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Using an Intersectional Approach To Study the Impact of Social Determinants of Health for African-American Mothers Living with HIV

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Introduction

This paper outlines an approach to conceptualizing social determinants of health and their role in producing health inequities. Health scientists and clinicians are increasingly recognizing that health care systems and the conditions in which people are born, grow up, live, work, and age -- collectively known as the social determinants -- profoundly influence the health of individuals and subsequently impact the health of populations at large.¹⁻³ Since the turn of the 21st century, a number of important publications illuminate the significant role social determinants play in producing health inequities. For instance, in 2003, the Institute of Medicine produced the first comprehensive report demonstrating that racial and ethnic minorities have less access to quality healthcare.⁴ In 2008, the World Health Organization announced a new global agenda for health equity, clearly asserting and substantiating that the social determinants of health, fashioned by the distribution of power and material resources, function to produce many avoidable health inequities.^{1,3} In 2010, the Centers for Disease Control and Prevention produced a white paper calling for new approaches, beyond individual interventions, to reduce health inequities in HIV, viral hepatitis, STDs, and tuberculosis in the United States.⁵ Within-country and between-country analyses show that social determinants such as gender, occupation, income, and race/ethnicity can radically influence health outcomes to create hierarchies of health and illness.^{3,4} In conjunction with these publications, Presidential communications and working groups,⁶ a national HIV/AIDS health strategy,⁷ legislation such as the Patient Protection and Affordable Care Act, and federally funded research efforts to promote the investigation of multifactorial, nonbiological factors of health disparities⁸ have heightened awareness of the role of social determinants in producing health outcomes.^{9,10}

Despite increased efforts and heightened awareness of social determinants of health, little to no progress has been made in the amelioration of those social determinants contributing to health inequities. In fact, a review of Healthy People 2010 reveals that during the decade between 2000 and 2010, the disparity gap for many of leading health indicators by race and ethnicity have actually *worsened*, rather than improved; a disappointing 70% of the objectives saw no change in disparity.¹¹ We argue, along with a growing number of health scientists, that reliance on traditional biomedical research paradigms, which reflect a positivist epistemology, serves to perpetuate these trends by failing to adequately consider the social and economic context of health, preserving the hegemony of the Euro- and androcentric perspectives often driving research, and ignoring the unequal power distributions contributing to health inequities.^{2,9,10}

In contrast to traditional biomedical research paradigms, many feminist and sociology scholars focus on the influence of unequal power distribution and social and economic situations in positioning people in the social world.¹²⁻¹⁵ Over the past three decades, these scholars have developed a conceptual framework called intersectionality or an intersectional approach when applied in research,¹⁶ aimed at understanding these complexities.^{2,10,16} Research endeavors using the intersectional framework generally manifest as multidisciplinary scholarship examining how the hierarchies of race, gender, and class mutually create structures of oppression and meaning.¹⁶ More recently, scholars began using intersectional approaches to examine the complex configurations of social determinants of health and how those social constructs interact to produce health inequities.^{2,9,10} Nevertheless, the utilization of intersectionality to aid nurse scientists in knowledge development and inform nursing practice regarding issues of social injustice and health inequities is only just evolving.⁹

The purpose of this paper is thus threefold. First, we will describe and analyze intersectionality as a conceptual framework and a means of understanding and addressing health and health care inequities. Second, we will apply the intersectional approach to the study of the social determinants of health for African-American mothers living with HIV and through this application explore the utility of an intersectional approach to generate knowledge in nursing. Lastly, we will discuss some potential methodological implications of using an intersectional framework in research.

An Intersectional Approach: Conceptualizing Health and Healthcare Inequities

Beginning roughly in the late 1980s and early 1990s, intersectionality developed through both scholarly endeavors and activist engagement.¹⁵ Kimberle Crenshaw, a lawyer and African-American feminist scholar, is most frequently cited as coining the term “intersectionality” in her early scholarly work,^{13,16,17} which was inspired by her activism in Harvard Law School's faculty integration of both women and people of color.¹⁵ Crenshaw emphasizes that intersectionality is not merely a multiplying of identity categories such as gender and race; rather, it is meant to provide a means of analysis for how particular identities and conditions are located within structures of power.¹⁵ Patricia Hill Collins, African-American sociologist and feminist scholar, began publishing extensively on intersectionality in 1990 with her work entitled *Black Feminist Thought: Knowledge,*

Consciousness and the Politics of Empowerment.¹⁴ Collins critiques the essentialism of feminist scholarship of that time and suggests that social theory that fails to acknowledge social context produces theories that appear to be universal but in reality reflect only the thought-models of the scholars located in their specific social context.¹² Intersectionality is a way of understanding social location in terms of the way systems of race, social class, and gender overlap with no one social category taking primacy.²

