false belief, by some, that differences in disease outcomes stem primarily from pathophysiological differences between racial groups (*3*, *4*).

We are particularly concerned that explanations for the disproportionate rates of coronavirus disease 2019 (COVID-19) in Black, Latino, Indigenous, and other communities of color will mistakenly point to innate racial differences instead of long-standing institutionalized racism and other underlying social, structural, and environmental determinants. Although genetic risk factors may contribute to severity of COVID-19 (*5*, *6*), race is a poor proxy to understand the population distribution of such risk factors (*7*). Compelling evidence shows that racism, not race, is the most relevant risk factor (*8*, *9*). We are hopeful that scientists will not turn to racial science—a reflection of long-standing beliefs about superiority and inferiority that have no place in scientific and clinical practice (*1*, *10*)—to explain COVID-19 disparities and justify policy responses to it. However, racial categories have been misused in the past.

In 2016, we called for the elimination of the use of race as a means to classify biological diversity in both laboratory and clinical research. Since that time, little has changed (*11*). The National Institutes of Health (NIH) made progress by releasing a request for applications in support of research leading to the creation of best practices for the study of race and other population identifiers (*12*). However, R01 awards could take years to address these issues, and NIH still offers no guidance about the use of racial and ethnic identifiers in research beyond recruitment. There is an urgent need for NIH to provide scientists with information about what utility racial data have beyond fostering diversity in research, how such information should or should not be used in data analysis, and what identifiers of human populations might be better suited for use in biomedical research.

To begin to address the misuse of racial measures in scientific and clinical practice, we urge the director of NIH to lead education efforts directed at both scientists and the public about the nature of human genetic diversity and the ongoing need and obligation to confront racism in science. In these troubled times, a clear statement regarding use and misuse of population identifiers in the pursuit of characterizing human difference could help alleviate ongoing and widespread confusion on such matters.

NIH should then support the National Academy of Sciences to bring together a diverse group of scientists and scholars to develop a consensus statement on best practices in genetic, clinical, and social scientific studies for characterizing human genetic diversity, including guidance for using racial categories to study racism's impact on human health. Guidelines for federally funded science should also include best practices for the integration of biological, social, structural, and environmental health determinants into the study of human health and disease.

NIH should continue and expand its work to hire more career scientists and clinicians from underrepresented minority groups. It should also substantially increase the extramural funding that supports scientists from underrepresented groups at every level of training and throughout career development. We have the tools to remedy this challenge. The time to act is now.

Michael Yudell[1]*, Dorothy Roberts[2], Rob DeSalle[3], Sarah Tishkoff[4], and 70 signatories
[1]Department of Community Health and Prevention, Drexel University School of Public Health,

A member of the Black Doctors COVID-19 Consortium, formed to help address health disparities in the African American community, tests a patient. Racial disparities in COVID-19 cases are better explained by structural racism than by genetic differences.

Published by AAAS

Source: *Science Magazine*, 2020
https://www.sciencemagazinedigital.org/sciencemagazine/11_september_2020/MobilePagedArticle.action?articleId=1618896#articleId1618896

By Thomas M. Selden and Terceira A. Berdahl

DOI: 10.1377/hlthaff.2020.00897
HEALTH AFFAIRS 39,
NO. 9 (2020): 1624–1632

COVID-19 And Racial/Ethnic Disparities In Health Risk, Employment, And Household Composition

