



# Intersectionality in HIV and Other Health-Related Research



## Question

What is the current knowledge/evidence on intersectionality in HIV and other health-related research?

## Key Take-Home Messages

- Human experiences cannot be reduced to singular characteristics as these characteristics interact with others to produce health outcomes.
- Using social categories, such as class, race, gender, sexual orientation, in HIV and health research risks obfuscating the lived experiences of people with multiple social identities that intersect and affect their health and wellbeing.
- Intersectionality theory posits that multiple social identities and categories are not additive. That is, an HIV-positive woman who injects drugs does not face the same challenges and have the same needs as the sum of an HIV-positive individual, a woman, and a person who injects drugs. The woman's lived experience is unique, and thus research and interventions should refrain from generalizing and categorizing in order to include the lived experiences of all populations.
- Intersectionality-based research encourages research that explores the roots of stigma, discrimination and health care barriers, and the development of interventions that addresses micro (personal/interpersonal), meso (society/community/provincial), and macro (national/policies) causes of health inequities.
- There is growing evidence from intersectional HIV and health-related research to support the need to incorporate intersectionality theory into health research, with the goals of identifying and addressing social and power structures that cause health inequities and poorer health outcomes within marginalized populations.

## EVIDENCE INTO ACTION

The OHTN Rapid Response Service offers HIV/AIDS programs and services in Ontario quick access to research evidence to help inform decision making, service delivery and advocacy. In response to a question from the field, the Rapid Response Team reviews the scientific and grey literature, consults with experts, and prepares a brief fact sheet summarizing the current evidence and its implications for policy and practice.

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## References

1. Remis RS, Swantee C, Liu J. HIV/AIDS in Ontario: Preliminary Report, 2010. Toronto, Ontario: Ontario HIV Epidemiologic Monitoring Unit; 2012.
2. Ontario Ministry of Health and Long Term Care. Ontario HIV/AIDS Infection Rates. 2012. Retrieved 1 June 2013 from: [http://www.health.gov.on.ca/en/public/programs/hivaids/charact\\_epidemic.aspx](http://www.health.gov.on.ca/en/public/programs/hivaids/charact_epidemic.aspx)
3. Bowleg L. The problem with the phrase women and minorities: Intersectionality - an important theoretical framework for public health. *American Journal of Public Health* 2012;102(7):1267-73.
4. 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.
5. Bowleg L, Teti M, Malebranche DJ, Tschann JM. "It's an uphill battle everyday": Intersectionality, low-income Black heterosexual men, and implications for HIV prevention research and interventions. *Psychology of Men & Masculinity* 2013;14(1):25-34.
6. Hankivsky O. An intersectionality-Based Policy Analysis Framework. Institute for Intersectionality Research and Policy, Simon Fraser University, Vancouver, BC, 2012.
7. Hankivsky O, Christoffersen A. Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*. 2008;18(3):271-283.
8. Hankivsky O, Reid C, Cormier R, Varcoe C, Clark N, Benoit C, Brotman S. Exploring the promises of intersectionality for advancing women's health research. *International Journal for Equity in Health* 2010;9(5).
9. Kazanjian A, Hankivsky O. Reflections on the future of women's health research in a comparative context: Why more than sex and gender matters. *Women's Health Issues* 2008;18(5):343-346.
10. Springer KW, Hankivsky O, Bates LM. Gender and health: Relational, intersectional, and biosocial approaches. *Social Science and Medicine* 2012;74(11):1661-1666.

## The Issue and Why It's Important

The number of new HIV cases in Ontario has remained relatively stable from 2002 to 2010 (~1,100 new diagnoses/year), according to latest estimates reported by the Ontario HIV Epidemiologic Monitoring Unit.[1] New infections continue to disproportionately affect specific populations in Ontario, including: gay and bisexual men, and other men who have sex with men; African, Caribbean and Black Ontarians; people who use injection drugs; Aboriginal Peoples; and women (who are members of the above populations or engage in HIV risk activity with them).[2] Although these higher risk populations are categorized as separate groups, they are not mutually exclusive. On the contrary, these groups should be considered as mutually constitutive – an individual could live an intersectional experience of being an African man who injects drugs and has sex with men and women.