Orientation and Purpose of Intersectionality

Said by some scholars to be a transformative paradigm, intersectionality's philosophical underpinnings are largely rooted in critical theory and feminism and no single theorist or discipline can be credited with its development.^{15,16} A core epistemological assumption of intersectionality is that knowledge development is from the perspective of the oppressed, not the dominant social group.⁹ Intersectional scholarship was developed from the unique position of women of color with the purposes of seeking social justice and framing social inequities as products of differences such as race, class, and gender.^{9,10} In other words, intersectionality is both an explanatory conceptual framework and an effort to address social inequality based on intersecting social constructions (such as race, class, and gender) manifested at both the individual and population level.¹⁸ Intersectional scholars consider the social constructions of gender, race, and class to be unequal social relationships between groups of people, rather than biological or genetic attributes of individuals, and they are concerned with how those relationships act as social determinants of health disparities.¹⁸

Central Theoretical Tenets of Intersectionality

We recognize that there are a multitude of conceptualizations of intersectionality and contradictions in the literature about intersectionality;^{2,9} it is simultaneously characterized it as a paradigmatic view, a theoretical framework, and a methodological approach.^{16,19} However, some basic theoretical tenets characterize much of the literature on intersectionality. Weber's work identifying the central theoretical tenets of intersectionality serves as a useful framework of the approach's central constructs: contextually specific social constructions, multilevel power relations and simultaneity.¹⁰

Contextually specific social constructions—Intersectionality describes broad social categories such as race, gender, and class, along with more specific social categories such as motherhood, as socially constructed phenomena that are fluid, flexible, and contextually grounded in history and geographical location.^{2,10} For example, social constructions of race are not based on the assumption that discrete, biological races exist; rather, they are concerned with how race is constructed by historical conditions such as slavery and segregation and leads to inequity based on hierarchies and systems of oppression.¹⁸

Social roles such as motherhood are also considered social constructions in intersectionality. For example, within an intersectional framework, motherhood is not assumed to be a universal phenomenon with a single, objective definition of mothering. Rather, mothering is thought of as a relationship in which a person's actions to nurture and care for another is based in a historical and cultural context.^{12,20} Collins' theorizing about motherhood explicitly challenges universalism, acknowledges inherent diversity in motherhood, and

suggests a shift to a concept that accommodates the diversity of race, ethnicity, and social class.¹² Her work on motherhood is firmly grounded in an intersectional approach - an approach she is credited with helping to shape.¹⁶ From an intersectional approach, there is no one meaning of motherhood, manhood, womanhood or the like; they are deeply embedded in the social context from which they arise.^{12,18}

Multilevel power relations—The exploration of social relationships marked by a power differential—in which one group is subordinate and another is dominant—as well as how those relationships persist is a central focus of intersectionality.¹⁰ Social relationships are interactions between the people assigned to socially constructed categories of difference noted above such as race, gender, and class; the persistence of power in such relationships is fashioned by the dominant group's access to greater material and social resources.¹⁰ As power relationships persist and hierarchies are perpetuated, the dominant social groups become the standard from which all group comparisons are made, and subordinate social groups are subsequently marginalized.¹⁰ Macrolevel power differentials manifest structurally in the form of policies, rules, or laws benefiting only certain groups; while microlevel power differentials present in individual relationships in which one individual exerts power over another.¹⁰

Simultaneity—Socially constructed differences in gender, race, and class do not simply intersect in an intersectional approach as an inequity that is additive or multiplicative.¹⁸ Rather, the constructs exist simultaneously and vary as a function of one another depending on the particular gender, race, and class to which an individual belongs.¹⁸ The ability of the constructs to vary as a function of one another is described as “mutually constituted,” creating a specific social location for individuals.^{10,16,21} An individual's social location based on mutually constituted social inequities is an important concept in intersectionality and is often best explicated by example. Using health as an example, the intersection of social determinants of health for an African-American (*race*) mother (*gender*) living in poverty (*class*) and with HIV may function quite differently than that of an African-American (*race*) father (*gender*) living in poverty (*class*) and with HIV. That is, race and class are gendered and may operate to produce different health outcomes¹⁸ as well as a unique social location for those individuals. Indeed, the combinations are innumerable depending on the social determinants of concern, as race and gender could just as conceivably be “classed” or gender and class could be “raced.”¹⁸ Finally, but very importantly, intersectionality challenges the idea of gender as the primary dimension of inequity; rather, it asserts that multiple dimensions can and do shape social inequality.²