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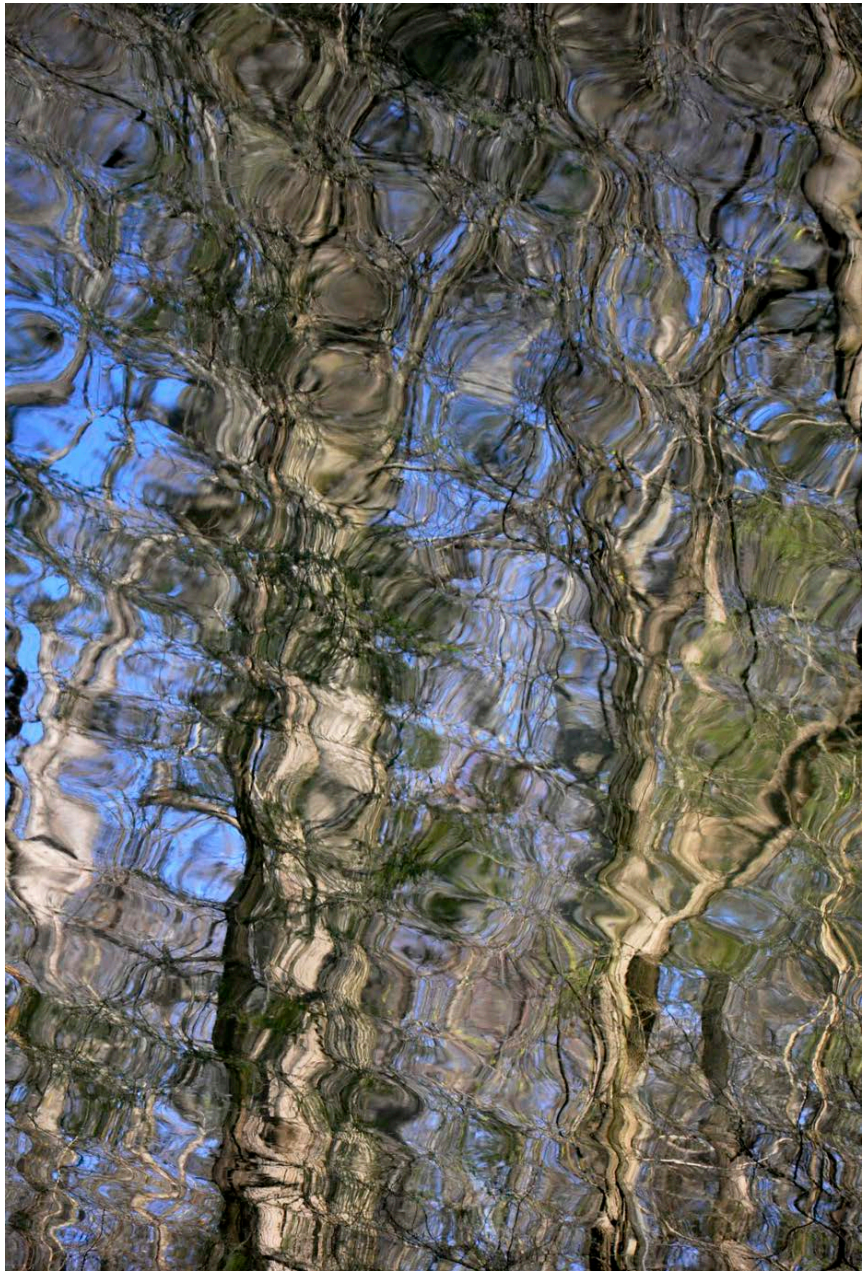
Terceira A. Berdahl is a social science analyst in the Division of Research and Modeling, Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality.

ABSTRACT We used data from the Medical Expenditure Panel Survey to explore potential explanations for racial/ethnic disparities in coronavirus disease 2019 (COVID-19) hospitalizations and mortality. Black adults in every age group were more likely than White adults to have health risks associated with severe COVID-19 illness. However, Whites were older, on average, than Blacks. Thus, when all factors were considered, Whites tended to be at higher overall risk compared with Blacks, with Asians and Hispanics having much lower overall levels of risk compared with either Whites or Blacks. We explored additional explanations for COVID-19 disparities—namely, differences in job characteristics and how they interact with household composition. Blacks at high risk for severe illness were 1.6 times as likely as Whites to live in households containing health-sector workers. Among Hispanic adults at high risk for severe illness, 64.5 percent lived in households with at least one worker who was unable to work from home, versus 56.5 percent among Black adults and only 46.6 percent among White adults.

Discussion

"Disparities in COVID-19 outcomes likely stem from structural racism on many levels."