An individual at the intersection of multiple identities and experiences could face different challenges and obstacles as a person living with or at-risk of HIV, and it is important that their lived experiences are not left out of HIV research and advocacy solely because they do not fit, categorically, into one of the high-risk populations. Rooted in social justice, applying the concept of intersectionality – an approach stemming from feminist theory that has recently emerged in health care research – to HIV research could reveal social inequities previously invisible, and more comprehensively address the social and structural determinants of the ongoing epidemic in Ontario.

## What We Found

We found 16 commentaries, editorials and reviews about applying intersectionality theory to HIV and other health-related research. Furthermore, nine original studies revealed new knowledge on intersectionality in HIV and health.

### What is intersectionality?

Intersectionality was born out of the Black feminist movement and has emerged in feminist theory as an approach that focuses on multiple historically oppressed populations.[3-10] "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)."[3] Furthermore, intersectionality challenges prevailing research practices that prioritize "any specific axis of inequality, such as race, class, or gender,"[11] and rejects the assumed additivity of those inequalities.[12] That is, the experience of an HIV-positive Caribbean gay man is not equal to the sum of the experiences of an HIV-positive person, a Caribbean person and a gay man. Accordingly, intersectionality-based research goes beyond studying the effects of multiple intersecting oppressions at the interpersonal level (e.g., day-to-day experiences of gay men as a consequence of heterosexism); it seeks to elucidate what are the upstream causes of those micro-level experiences in terms of sociopolitical and economic history (e.g., colonialism and its long-term effects on Aboriginal health in Canada) and other forms of systemic and structural violence.

The central tenets of intersectionality are as follows:

- Human lives and their social dimensions cannot be reduced to single characteristics and separated into discrete strands.[6, 8]
- Social identities are not independent but are multiple and intersecting [3]. These social identities/categories/locations are “socially constructed, fluid and flexible” (i.e., they change according to time and place, and are influenced by changing power structures), and one cannot be prioritized over another in order to accurately understand human experiences.[6]
- “People from multiple historically oppressed and marginalized groups are the focal or starting part.” [3]
- Multiple social identities at the micro-level (personal/interpersonal experiences) intersect with meso-level factors (social/community/provincial), and macro-level structural factors (e.g, national/organizational policies and structures) to produce health inequities.[3, 6]
- Intersectionality is rooted in the promotion of social justice and equity, and seeks to challenge and shift power structures.[6, 8]

### Why should intersectionality approaches be applied to HIV research?

Health and public health research has goals of improving the health and well-being of populations, which inherently involves resolving health inequities that may result from social, political, economic and historical disparities and oppression. It should follow then, as Lisa Bowleg [3] argues, that intersectionality stands to benefit public health and health care research in at least five ways:

1. Serving as a unifying language and theoretical frameworks for public health scholars who are already engaged in investigating intersections of race, ethnicity, gender, sexual orientation, socio-economic status (SES), and disability to reduce and eliminate health disparities
2. Prompts public health scholars to conceptualize and analyze disparities and social inequities in complex and multidimensional ways that mirror the experiences of populations for whom adverse health outcomes are most disproportionate
3. Focusing on the importance of macro-level social-structural factors beyond the level of individual health
4. Facilitating and informing the development of well-targeted and cost-effective health promotion messages, interventions, and policies for historically oppressed or marginalized populations
5. Summoning and supporting the collection, analyses, and presentation of surveillance and health data that allow examination of multiple interlocking social identities across several categories beyond race and gender. [3]

Much of the literature on intersectionality in HIV and other health-related research suggests that the majority and tendency of existing research is to overlook intersections between different social categories, and to treat categories such as race and gender separately.[5, 13-15] However, this approach undermines efforts to eliminate health disparities and risks excluding certain populations from the benefits of research and health promotion. For example, despite substantial evidence on the negative health impacts of HIV-related stigma, there is a paucity of research exploring the intersection of HIV-related stigma and other forms of stigma, such as racism, heterosexism, sexism

