






The feminist perspective of intersectionality in the field of public health: a narrative review of the theoretical-methodological literature


La perspectiva feminista de la interseccionalidad en el campo de la salud pública: revisión narrativa de las producciones teórico-metodológicas

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ABSTRACT The intersectionality approach emerged in the late 1990s in the field of black feminist activism in the USA, as a critique of one-dimensional analyses of social inequalities. This descriptive-analytical narrative review presents the current state of theoretical-methodological inclusion of intersectionality in public health. Seven scientific literature databases were consulted: Web of Science, Embase, Cinahl, Scopus, Sociological Abstracts, Lilacs, and Medline, resulting in 1763 papers. After duplicates were eliminated and the titles and abstracts screened, 30 papers produced in five countries between 2006 and 2017 were selected. The analysis, structured into three central themes (theoretical-methodological debates, social markers – gender, race, ethnicity and sexual orientation – and health policies and practices), shows intersectionality to be a promising analytical resource for understanding and facing the global challenge of inequalities in health.

KEY WORDS Public Health; Review; Health Disparities; Gender Identity, Race and Health.

RESUMEN El abordaje de la interseccionalidad emergió a fines de la década de 1980, en el campo del activismo feminista negro en EEUU, como crítica a los análisis unidimensionales de las desigualdades sociales. Esta revisión narrativa descriptivo-analítica presenta el estado actual de la inclusión teórico-metodológica de la interseccionalidad en la salud pública. Se consultaron siete bases de bibliografía científica: Web of Science, Embase, Cinahl, Scopus, Sociological Abstracts, Lilacs y Medline, y se obtuvieron 1.763 artículos. Eliminados los duplicados y leídos los títulos y resúmenes, se seleccionaron 30 artículos producidos en cinco países entre 2006 y 2017. El análisis, estructurado en tres temas (debates teórico-metodológicos; marcadores sociales –género, raza, etnicidad, orientación sexual–; y políticas y prácticas de salud), muestra que la interseccionalidad es un recurso analítico prometedor para la comprensión y el enfrentamiento del desafío global de las desigualdades en salud.

PALABRAS CLAVES Salud Pública; Revisión; Disparidades en el Estado de Salud; Identidad de Género; Raza y Salud.

INTRODUCTION

From both the perspective of social determinants of health and the socio anthropological perspective of health and disease, the fields of public health and collective health have long since contemplated the social markers of class, gender and race/ethnicity as important references in the analysis of differentiations in social inequalities.^(1,2) More recently, other social markers such as sexual orientation and generation have been incorporated as important empirical and conceptual references in studies regarding health inequalities among different social sectors as well as those focused on sociocultural processes in health, disease, death, and care in specific or minority social groups.^(3,4)

The categories of social differentiation, or markers of social differentiation, can be defined as social constructions established prior to the existence of the subjects that work together to produce greater or lesser social inclusion or exclusion depending on the positions occupied by each subject in the classification systems; that is, the way in which social positions are represented, the type of social control exercised over subjects, and the subjects' agency in the complex social system in which they are immersed. Additionally, in the process of shaping the social identities of subjects, social markers act dynamically, fluidly and flexibly based on particular historical contexts, power dynamics, and according to privileges and structural processes of oppression.

Intersectionality has recently emerged as an alternative and promising theoretical and methodological option in analyses that look into the dynamics and complexities of the interactions of social markers at the individual, institutional and structural levels by taking into consideration the multiple levels of articulation of social markers in the production of the social processes of domination and oppression and their impacts in the health-disease process.⁽⁵⁾

Originating in the American critical feminist production on race and gender at the end

of the 1980s and beginning of the 1990s,⁽⁶⁾ intersectionality constitutes a theoretical-methodological perspective of a transdisciplinary character oriented toward understanding the complexity of identities and their relationships with social inequalities. Using an integrated approach, the epistemic base of which is rooted in the refutation of the compartmentalization and hierarchization of markers of social difference (gender, class, race, ethnicity, disability and sexual orientation),⁽⁷⁾ the intersectionality movement has grown within different disciplines, and has also questioned rigid disciplinary borders, constructing bridges for debate in methodological and theoretical terms. In this sense, since the start of the 2000s there has been an extrapolation of intersectionality, from an approach centered in critical black feminist thought to consider the experiences of black women in systems of oppression, to the analysis of a broad set of topics, objects, and social groups in Europe and countries like the US and Canada.⁽⁶⁾