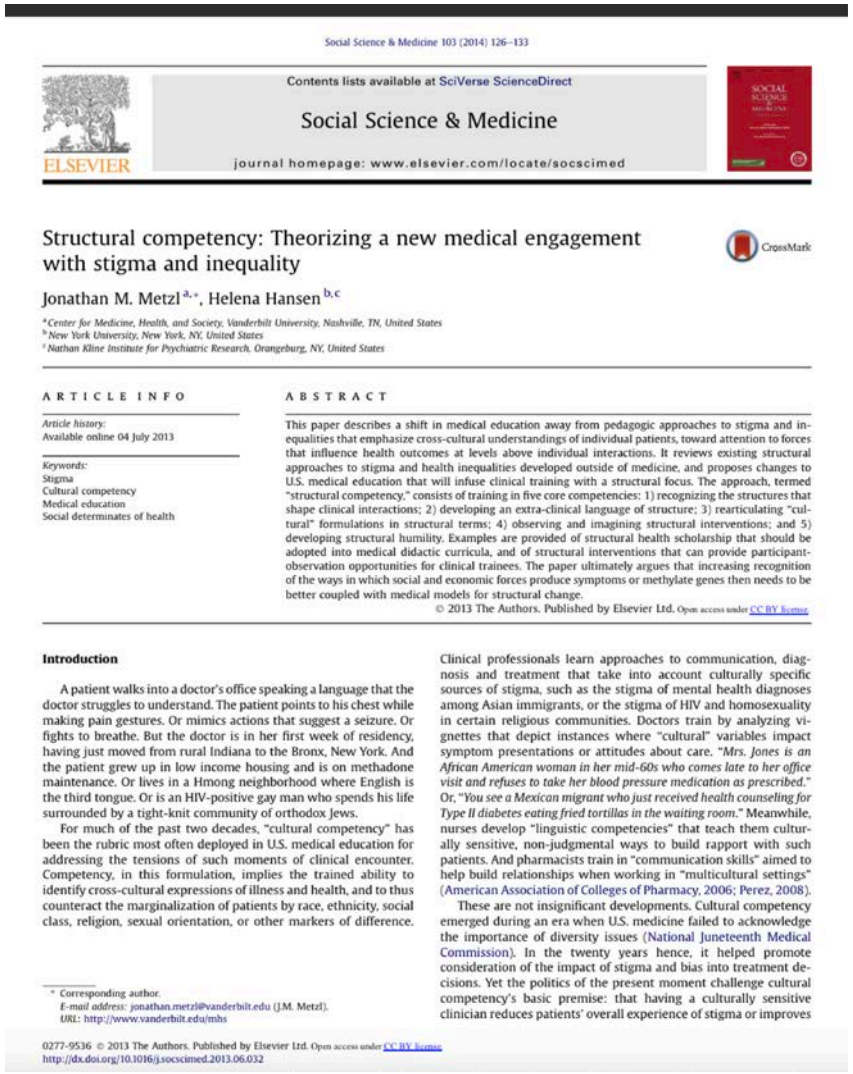


6 Takeaways

4. Develop critical and structural competence
5. Commit to "ask[ing] the other question"
6. Because we are not all in this together, one size-fits all interventions/approaches are likely to be ineffective

Structural Competency
(Metzl & Hansen, 2014)

1. Recognize [intersectional] structures that shape health outcomes of interest
2. Develop an “extra-clinical” language of structure
3. Rearticulate “cultural” formulations in structural terms
4. Observe and imagine structural interventions
5. Develop structural humility



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Structural competency: Theorizing a new medical engagement with stigma and inequality

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ABSTRACT

This paper describes a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. It reviews existing structural approaches to stigma and health inequalities developed outside of medicine, and proposes changes to U.S. medical education that will infuse clinical training with a structural focus. The approach, termed "structural competency," consists of training in five core competencies: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating "cultural" formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility. Examples are provided of structural health scholarship that should be adopted into medical didactic curricula, and of structural interventions that can provide participant-observation opportunities for clinical trainees. The paper ultimately argues that increasing recognition of the ways in which social and economic forces produce symptoms or methylate genes then needs to be better coupled with medical models for structural change.

Introduction

A patient walks into a doctor's office speaking a language that the doctor struggles to understand. The patient points to his chest while making pain gestures. Or mimics actions that suggest a seizure. Or fights to breathe. But the doctor is in her first week of residency, having just moved from rural Indiana to the Bronx, New York. And the patient grew up in low income housing and is on methadone maintenance. Or lives in a Hmong neighborhood where English is the third tongue. Or is an HIV-positive gay man who spends his life surrounded by a tight-knit community of orthodox Jews.

For much of the past two decades, "cultural competency" has been the rubric most often deployed in U.S. medical education for addressing the tensions of such moments of clinical encounter. Competency, in this formulation, implies the trained ability to identify cross-cultural expressions of illness and health, and to thus counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference.