Analysis of Intersectionality

We assert that the strengths of intersectionality as an approach for investigating health disparities are clear; namely, it provides insights into the nature of social inequality, social determinants of health, and power structure. Indeed, it provides some clear advantages over the biomedical paradigm. First, acknowledgement of social constructions of difference requires the researcher(s) to develop a specific awareness of the community of interest, including nuances of community strengths, weaknesses, historical context, political context, and more.¹⁰ This awareness, long advocated for by feminist and critical scholars, fosters

researcher and participant engagement, self-reflection, and involvement¹⁰ such that participants are no longer subjects to the research process but involved at a level in which a process of conscientisation may occur.²² Conscientisation, a concept originally developed by Paulo Freire, is a process of consciousness raising and critical awareness through practice and participation.²² Such participant involvement and conscientisation is in itself a community intervention and may lead to more appropriate community-based interventions where biomedical approaches have failed.

Second, the acknowledgement of power relations in intersectionality has three important consequences. One, as discussed earlier, the intentional privileging of the perspectives of groups traditionally subordinated means that dominant groups are no longer considered the standard from which all group comparisons are made and moves health research away from a traditional Euro- and androcentric perspective.^{9,10} Two, comprehensive examination of power structures leaves room for the study of privilege and how the process of whiteness is central to producing health inequities.^{2,23} Whiteness is not only a social location of structural privilege by white people, but also the unmarked and seemingly transparent practices and discourse that perpetuate racial domination and reproduce social inequality in society.²³ A worthy endeavor and example of research investigating the role of whiteness might be using an intersectional approach to examine of the discourse between elite, white politicians who are largely responsible for brokering health policy in the US. Three, exploration and disclosure of power differentials at the macrolevel requires health scientists to consider health interventions aimed at balancing power at the structural or institutional level rather than the microlevel interventions, such as individual behavior change, traditionally targeted by biomedical research.¹⁰

Third, by stressing simultaneity, intersectionality moves beyond the single-axis analysis centered on dichotomies such as man/woman, African-American/White, and wealthy/poor and provides a means for multi-axis analyses in which heterogeneity is implicit² and no social group is considered homogeneous.⁹ In doing so, intersectionality creates a more empirically sound model of diversity and challenges the “binary thinking which tends to place certain groups in opposition to one another” in the biomedical paradigm.^{2 (p.1713)}

We do acknowledge that the methodological complexities of executing an intersectional approach can be daunting and might be considered a potential weakness of the framework.^{16,19} These complexities have likely evolved because intersectionality grew out of multiple disciplines, and the methodological boundaries of various disciplines can vary significantly.¹⁰ We suggest the lack of clarity as to the nature of intersectionality as a paradigm or theory and the methodological complexities associated with intersectionality are not weaknesses, but opportunities for creating new ways of knowing. In the following section we will address some of these issues through application of an intersectional approach to research involving African-American mothers living with HIV and suggest a model of the theoretical relationships within the framework.

Exemplar: The Practical Application of an Intersectional Approach

As a means of evaluating intersectionality, we will discuss the applicability and limitations of the conceptual framework for investigating the health inequities and social determinants

of African-American mothers living with HIV. To begin, it is important to explain the rationale for the population and disease process chosen, as the choices have distinct methodological implications in an intersectional framework.

Population and disease process rationale—The rationale for choosing one socially constructed group (African-American women) at the intersection of multiple social identities (female, African-American, mothers, living in poverty) is driven by the intersectional framework itself. Managing the complexity of multiple categories simultaneously has proven to be challenging for intersectional scholars.¹⁹ Efforts to manage complexity and still produce findings led to three primary methodological approaches – anticategorical, intracategorical, and intercategorical.¹⁹ These approaches fall on a continuum, with anticategorical and intercategorical landing on the extremes of the spectrum.¹⁹ Simply stated, anticategorical approaches deny any fixed categories, and intercategorical approaches, similar to traditional biomedical approaches, analyze multiple social groups within and across categories.^{9,19} The approach chosen for this discussion, intracategorical, focuses on one social group at the intersection of multiple social identities so that within-group differences and larger social structures influencing their lives can be explicated.^{9,19}