In Latin America, given the existence of profound social inequalities, markers of class, gender, and race have been a part of academic debates and political agendas in the region for over two decades,⁽⁸⁾ especially due to public and political interventions of black women in the feminist movement. Looking mainly at the experiences of poor, black or Afro-descendant women, discussions of topics such as the position of women in the labor market, public and private forms of violence, health issues, and representations of women in the media signal social and health inequalities and oppressive processes that deepen when analyzed from a racial perspective. The supposedly universal female gender, installed in society at that time, made invisible the experiences of oppression of these women. After this universalizing category was rejected by local black feminists in Brazil, guidelines were established by governmental agencies to generate actions that could combat social inequalities based on gender and racial disparities.⁽⁹⁾

The approach of intersectionality has been critically utilized by Latin American researchers, highlighting that the analysis of social inequalities marked simultaneously by

class, gender and race/ethnicity must be carried out in conjunction with a critique of the colonizing, capitalist and globalized system of subordination characteristic of local societies.^(8,10) This system of power socially classifies subjects and, in the social hierarchy, relegates as inferior those who do not match the physical and sexual stereotype of the occidental colonizer: male, white, heterosexual, middle or upper class. Colonialism penetrates all aspects of social life, presenting itself in material domination as well as in people's personal experiences.⁽¹⁰⁾ Among other aspects, compulsory heteronormative sexuality is highlighted in terms of class, gender and citizenship status.⁽¹¹⁾

In the feminist academic production of the last decade, intersectionality has been deemed the most important theoretical contribution of feminism,⁽¹²⁾ given its promising attempt to constitute both a theoretical approach and approach for the production of empirical investigations;⁽¹³⁾ in addition to serving the renewed political impetus of feminist academic production. As can be seen in reviews from the fields of psychology,⁽¹⁴⁾ sociology,⁽¹⁵⁾ and public health,^(16,17) the acceptance of intersectionality as a perspective, approach, or field of study is growing.⁽¹⁸⁾

In relation to health-disease processes, intersectionality has been gradually incorporated into the field of public health.^(16,17,18,19) For authors like Hankivsky,⁽¹⁹⁾ intersectionality is a research paradigm, the aim of which is to consider the complexity surrounding the creation and maintenance of health disparities. Taking into account the dissemination and growing utilization of intersectionality in research on disparities and inequalities in health-disease processes, and the lack of studies analyzing the state of the issue in the field of public and collective health, this study seeks to answer the following questions: What is the current state of the theoretical-methodological debate of intersectionality in the field of public and collective health? How do authors in the field utilize the theoretical language and methodological justifications of intersectionality? What are the possibilities and limitations of intersectionality in the study of health

inequalities and inequality in the contemporary agenda of public and collective health? The final objective is to situate the theoretical-conceptual and methodological debate of intersectionality in the field of public and collective health.

METHODS

We present a descriptive-analytic narrative review based on the scientific production of different areas of study that mention the incorporation of intersectionality in topics of public and collective health. *Selection criteria:* the articles selected were published in Spanish, English or Portuguese and consisted of essays of a theoretical or methodological character, that discussed intersectionality in the field of public and collective health or topics related to that field, such as: disparities in health care; inequalities and health; gender and health; sexual orientation and health; race, ethnicity and health; social class and health. *Exclusion criteria:* Articles based on empirical studies were excluded, both those of a qualitative and of a quantitative nature, as were those that only cited intersectionality without discussing the incorporation, potential and/or limitations of the approach in the field, the topic or object under study.

In relation to the operational process, the selection phase of the articles through the screening of titles was carried out independently by two researchers, and a third researcher weighed in on any discrepancies found. All researchers took part in the phase of full-text reading, data extraction and development of the interpretative analysis.

The searches were carried out in April 2017. In the first, in the PubMed portal, the nomenclature most sensitive to the research question was identified: *intersectionality* [All Fields] AND ("*health*"[MeSH Terms] OR "*health*"[All Fields]). The search was applied in all the databases except Sociological Abstracts, in which the term *intersectionality* did not exist and the word *intersection* was used. In the different scientific literature databases,

combinations of search terms were utilized based on the nomenclature accepted by each source.