11. Hankivsky O. Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science & Medicine* 2012;74(11):1712-20.
12. Rogers J, Kelly UA. Feminist intersectionality: Bringing social justice to health disparities research. *Nursing Ethics* 2011;18(3):397-407.
13. Cole ER. Intersectionality and research in psychology. *American Psychologist* 2009;64(3):170-80.
14. Kelly UA. Integrating intersectionality and biomedicine in health disparities research. *Advances in Nursing Science* 2009;32(2):E42-56.
15. Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science and Medicine* 2012;75(12):2099-106.
16. Logie CH, James L, Tharao W, Loutfy MR. HIV, gender, race, sexual orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada. *PLoS medicine* 2011;8(11):e1001124.
17. Haile FR. Social stigma and HIV/AIDS in Black MSM. Dissertation, University of Michigan, 2009.
18. Smye V, Browne AJ, Varcoe C, Josewski V. Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context. *Harm Reduction Journal* 2011;8(1):17.
19. McCall L. The complexity of intersectionality. *Signs: Journal of Women, Culture and Society* 2005;30(3):1771-1800.
20. Griffith DM. An intersectional approach to Men's Health. *Journal of Men's Health* 2012;9(2):106-112.
21. Doyal L. Challenges in researching life with HIV/AIDS: An intersectional analysis of black African migrants in London. *Culture, Health and Sexuality* 2009;11(2):173-188.
22. Collins PY, von UH, Armbrister A. Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. *Social Science & Medicine* 2008;67(3):389-97.

23. Logie CH, James L, Tharao W, Loutfy MR. "We don't exist": a qualitative study of marginalization experienced by HIV-positive lesbian, bisexual, queer and transgender women in Toronto, Canada. *Journal of the International AIDS Society* 2012;15(2):17392.
24. Warner DF, Brown TH. Understanding how race/ethnicity and gender define age-trajectories of disability: An intersectionality approach. *Social Science & Medicine* 2011;72(8):1236-48.
25. Veenstra G. Race, gender, class, and sexual orientation: Intersecting axes of inequality and self-rated health in Canada. *International Journal for Equity in Health* 2011;10(1):3.

and classism.[16, 17] Applying an intersectional approach to HIV research would focus on multiple disadvantaged social statuses, which is key to “identifying the root causes of health disparities and to designing effective interventions.”[18]

### How is intersectionality applied to HIV and other health-related research?

There is no singular approach to conducting intersectionality research, and the knowledge in this area is only starting to emerge in the literature, particularly regarding applying intersectionality theory to health research. One often-cited, quintessential paper on intersectionality methodology by Leslie McCall [19] suggests three different approaches:

1. *Intercategorical approach*: a researcher is critical of categories but recognizes that inequitable relationships within social groupings are associated with worse health outcomes, and thus would choose categories on which to focus their analysis. For example, one study could specifically explore the health outcomes of HIV-positive immigrant African women living in Ontario.
2. *Anticategorical approach*: a researcher jettisons all categories and deconstructs them, often using in-depth ethnographic methods, and asking open-ended questions [4] in order to flesh out the effects of intersecting social identities and experiences.
3. *Intracategorical approach*: this is a more statistics-oriented approach that involves identifying master categories (such as gender and race) on which analyses are conducted to identify interaction between those categories. This is a common approach used in epidemiology research – for example, a study looking at the HIV risk factors among men who have sex with men would also analyze the (statistical) interaction between “race” and “income-level.”