Clinical professionals learn approaches to communication, diagnosis and treatment that take into account culturally specific sources of stigma, such as the stigma of mental health diagnoses among Asian immigrants, or the stigma of HIV and homosexuality in certain religious communities. Doctors train by analyzing vignettes that depict instances where "cultural" variables impact symptom presentations or attitudes about care. "*Mrs. Jones is an African American woman in her mid-60s who comes late to her office visit and refuses to take her blood pressure medication as prescribed.*" Or, "*You see a Mexican migrant who just received health counseling for Type II diabetes eating fried tortillas in the waiting room.*" Meanwhile, nurses develop "linguistic competencies" that teach them culturally sensitive, non-judgmental ways to build rapport with such patients. And pharmacists train in "communication skills" aimed to help build relationships when working in "multicultural settings" (American Association of Colleges of Pharmacy, 2006; Perez, 2008).

These are not insignificant developments. Cultural competency emerged during an era when U.S. medicine failed to acknowledge the importance of diversity issues (National Juneteenth Medical Commission). In the twenty years hence, it helped promote consideration of the impact of stigma and bias into treatment decisions. Yet the politics of the present moment challenge cultural competency's basic premise: that having a culturally sensitive clinician reduces patients' overall experience of stigma or improves

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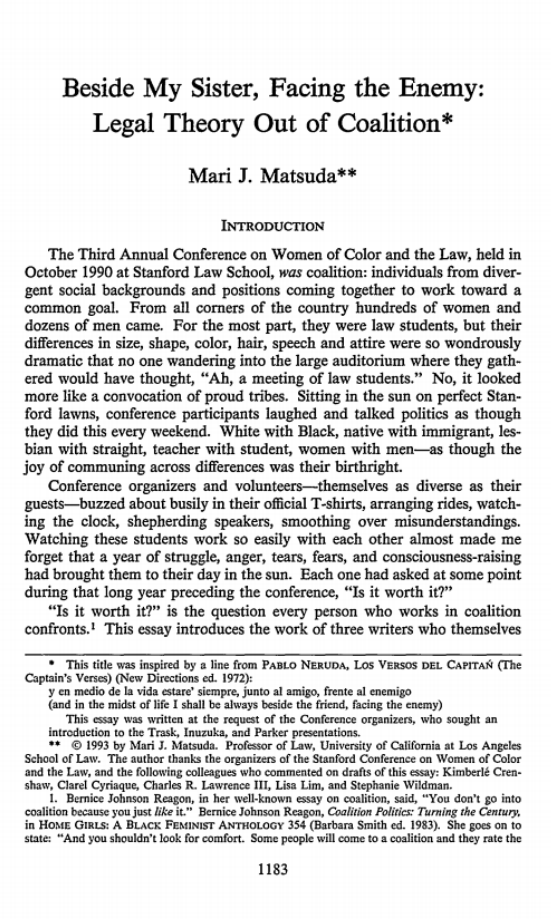
0277-9536
http://dx.doi.org/10.1016/j.socscimed.2013.06.032

“Ask the Other Question”

“The way I try to understand the interconnections of all forms of subordination is through a method I call “Ask the other question.” When I see something that looks racist, I ask “Where is the patriarchy in this?” When I see something that looks sexist, I ask, “Where is the heterosexism in this?” When I see something that looks homophobic, I ask, “Where are the class interests in this?” (Matsuda, 1991, p. 1189)



Beside My Sister, Facing the Enemy:
Legal Theory Out of Coalition*

Mari J. Matsuda**

INTRODUCTION

The Third Annual Conference on Women of Color and the Law, held in October 1990 at Stanford Law School, *was* coalition: individuals from divergent social backgrounds and positions coming together to work toward a common goal. From all corners of the country hundreds of women and dozens of men came. For the most part, they were law students, but their differences in size, shape, color, hair, speech and attire were so wondrously dramatic that no one wandering into the large auditorium where they gathered would have thought, “Ah, a meeting of law students.” No, it looked more like a convocation of proud tribes. Sitting in the sun on perfect Stanford lawns, conference participants laughed and talked politics as though they did this every weekend. White with Black, native with immigrant, lesbian with straight, teacher with student, women with men—as though the joy of communing across differences was their birthright.

Conference organizers and volunteers—themselves as diverse as their guests—buzzed about busily in their official T-shirts, arranging rides, watching the clock, shepherding speakers, smoothing over misunderstandings. Watching these students work so easily with each other almost made me forget that a year of struggle, anger, tears, fears, and consciousness-raising had brought them to their day in the sun. Each one had asked at some point during that long year preceding the conference, “Is it worth it?”