In the search strategy, seven informational resources were used, six of which were scientific literature databases: Web of Science (multidisciplinary); Embase (biomedicine and health sciences); CINAHL – Cumulative Index to Nursing and Allied Health Literature (nursing, biomedicine and health sciences); Scopus (multidisciplinary); Sociological Abstracts (sociology); LILACS – *Literatura Latinoamericana y del Caribe en Ciencias de la Salud*, (biomedicine and health sciences); and the portal Pubmed, which encompasses Medline (biomedicine and health sciences). In the second phase, the references listed in the selected publications were examined to find those not captured in the previous searches.

The analysis of the material began with the extraction of information regarding the authors (gender and country of institutional affiliation of the lead author) and the articles (year and journal of publication). Information was then sought regarding the topics under investigation, the markers of social difference included, and the theoretical references on intersectionality cited. In the following phase, the articles were grouped into three themes: 1) theoretical-methodological debates on intersectionality and health; 2) social markers of gender, race, ethnicity and sexual orientation, intersectionality and health; and 3) health policies and practices. Based on these themes, the articles were read with the objective of understanding the general content and identifying the conceptual framework. In the last phase, the different thematic nuclei were compared in terms of the theoretical-methodological incorporation of intersectionality and the final interpretive analysis was carried out.

RESULTS AND DISCUSSION

The initial search strategy yielded 1,763 articles, which were exported into the citation manager EndNote Web to eliminate

duplicates. Once excluded (n=629), 1,134 articles remained. After reading the titles and abstracts 1,106 were eliminated, and 28 articles remained to be read in full text that met established inclusion criteria. Two articles found after the exploration of the references of the material read in full text were added. Therefore, 30 articles were included in the corpus (Figure 1).

Editorials, commentaries, theses, dissertations and book chapters were among the 1,106 references excluded, as well as articles from the areas of education, psychology, law, news media that discuss intersectionality, but without connection to the health field. Regarding the empirical articles excluded, although an intersectionality methodology was used in the research practice, they did not include the deep methodological-theoretical discussion central to this article.

In relation to the year of publication, the first studies are from 2006 and a growing tendency can be seen over the last 12 years, with a greater concentration in 2014, with seven articles, and 2016, with six. In relation to the country of origin, considering the institutional affiliation of the lead author, the countries that most contributed were the US (n=13), Canada (n=10) and Australia (n=3). The journals that published the selected articles are varied yet concentrated – as would be expected – in the health field. If only these last two aspects are considered – country of origin and journal in which the articles are published – it is worth recognizing that in this literature review, the intersectionality approach in the health field is strongly produced in developed English-speaking countries. The production is also mostly female, given that women are the lead authors (first or corresponding authors) in 27 articles. The social markers considered were: race, ethnicity, social class, gender, generation, sexual orientation, migratory status, geographic location and socioeconomic status.

Table 1 presents the selected articles, classified according to themes and authorship; with the years of publication, the gender of the lead author, the name of the journal, the country of academic affiliation of the lead author and the social markers included.

Theoretical-methodological debates on intersectionality and health

The theme *theoretical-methodological debates on intersectionality and health* encompasses the challenges of incorporating conceptual and methodological assumptions in research and the potential of intersectionality for the research field. Ten studies^(16,17,19,20,21,22,23,24,25,26) were included that were produced in the last ten years, five of which were produced by Canadian women researchers. Authors like Olena Hankivsky and Lisa Bowleg, originally connected to women's studies, promote "critical reviews" based on their areas of research (Canadian studies of the social determinants of health and US studies on race, minorities, and health, respectively), listing and proposing a critical discussion of the possible contributions of the intersectionality approach as

a theoretical-methodological tool to better understand and confront differences and inequalities in health, something that has been considered a global challenge.^(17,18,19)

Havinsky *et al.*⁽²⁶⁾ maintain that intersectional analysis does not seek to be a sum of categories (for example, sex, race, class, sexuality); rather, the effort is to understand what has been created in the intersection of two or more axes of oppression. In doing so, the multidimensional and relational nature of markers of social differentiation is recognized, as is the way in which these create social spaces riddled with power dynamics that are superposed in systems of discrimination and subordination. In this way, intersectional analysis captures various levels of differentiation that produce different health inequalities.