Arguably, there exists HIV and health-related research focused on intersecting social identities and experiences, such as research focusing on HIV-positive women who inject drugs or African men who have sex with men; however most of this research has not been explicitly based on an intersectionality approach. According to leading researchers in the field of intersectionality, this sort of research should go beyond identifying associations and correlations (e.g., HIV-positive women who inject drugs have worse health outcomes than those who do not inject drugs), and should place those findings within the context of sociopolitical and historical structures,[11] and identify interventions that go beyond addressing interpersonal level outcomes to addressing systemic and structural causes for those disparities.[4] In addition to identifying who to include in a study and why, an intersectionality-informed researcher should ask what role inequality plays and where there are similarities across categories under study.[13, 20] For example, a study could find that HIV-positive bisexual women have similar coping mechanisms to HIV-related stigma as heterosexual HIV-positive men, and thus interventions targeting those populations could borrow from each other.[21] A prevalent suggestion for beginning intersectionality research is to conduct it with the full participation of the community throughout its entire process (community-based research). This approach would encourage inclusion of multiple social identities and would ensure appropriate interventions to be developed from the research.[14]

## What has existing intersectionality-based HIV and other health-related research revealed?

Our literature search found nine intersectionality-based studies in HIV and health. Below is a summary of their methods and findings:

### *HIV-related research*

- Collins et al. [22] conducted a qualitative study to understand the multiple identities that intersect to affect the sexuality and HIV risk of Latina women living with severe mental illness in New York City. Their study analyzes firsthand accounts obtained through in-depth interviews with the women in order to identify themes and main patterns in their stories and experiences. They found the effects of those multiple identities (gender, race/ethnicity, poverty, and immigrant status) could not be “meaningfully separated” and were “not always additive, but the interlocking effects can facilitate increased HIV risks.” The stigma associated with their mental illnesses often left the women more vulnerable to gender norms within their culture, and as a result, “the women describe feeling disrespected and used as sexual subjects with little power to insist on safer sex.” However, they also found that the women resisted the stigma attached to their mental illness within their communities by “aligning themselves with identities that bestow dignity and respect,” such as becoming religious and using their faith in God as tools to help cope with their situations. The researchers concluded that “women’s HIV risk is embedded in contextual factors that also need to change,” which includes access to economic self-sufficiency, challenging stigma and increasing women’s power.
- Bowleg et al. [5] interviewed a sample of Black heterosexual men to explore the multiple intersections of race, gender and socioeconomic status, and the implications for HIV research and interventions. Their analyses found individual-level experiences reflected macro social-structural inequalities through four themes: 1) racial discrimination and micro-aggressions; 2) unemployment; 3) incarceration; and 4) police surveillance and harassment. They conclude that “HIV prevention research and interventions informed from Black heterosexual men’s perspectives would necessarily have to address the social-structural issues that they perceive to be most relevant to their lives; not just the priorities of researchers” (e.g., increasing HIV risk perception, condom use or condom self-efficacy). This would include addressing issues resulting from incarceration histories as well as increased police surveillance and harassment.
- Using ethnographic methods of in-depth individual and focus group interviews, as well as naturalistic observation, Smye et al. [18] conducted a qualitative study to explore the intersectional experiences of Aboriginal Canadian men and women with mental health illness and who are on methadone maintenance treatment (including some who are HIV-positive). They found many individuals “had profound histories of abuse and violence, most often connected to the legacy of colonialism,” and “expressed mistrust with the healthcare system due to everyday experiences both within and outside the system that further marginalize them.” Although their experiences could be compared to other marginalized groups, their specific experiences represent a special set of challenges to harm reduction strategies.

For example, some women whose children have been apprehended by the state “as a consequence of the complex intersections of poverty, gender and problematic drug use,” reported difficulties visiting their children due to the lack of access to methadone maintenance clinics where their children were living. They concluded that these intersectional experiences more fully capture these men and women’s lived experiences with stigma and discrimination, and call for targeted interventions that address these root causes of health disparities.

