

INTERSECTIONALITY AND HEALTH WHY IT MATTERS

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ACKNOWLEDGMENT

TRAINING OBJECTIVES

- ❖ Describe the tenants of intersectionality
- ❖ Demonstrate the importance of intersectionality in medical and health settings
- ❖ Apply principles of intersectionality in medical and health professions

INTERSECTIONALITY EXPLAINED

Coined in 1989 by Crenshaw to explain the differences of Black women in the legal system compared with White women and men.

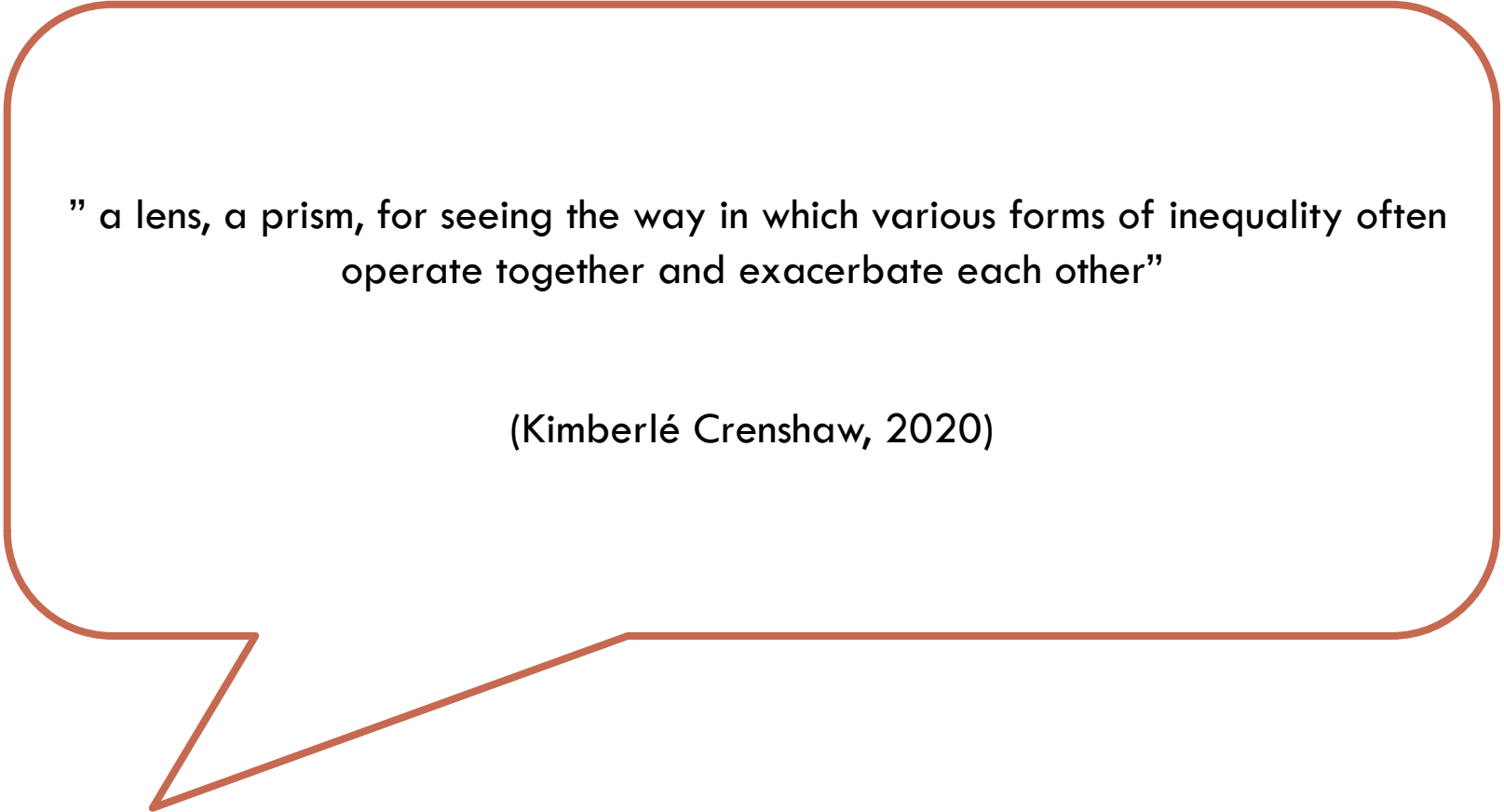
A lens for understanding how individuals experience the social environment.