In the oldest article on this theme, Hankivsky and Christoffersen⁽²⁰⁾ mention that,

even in countries like Canada that are considered leaders in the field of public health, certain important health disparities continue to challenge researchers. Understanding the roots of the determinants of health inequalities and the ways in which inequalities take shape within the complex relations among determinants that often intersect and reinforce one another has proven particularly demanding. In a more recent study, for example, Hankivsky *et al.*⁽²⁶⁾ carry out a critical examination of the bibliography in the field of health inequities and utilize the perspective of intersectionality to encourage the coming together of biomedical and social approaches.

Various studies highlight the methodological challenges of applying intersectionality in public and collective health research. These include both the difficulty of implementing analyses that are not overly

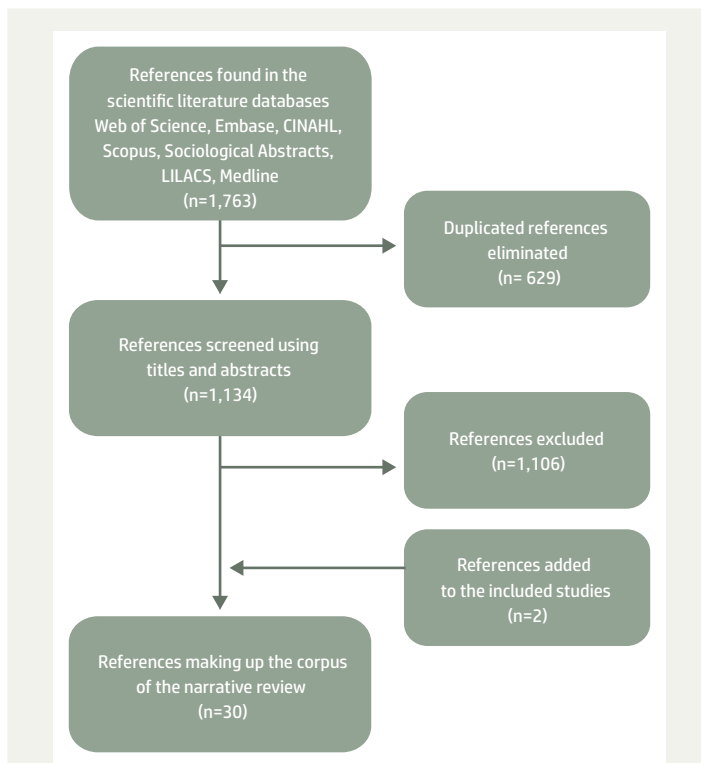


Figure 1. Flow diagram of the selection of articles on intersectionality in the field of public and collective health, 2017.

Source: Own elaboration.

Table 1. Selected articles on intersectionality, according to themes, authorship, year of publication, gender (of lead author), name of journal and country of academic affiliation (of lead author) and social markers considered.