- To explore the intersectional experience of social stigma and HIV/AIDS among Black men who have sex with men (MSM), Haile [17] conducted a two-part study. The first consisted of a 75-minute telephone survey with MSM in major U.S. cities to compare attitudes of White and Black MSM, which asked about their perceptions of racism within the gay community, whether they felt men of colour were an important part of their city’s gay community, and whether they felt their participation in the gay community was more positive or negative. The second part consisted of analyzing in-depth semi-structured interviews with ten New York City Black gay and bisexual men ages fifty and older, who have been living with HIV/AIDS since prior to 1996. These interviews explored the subjective constructions of social stigma and its management, and included topics such as experiences of social stigma, methods of coping with the diagnosis, perceptions of social support and perceptions of the future. The study found that Black men were more likely to perceive racism within the gay community, and less likely to feel positively affiliated with the gay community, than White men. He concluded: “future studies must explicitly address the empirical link between racial stigma, affiliation with the gay community and sexual-risk behaviour, as well as more directly assess the relationship between stigma and HIV-related vulnerability.”
- In an interview-based study of black African migrants living with HIV in London, UK, Doyal [21] observed that both heterosexual women and men turned to their spiritual beliefs and religion as a coping mechanism with their illness, however men were less likely to attend services regularly due to perceived homophobia and HIV-related stigma. Furthermore, many men and women reported feeling excluded from voluntary organizations set up to meet their needs because most organizations have an assumed sense that women and men share a common background and therefore a common plight. Because of these assumptions, they felt uncomfortable sharing their problems in mixed settings.
- Logie et al. [16] found in their community-based qualitative study with HIV-positive women from marginalized communities in Ontario that many women reported experiences of discrimination and stigma, social exclusion and ostracism, and institutionalized racism on the basis of having one or more stigmatized social identities. The narratives of the women were obtained through focus groups interviews, and were analyzed using thematic analysis. Their analysis revealed that stigmatizing processes, as well as barriers to health and well-being, operated on micro, meso and macro-levels, which highlight the need for researchers and policy-makers to understand the effects of intersecting stigma and discrimination in order to tailor interventions and health policy to improve the women’s health and well-being.

- In another community-based study, Logie et al. [23] conducted separate focus group interviews with HIV-positive lesbian, bisexual and queer women, and HIV-positive transgender women in Toronto. Researchers analyzed the interviews using a thematic approach and found the women felt excluded from and under-represented in HIV-research, and faced “interlocking barriers (e.g. HIV-related stigma, heteronormative assumptions and discriminatory treatment) that reduced access to HIV care and support.” Thus, “intersectional interventions are required to reduce the marginalization of LBQT women,” and “they should operate across micro, meso and macro levels of change.”

#### *Other health-related research*

Warner and Brown [24] used an intersectionality approach, grounded in life course theory, to explore differences in the trajectories of functional limitations (disabilities) throughout the life course, and compared those of White men to those of White women, Black men, Black women, Mexican American men, and Mexican American women. They used data from “the nationally representative 1994-2006 US Health and Retirement Study to investigate intra-individual change in functional limitations” among the different subpopulations, and used self-reported race/ethnicity and gender to create dummy variables for the groups analyzed. Their study found that Black women experienced “a more rapid accumulation of functional limitations through the mid-60s than other groups;” however, the gap in functional limitations and disability becomes smaller as the other groups catch up between their 60s and mid-70s. They concluded that “an intersectionality approach to the study of health disparities is needed to better understand the social construction of health in later life.”

In his research comparing self-reported health among Canadians, Veenstra [25] found that although South Asian Canadians self-reported poorer health than White Canadians, this difference only existed among women. That is, South Asian women reported lower health than White women, but South Asian men did not report lower health than White men.

## **Factors That May Impact Local Applicability**

One of the central tenets of intersectionality theory is that social identities, locations and categories are fluid and constantly changing based on time, place, social structures and powers. Thus, intersectionality-based research in one community is unlikely to be relevant for another community, despite some similarities between populations. Thus, it is important that intersectionality-based research be conducted according to the specific historical, social, political, economic and cultural contexts.

## **What We Did**

We searched Medline, Embase and PsychInfo for the term “intersectionality.” Results were limited to English articles and those published between 2003 and April 2013. We reviewed further articles found through citation searches and consulted experts in the field. All searches were conducted in late April, 2013.