Individuals are shaped by their intertwined social identities.

Each identity has different levels of power and privilege in our society but the person is shaped by the totality of this power.

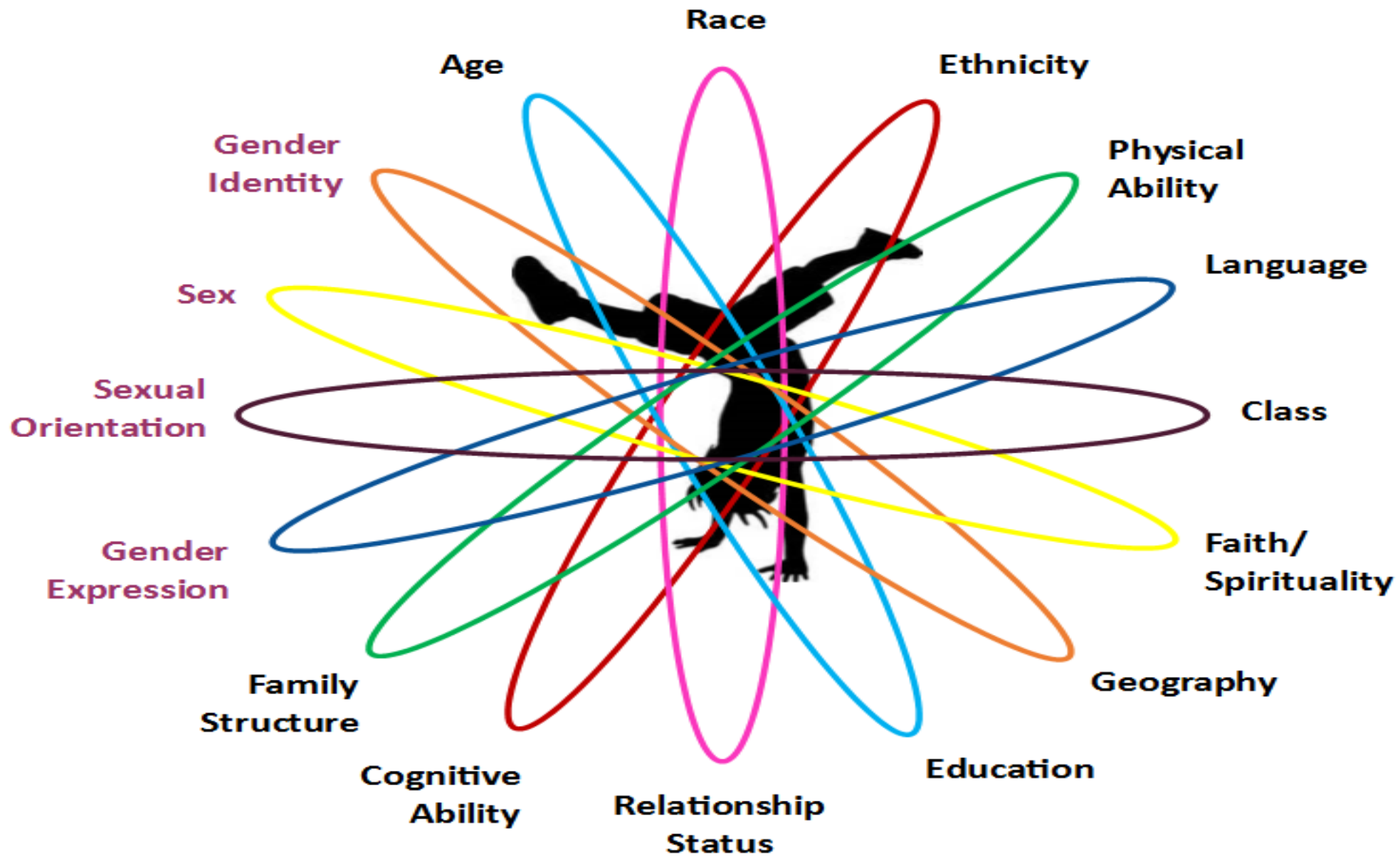
The interdependence of your identity interacts with systems and structures of power.