Themes	Authorship	Year of publication	Gender (lead author)	Name of journal	Country of academic affiliation (lead author)	Social markers considered
Theoretical-methodological debates	Hankivsky, Christoffersen ⁽²⁰⁾	2008	Female	Critical Public Health	Canada	Race/ethnicity, social class, sexual orientation
	Bowleg ⁽¹⁷⁾	2012	Female	American Journal of Public Health	USA	Gender, race/ethnicity, "social" status
	Hankivsky ⁽¹⁹⁾	2012	Female	Social Science & Medicine	Canada	Social class, race/ethnicity, generation, sexuality
	Nygren, Olofsson ⁽¹⁶⁾	2014	Female	Sociology Compass	Sweden	Not specified
	Choby, Clark ⁽²¹⁾	2014	Female	Nursing Philosophy	Canada	Race, social class
	Bauer ⁽²²⁾	2014	Female	Social Science & Medicine	Canada	Not specified
	Olofsson, Zinn, Griffin, Nygren, Cebulla, Hannah-Moffat ⁽²³⁾	2014	Female	Health, Risk & Society	Australia	Gender, race, risk
	Kapilashrami, Hill, Meer ⁽²⁴⁾	2015	Female	Social Theory & Health	United Kingdom	Ethnicity, gender, caste
	Larson, George, Morgan, Poteat ⁽²⁵⁾	2016	Female	Health Policy and Planning	USA	Gender, race/ethnicity, generational group, region, sexuality
	Hankivsky, Doyal, Einstein, Kelly, Shim, Weber, <i>et al.</i> ⁽²⁶⁾	2017	Female	Global Health Action	Canada	Gender, social class, race/ethnicity, sexuality, religion
Social markers: gender, race, ethnicity and sexual orientation	Guthrie, Low ⁽²⁷⁾	2006	Female	Journal for Specialists in Pediatric Nursing	USA	Race, gender, social class
	Bredström ⁽²⁸⁾	2006	Female	European Journal of Women's Studies	Sweden	Race/ethnicity, class, generational group and sexuality
	Fish ⁽²⁹⁾	2008	Female	Sociological Research Online	United Kingdom	Gender, ethnicity/race, sexual identity (LGBTQ+)
	Benoit, Shumka, Vallance, Hallgrimsdóttir Phillips, Kobayashi <i>et al.</i> ⁽³⁰⁾	2009	Female	Sociological Research Online	Canada	Gender, social stratum, race, ethnicity, job, geographic location
	Lekan ⁽³¹⁾	2009	Female	Advances in Nursing Science	USA	Race, gender, class, age
	Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit, <i>et al.</i> ⁽³²⁾	2010	Female	International Journal for Equity in Health	Canada	Not specified
	McGibbon, McPherson ⁽³³⁾	2011	Female	Women's Health & Urban Life	USA	Age, culture, (dis)ability, ethnicity, gender, immigration status, race, sexual orientation, social class, spirituality
	Viruell-Fuentes, Miranda, Abdulrahim ⁽³⁴⁾	2012	Female	Social Science & Medicine	USA	Race, immigration status
	Koehn, Neysmith, Kobayashi, Khamisa ⁽³⁵⁾	2013	Female	Ageing & Society	Canada	Age, immigration, race, ethnicity, social class
	Robinson, Ross ⁽³⁶⁾	2013	Female	Ethnicity and Inequalities in Health and Social Care	Canada	Gender, sexuality, generational groups, race
	Caiola, Docherty, Relf, Barroso ⁽³⁷⁾	2014	Female	Advances in Nursing Science	USA	Gender, race, class
	Watkins-Hayes ⁽³⁸⁾	2014	Female	Annual Review of Sociology	USA	Class, race, gender, neighborhood and place of residence
	O'Brien, Tolosa ⁽³⁹⁾	2014	Female	International Journal of Human Rights in Healthcare	Australia	Gender, class
	Gilbert, Ray, Siddiqi, Shetty, Baker, Elder, <i>et al.</i> ⁽⁴⁰⁾	2016	Male	Annual Review of Public Health	USA	Gender, race, ethnicity, class
	Fields, Morgan, Sanders ⁽⁴¹⁾	2016	Male	Pediatric Clinics of North America	USA	Generational groups, race, gender, sexuality
	Sutherland ⁽⁴²⁾	2016	Female	Health Psychology Open	USA	Not specified
	Sifris ⁽⁴³⁾	2016	Female	Griffith Law Review	Australia	Race, gender, social class

Source: Own elaboration. Continued on the next page.

Table 1. Continued.

Themes	Authorship	Year of publication	Gender (lead author)	Name of journal	Country of academic affiliation (lead author)	Social markers considered
Health policies and practices	Williams, Kontos, Viswanath, Haas, Lathan, Macconail <i>et al.</i> ⁽⁴⁴⁾	2012	Male	Health Services Research	USA	Race/ethnic origin, socioeconomic state (indicator of socioeconomic status, for example, income, education, occupation), gender
	Hankivsky, Grace, Hunting, Giesbrecht, Fridkin, Rudrum, <i>et al.</i> ⁽⁴⁵⁾	2014	Female	International Journal for Equity in Health	Canada	Gender, generational group, ethnicity, sexuality
	Corus, Saatcioglu ⁽⁴⁶⁾	2015	Female	Service Industries Journal	USA	Class, immigration status, race and ethnicity, gender and sexuality

Source: Own elaboration.