“Is it worth it?” is the question every person who works in coalition confronts.[1] This essay introduces the work of three writers who themselves

* This title was inspired by a line from PABLO NERUDA, LOS VERSOS DEL CAPITÁN (The Captain’s Verses) (New Directions ed. 1972):
y en medio de la vida estare’ siempre, junto al amigo, frente al enemigo
(and in the midst of life I shall be always beside the friend, facing the enemy)
This essay was written at the request of the Conference organizers, who sought an introduction to the Trask, Inuzuka, and Parker presentations.

** © 1993 by Mari J. Matsuda. Professor of Law, University of California at Los Angeles School of Law. The author thanks the organizers of the Stanford Conference on Women of Color and the Law, and the following colleagues who commented on drafts of this essay: Kimberlé Crenshaw, Clarel Cyriaque, Charles R. Lawrence III, Lisa Lim, and Stephanie Wildman.

1. Bernice Johnson Reagon, in her well-known essay on coalition, said, “You don’t go into coalition because you just *like* it.” Bernice Johnson Reagon, *Coalition Politics: Turning the Century*, in HOME GIRLS: A BLACK FEMINIST ANTHOLOGY 354 (Barbara Smith ed. 1983). She goes on to state: “And you shouldn’t look for comfort. Some people will come to a coalition and they rate the

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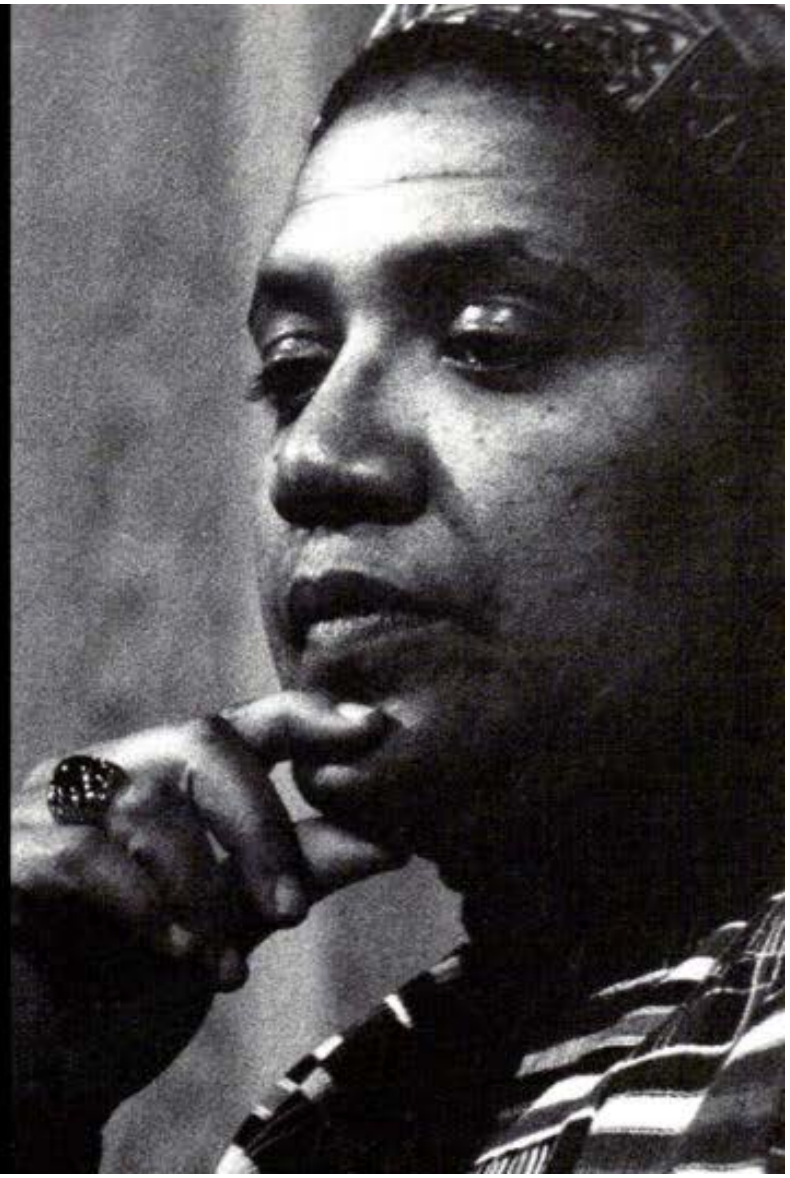
There is no such thing as single-issue struggle because we do not live single-issue lives.

–Audre Lorde



The End. Thank You.

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