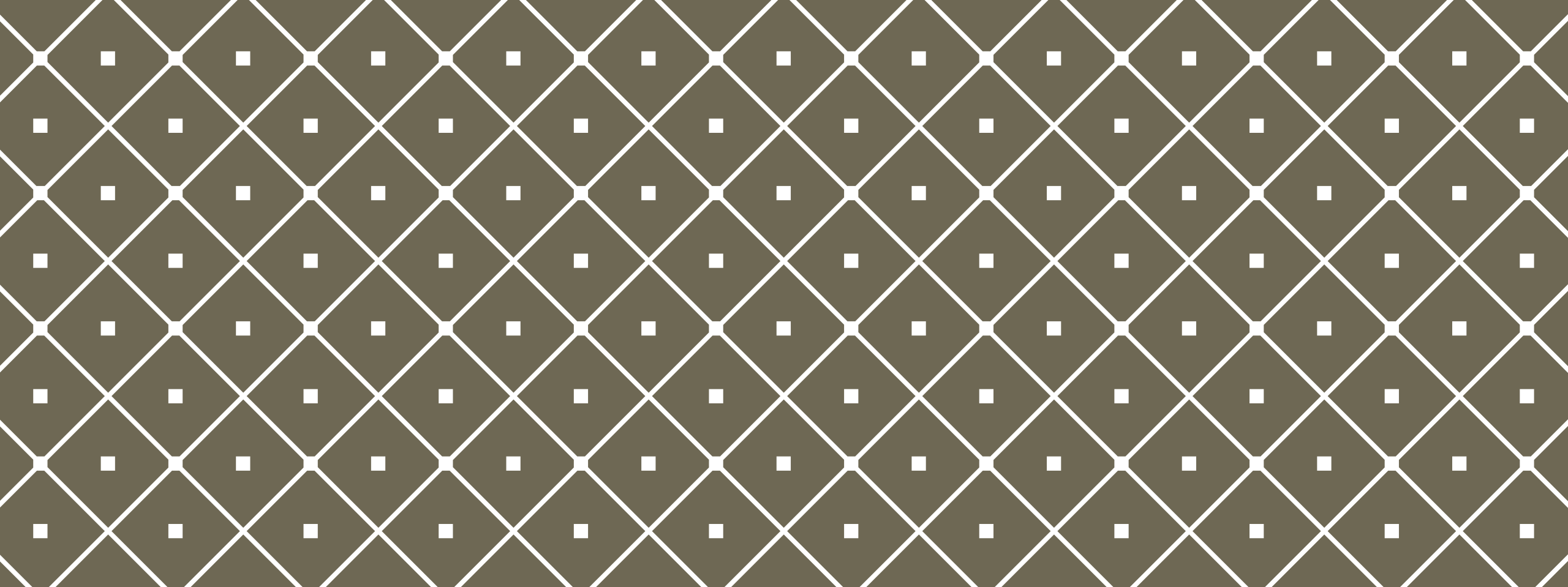
These systems and structures of power help to create and perpetuate oppression of marginalized groups.



” a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other”

(Kimberlé Crenshaw, 2020)