rigid or that consist of more than the simple sum of categories in epidemiological models,^(17,18,19,21,22,23,24,26) and that of attempting to contemplate, in terms of research design, the levels of experiences of subjects in situations of domination, in relation to the structures of oppression of specific groups and segments,⁽²¹⁾ and their corresponding impacts on health. Bauer,⁽²²⁾ Nygren and Ologson⁽¹⁶⁾ and Hankivsky,⁽¹⁹⁾ for example, show some concern regarding the assumption that intersectional analyses are frequently found in empirical studies with a qualitative design given the affinity between the theoretical approach of intersectionality and the references of qualitative research. Recognizing that research in public health, epidemiology and medical sociology are significant, they make an effort to produce a methodological debate that promotes the appropriation of intersectionality as a transformational paradigm in the studies of social determinants. In the words of Hankivsky and Christoffersen⁽²⁰⁾:

The intersectional paradigm provides a normative framework that captures the complexity of lived experiences and concomitant, interacting factors of social inequity, which in turn are key to understanding health inequities.

In considering the study of health determinants^(16,17,18,19,21,22,24,26) and the study of health risks,^(20,23) the discussion points to the importance of taking into account the theoretical

status of the categories (whether all have the same value or enough value to ensure inclusion in analyses). It is proposed that, in recognizing the importance of multiple markers of social difference, the intersectional approach does not *a priori* assume the importance of one category over another. In terms of a conceptual-methodological map for the study of the social determinants of health, the analysis of health inequities reduced to a single determinant would be considered inadequate to comprehend the various dimensions at play in shaping and influencing social positions and power relations.

Another aspect of convergence in the majority of studies in the theme *theoretical-methodological debates on intersectionality and health* is the defense of the effort to go beyond the simple recognition of the multidimensional nature of health inequities to construct references of research designs and models of analysis capable of measuring and analyzing the multidimensionality of the markers of social differentiation in processes of inequities with consequences for the health of individuals and populations. This cannot be reached solely through "arithmetical" notions, in which markers are simply added, multiplied, divided or subtracted.

Finally, the primary theoretical-conceptual references underlying the debate on this topic come from fields outside of health, such as sociology^(47,48) and US black feminist studies, in which authors such as Crenshaw⁽⁴⁹⁾ and Collins⁽¹⁸⁾ are frequently cited.

The health researchers most cited, including in more recent studies, include Hankivsky,⁽¹⁹⁾ Hancock⁽¹³⁾ and Dworkin.⁽⁵⁰⁾ Concern for theoretically and conceptually justifying the discussion of intersectionality is present in all the articles on this subject. As Bauer⁽²²⁾ and Krieger⁽⁵¹⁾ highlight, so-called “population health research” has been highly criticized over the two last decades, both for not explicitly recognizing (or lacking) a theoretical base in the analysis, as well as for the lack of consideration of a methodological framework in the research design. Even among authors that encourage population health studies to integrate theory and methodology in research, the approach to health inequalities is frequently unitary, for example, exploring results through a main category such as sex/gender or race/ethnicity. Undoubtedly this unitary approach is a negative aspect of health studies, to which intersectionality can make an important contribution.

In addition to the central debates connected to epistemological, methodological and conceptual issues, other debates that appear in the contributions of intersectionality in public and collective health relate to the markers of social differentiation highlighted in the field. These are presented in the next section.

Social markers of gender, race, ethnicity and sexual orientation, intersectionality and health

Studies on topics such as gender, women’s health and violence,^(30,31,32,33,39,40,43) race, ethnicity and cultural minorities,^(27,34,35) HIV-AIDS,^(28,37,38,42) and LGBTQ+ populations^(29,36,41) stand out when looking at intersectionality and health. Markers of social differentiation emerge as shapers of social inequalities in all of these areas.

McGibbon and McPherson⁽³³⁾ and Benoit *et al.*⁽³⁰⁾ highlight the structural causes that contribute to health inequalities in Canadian women, particularly those in situations of social vulnerability such as black or older women, and women from indigenous or immigrant communities. Analyzing the

socioeconomic differences among indigenous and nonindigenous Canadian women, Benoit *et al.*⁽³⁰⁾ discuss how being indigenous places women in a more vulnerable position given the difficulties they face accessing jobs, formal education, guarantees of physical safety and social protection. They suggest that new situations of social inequalities that impact health can be perceived at the intersection of the multiple differences that socially stratify individuals.