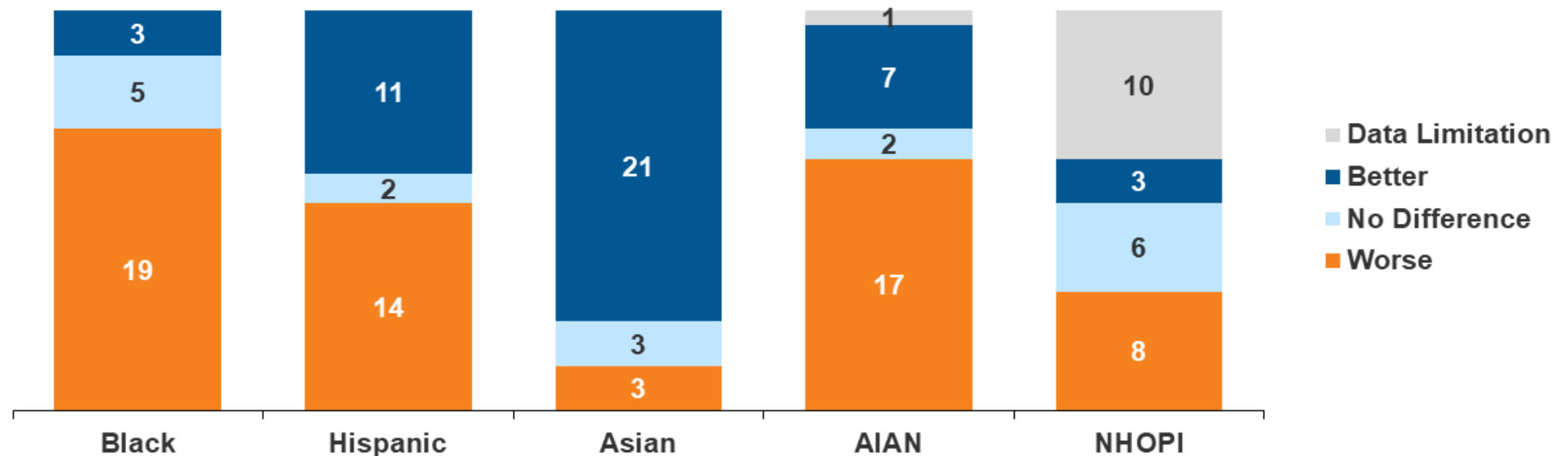




WHY IT MATTERS IN MEDICAL & HEALTH SETTINGS

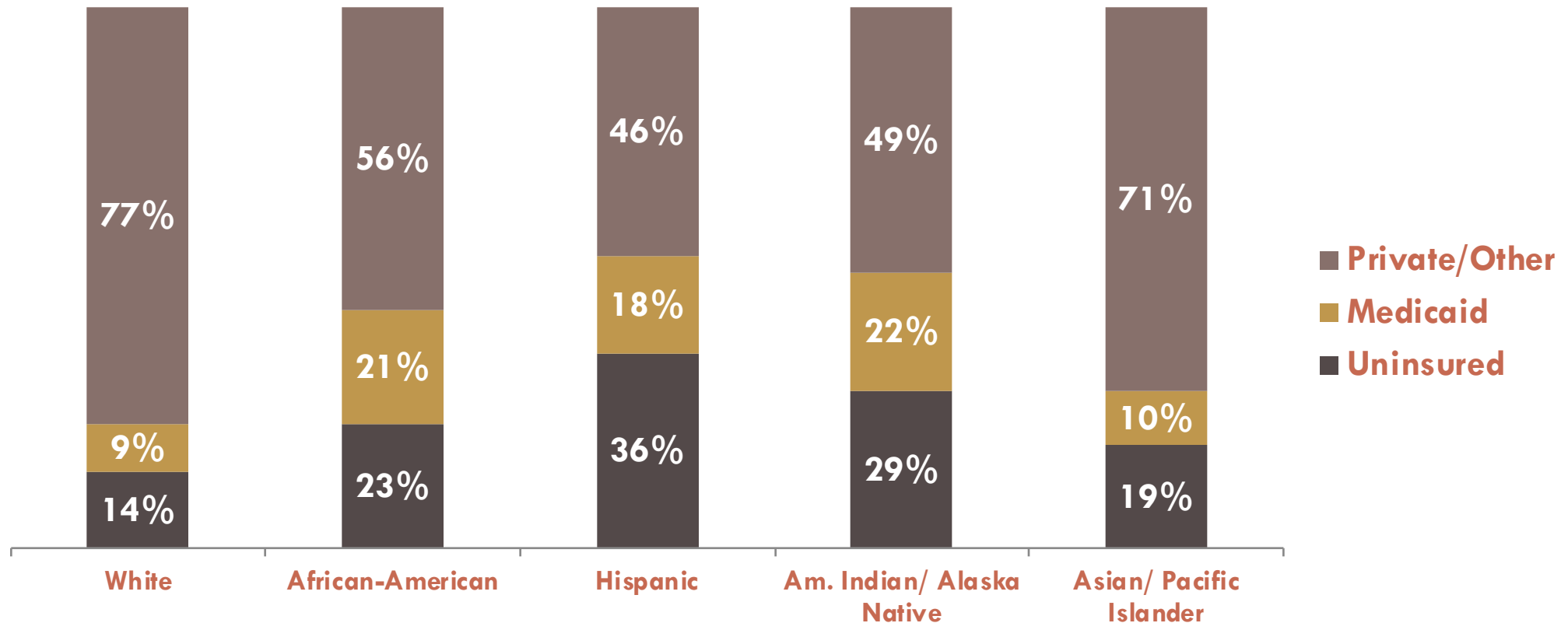
POST-ACA HEALTH STATUS AMONG GROUPS OF COLOR COMPARED TO WHITES

NUMBER OF MEASURES FOR WHICH GROUP FARED BETTER, THE SAME, OR WORSE COMPARED TO WHITES:



Note: Measures are for 2018 or the most recent year for which data are available. "Better" or "Worse" indicates a statistically significant difference from Whites at the $p < 0.05$ level. No difference indicates no statistically significant difference. "Data limitation" indicates data are no separate data for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible due to overlapping samples. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

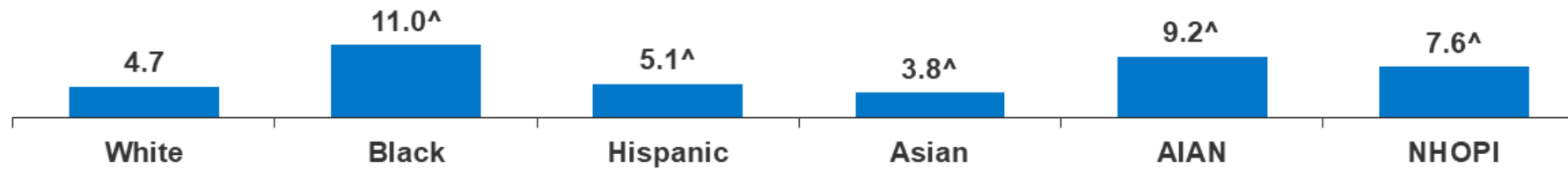
WOMEN OF COLOR MORE LIKELY TO BE UNINSURED OR COVERED BY MEDICAID, 2012



NOTE: Includes women ages 18 to 64. *Other* includes Medicare, TRICARE, and other coverage.

SOURCE: Kaiser Family Foundation and Urban Institute analysis of March 2013 Current Population Survey, U.S. Bureau of the Census.

INFANT MORTALITY RATE (PER 1,000) BY RACE/ETHNICITY, 2017

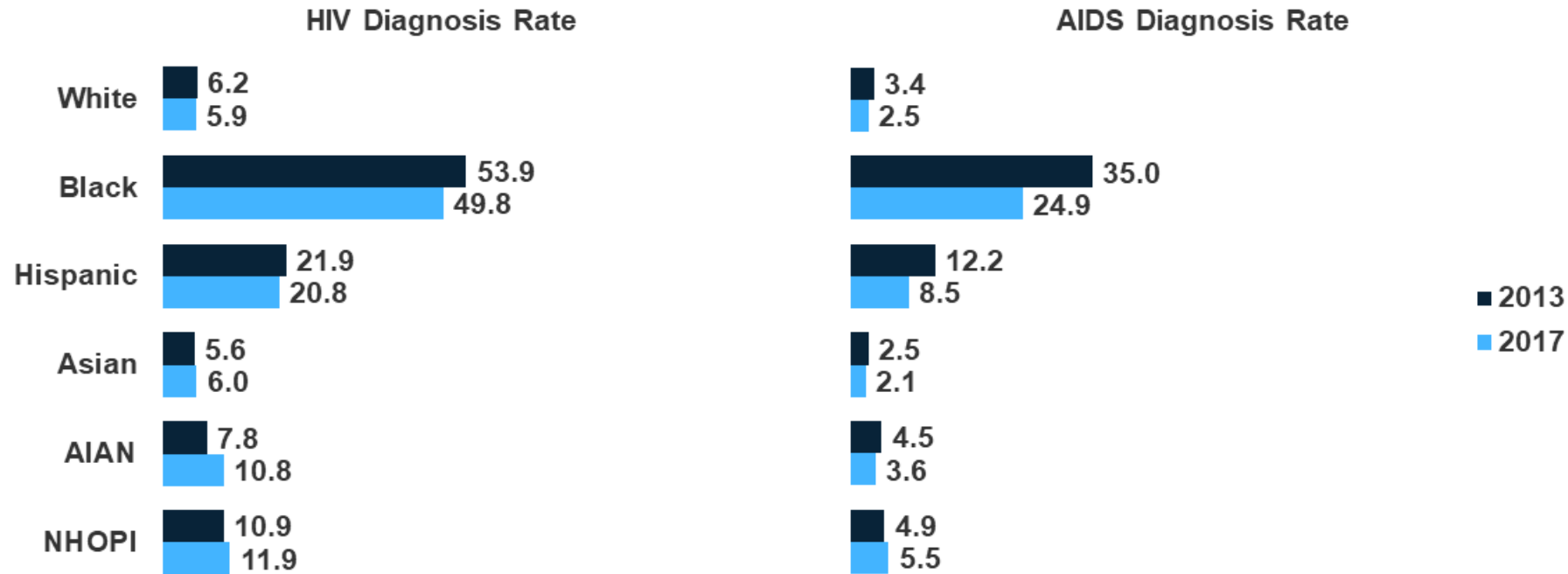


[^] Indicates statistically significant difference from Whites in the respective year at the $p < 0.05$ level.