O’Brien and Tolosa⁽³⁹⁾ point to the asymmetrical gender relations that expose women from Sierra Leone, Liberia and Guinea to a greater risk of contracting Ebola, both from carrying out the work of preparing the bodies of the ill for burial and from giving birth. The Ebola epidemic reduced the maternal health care access of women in urban and rural areas, healthy or not, given the professionals’ fear of contagion while attending births. Another study⁽⁴³⁾ highlights the forced sterilization of marginalized women, especially handicapped or HIV-positive women, citing cases in countries such as Peru, Hungary, Slovakia and Czech Republic. The author emphasizes that an intersectional analysis makes it possible to understand how other processes of social exclusion come together in groups marked by gender, race/ethnicity and class differences, accentuating vulnerabilities.

Lekan⁽³¹⁾ related chronic stress and social markers of gender and race in African American women. The contributions of intersectionality are shown using data from studies on African American women who suffer racism and sexism. These studies indicate that women show characteristics of resilience when faced with recurring discriminations, but also reveal the socialization process that imposes upon these women the need to be strong in the face of adversity, to assume burdensome work inside and outside of the home, and to carry out the role of sole caretakers and educators of their families, elements that aggravate the stressful processes they experience.

Gilbert *et al.*⁽⁴⁰⁾ sought to comprehend the complexity of the genesis of health disparities by centering on men’s health. They

researched causes of death in black men in the US and associated risk factors using the contributions of intersectionality. The constructions of masculinity of black men are shaped by notions of the economic provider, which contrast with the high rates of unemployment and the experiences of imprisonment of these men, generating frustration, stress, and a devaluing of the self, among other problems directly related to their health. The authors recommend the joint analysis of markers of social difference and the social determinants of health, above all work and income, as these influence male identities in general and structure, in particular, the complexity of health inequalities experienced by black men in the US. They highlight the need to add other theories to an intersectional analysis, given that critical race theory alone is not enough to analyze the social disadvantages and health of these men, which are often invisible in official health research.

Hankivsky *et al.*⁽³²⁾ highlight that for the approach of intersectionality to be effectively carried out in studies on women's health, study designs and methodologies should be refined, so as to reflect innovative analytic thought regarding identities, equity and power dynamics.

Studies that explore LGBTQ+ themes with the aim of contributing to the theoretical-methodological debate of intersectionality in public and collective health point out the annulment of significant differences within groups carried out in health research which homogenizes the multiple lived experiences within those groups and reduces the study profile to those who are white, middle class and thus socially privileged.^(29,36,41) Methodologies are discussed that, although incipient, are utilized to produce data that is sensitive to differences within LGBTQ+ groups.^(29,36,41) Fish,⁽²⁹⁾ for example, shows that in the United Kingdom, it is difficult to obtain representative samples of lesbians who are black or of ethnic minorities. Given that sexual orientation is provided by the participant, and given the important restrictions of the social context in which the data is collected, this information is generally omitted. There

are also theoretical debates about the fluidity of sexual identity, which is often understood as less stable than other categories of social differentiation, such as race, for example, complicating the development of an intersectional approach.

Fields *et al.*⁽⁴¹⁾ sought to show how young, black, gay or bisexual men in the US experience multiple health inequalities, primarily in sexual health, when compared to their white peers. The social inequalities added to the processes of oppression experienced by these young men, marked by racism and stereotypes regarding gender and sexual orientation – such as the idea of hypermasculinity expressed through sexual prowess, physical aggression, competitiveness, and lack of femininity – make them more vulnerable to sexually transmitted diseases and HIV-AIDS.