Note: AIAN refers to American Indians and Alaska Natives. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, Linked Birth/Infant Death Records, 2013 & 2017, WONDER Online Database.

HIV OR AIDS DIAGNOSIS PER 100,000 AMONG TEENS AND ADULTS BY RACE/ETHNICITY, 2013-2017



Note: Data based on surveillance data reported by states to the CDC. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons categorized by race were not Hispanic or Latino. Individuals in each race category may, however, include persons whose ethnicity was not reported. Includes individuals age 13 and older. Data for HIV and AIDS diagnoses are as of 2017.
 Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2013-2017.



These health outcomes illustrate how systems and structures influence health outcomes.

These same systems and structures interact with the social and economic determinants of health to create disparities.

While indicators only provide a snapshot, we have to overlap these disparities to better understand people who interact with the medical and health systems.

Social and Economic Factors Drive Health Outcomes

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Racism and Discrimination					
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Food security Access to healthy options	Social integration Support systems Community engagement Stress Exposure to violence/trauma	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes: Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

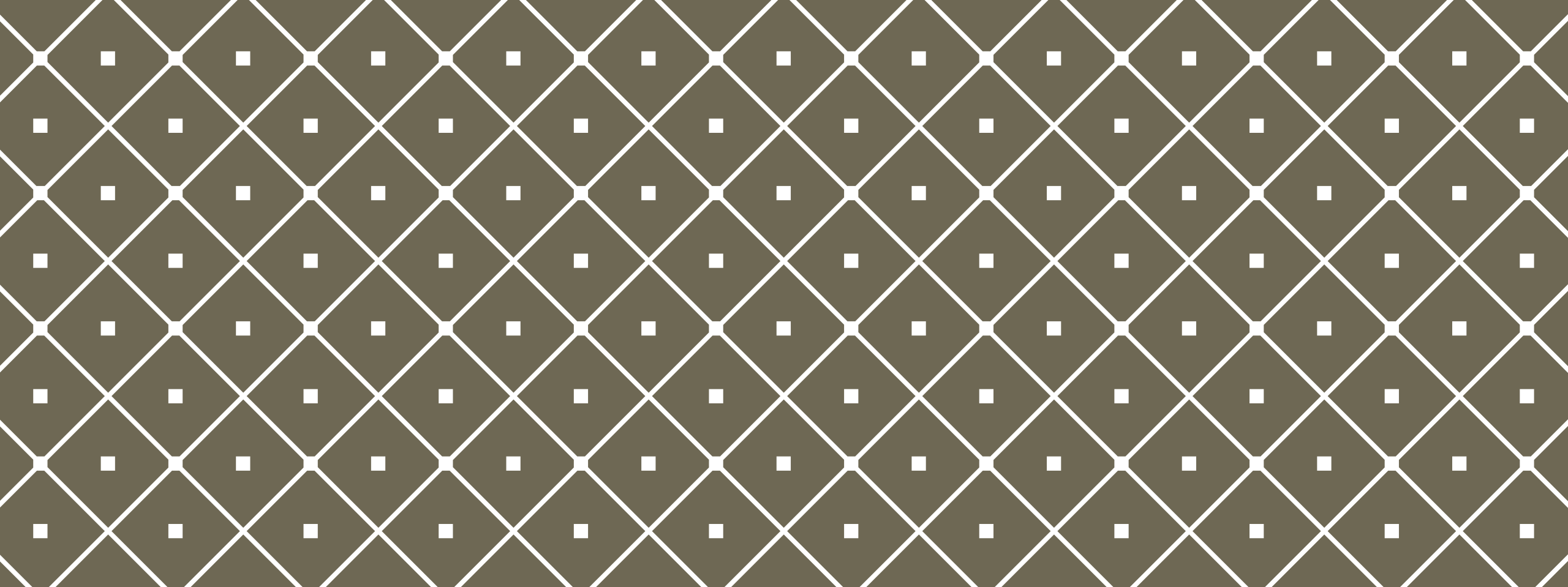
PULLING IT TOGETHER

Reflect on your own intersectional identity and how power will shape patient-provider relationship

Important to attend to the totality of patient's identities

Assess individual identities

Assess for social and economic determinants of health



BREAKOUT SESSION |



INSTRUCTIONS FOR BREAKOUT SESSION

In your group, discuss how you might implement an intersectional lens to your work with patients?

What changes can be made by yourself and your practice to attend to the issues of power in the patient-provider relationship?