It should be kept in mind that there are aspects that modify the exposure to the risk of contracting sexually transmitted diseases or HIV-AIDS in groups marked by racial segregation and a negatively stereotyped view of sexuality.⁽⁴¹⁾ An intersectional approach and a refinement of the methodology in the research in these groups is recommended to analyze the processes of social discrimination.⁽²⁹⁾ In the case of quantitative research, the challenge revolves around how to measure oppressive processes that cannot be combined like fixed, discreet and individual variables; and in the case of qualitative research, shared experiences of oppression should be recovered without reducing them to the individual. The importance of longitudinal studies is stressed, so as to hone in on the effect of the superposition of oppressive processes in health and understand the identity dynamics shaped by the intersection of social differentiations, which mark certain groups and marginalize them at different levels: the social, the structural, and the individual.⁽³⁶⁾

Health policies and practices

Studies that look at the intersectionality of health policies and practices seek to establish models for the formulation and

implementation of public health policies, primarily directed at marginalized groups.^(44,45,46)

For Corus and Saatcioglu,⁽⁴⁶⁾ the challenge for researchers is in the elaboration of intervention projects with the potential to benefit socially marginalized populations marked by multiple processes of social exclusion. It is highlighted that markers of social difference such as gender, race, and class, often tend to be analyzed separately from the social determinants of health; however, when they are superposed, different patterns of risk and resilience to disease emerge. These markers shape variations in the health and use of health services of different social groups in the USA.⁽⁴⁴⁾

Hankivsky *et al.*⁽⁴⁵⁾ propose a model for critical intersectional analysis in the formulation and implementation of health programs and policies. They suggest considering the worldviews of the groups experiencing the health issues, which makes it possible to understand existing privileges and inequities and thereby intervene positively and effectively, correcting any misalignments that occur during implementation. Researchers and those who implement interventions should be attentive to the multiple factors that intersect to form health inequalities, among them the axes of oppression marked by the categories of social differentiation, and how these generate health disparities and asymmetrical power relations, so as to seek their transformation.⁽⁴⁵⁾

In general terms, the refinement of research methodologies and techniques that can illuminate an intersectional view and guarantee rigor and applicability to public health policies is sought,^(44,45,46) especially in research directed at the analysis of the utilization of health services⁽⁴⁴⁾.

FINAL CONSIDERATIONS

The work analyzed – including both articles taking on theoretical, epistemological and methodological debates and those that examine well-established issues in the field of pub-

lic and collective health – strongly calls for the field to move towards the incorporation of intersectionality, given its potential to support empirical studies and formulate health policies committed to social justice in the face of growing health inequalities worldwide.

According to the studies analyzed, research into the social determinants of health is particularly significant in Canada and has historically oriented critical analyses of health-disease processes. This area of research has incorporated the most feminist perspective of intersectionality. The search to overcome the reductionist tendencies increasingly present in the examination of the social determinants of health, added to the need to include other aspects of social life beyond those related to economic dimensions (work, housing, sanitation, education, income, etc.), brings authors like Bauer,⁽²²⁾ Nygren, Olofsson⁽¹⁶⁾ and Hankivsky⁽¹⁹⁾ to the feminist social theory of intersectionality. This approximation has to do with recognizing that science can produce not only a scientific paradigm, but a social one as well: that of a decent life.⁽⁵²⁾

To this end, it is recommended that care be taken on a theoretical-methodological level. These precautions include avoiding hierarchization of categories of social difference in comprehending processes of oppression and marginalization that shape health inequalities. Given their complexity, these processes require multiple analytical approaches, historical contextualization and the articulation of different social categories to understand the empirical reality that creates them.

Another aspect to consider, based on the work analyzed here, is the multidimensionality of the markers of social differentiation in the processes of health inequalities which cannot be understood using “arithmetical” operations, merely adding multiplying, dividing or subtracting markers. This precept appeared in the studies debating theories and methodologies as well as in those from thematic areas such as gender and women’s health – significantly more advanced in the application of an intersectionality perspective – and HIV-AIDs,

sexual and reproductive health, health of LGBTQ+ populations, and race, ethnicity and cultural minorities.

In conclusion, intersectionality, originally stemming from the field of feminist studies, has come to contribute to the field of public and collective health given its capacity to establish itself as a theoretical perspective and a framework for empirical research. The analysis of the production carried out shows the growing acceptance of the perspective,

the tensions and challenges it poses for the health field, and above all, the recognition that exists that this perspective can shed light on and broaden the view of both well-established and novel issues and objects in conceptual and methodological terms. The growing application of intersectionality in studies in the health field, and the ensuing debates, reinvigorate interdisciplinary production in public and collective health.

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