The rationale for choosing African-American mothers living with HIV is twofold. One, this choice is in keeping with the premise that intersectional approaches focus on knowledge development via non-dominant, minority, and frequently marginalized groups. Two, this choice is based on magnitude of disease burden and disparity in health outcomes. Indeed, disparities in the health outcomes for African-American mothers living with HIV are clear across racial, gender, and socioeconomic groups. Women now represent 25% of all HIV infections in the US.²⁴ African-American women are 20 times more likely than White women to be newly infected with HIV,²⁴ and once infected, they are likely to die from AIDS earlier than their White counterparts.²⁵ Moreover, African-American women are disproportionately poorer than other subpopulations in the US,²⁶ and at least twice as likely as White women to be living in poverty, a significant precipitating factor for HIV infection.²⁷ Being a mother adds an extra layer of complexity to the lives of women living with HIV. Studies show that the primary goals of mothers living with HIV are to protect their children from HIV infection and HIV-related stigma;²⁸ these mothers describe higher levels of stress than non-mothers as they manage their own needs and the needs of their children in circumstances such as poverty.²⁹ HIV-related stigma brings poorer mental and physical health outcomes across a broad range of demographic profiles.³⁰ If vulnerability is defined as the “susceptibility to poor health,”^{31 (p.2)} then the vulnerability of African-American mothers living with HIV functions at the intersection of gender,³² race,³³ class,²⁷ HIV-related stigma,²⁸ and motherhood,^{28,29} and necessitates multidimensional and transdisciplinary approaches to address the complex social and economic conditions of these mother's lives, collectively known as social determinants of health.

Intersectional Approach for Research Involving African-American Mothers Living with HIV

The intersectional approach is based on a model titled Motherhood and HIV: An Intersectional Approach. In this model (Figure 1), informed by the work of Shi and Steven's,³¹ the concept of vulnerability, defined as a “susceptibility to poor health,”^{31 (p.2)} is

at the center. The model represents the intersection of specific factors as mutually constituted^{2,10,18,21} vulnerability in which these factors jointly determine health status and access to quality health care.

To illustrate the conceptual relationships in the intersectional model (Figure 1), a mother living with HIV is standing at a large traffic intersection with her children in tow. Her challenge is to cross the intersection safely, protecting both herself and her children. In the model, 1) the social determinants of health (represented by roads) intersect to create a mutually constituted vulnerability; 2) the larger the intersection (i.e., the more vulnerabilities), the more difficult the mother's task of managing her condition and accessing quality health care, leading to a greater likelihood of poor health outcomes; 3) gender, race, and class are socially constructed categories involving sometimes unequal relationships between groups of people, rather than biological or genetic attributes of individuals;¹⁸ 4) certain factors (represented by bridges) can positively influence the ability of a mother living with HIV to navigate the intersection and her subsequent health outcomes; and 5) the health outcomes of the children are at least partially dependent on the health outcomes of the mother and her ability to navigate the intersection. Definitions of the concepts used in the model, along with rationale for their inclusion, follow.

Gender/Gender Inequality—Gender is a socially constructed category with differences in how it is enacted and arranged hierarchically in society.¹⁸ Gender inequality based on hierarchical structures can lead to differences in health outcomes between men and women due to distinctive social roles and expectations.³⁴ Gender inequality³⁵ and gender-based violence³⁶ increase the risk of HIV infection, and increased violence among women already living with HIV leads to poorer health outcomes.³⁶

Race/Race Inequality or Racism—Race is a socially constructed group of categories that can lead to inequity based on hierarchies and systems of oppression.¹⁸ Health scientists have found that the social impact of race on daily life experiences, not innate biological differences or poverty, actually mediates differences in race-associated health outcomes.³⁷ High levels of self-reported experiences of racism have been associated with numerous poor health outcomes, from cardiovascular disease to certain forms of cancer.³³

Class/Class Inequality—Class is a relative position along a socioeconomic gradient and it has been associated with poor health through material deprivation or “the lack of material resources that enable the protection or promotion of health.”^{31 (p.66)} Epidemiological studies have found an association between HIV infection risk and poverty²⁷ and have shown that socioeconomic status is a major determinant of high morbidity among nonwhite women living with HIV in the Southern region of the United States.³⁸

HIV-related Stigma—In his landmark work, Erving Goffman³⁹ defined stigma as both a discrediting attribute of an individual and a social process in which the discredited individual is rejected by society.³⁹ A recent meta-analysis concluded that high HIV-related stigma is correlated with poor physical outcomes such as AIDS symptoms; poor mental health outcomes such as depression, anxiety, and psychological distress; and low social support.³⁰ In addition, HIV-related stigma has been identified as a significant barrier to

initiation of HIV care⁴⁰ and associated with greater gaps in medical care as measured by days, ARV non-adherence, low CD4 cell counts (<200) and higher chronic illness comorbidity.⁴¹

Motherhood—Nakano Glenn and colleagues²⁰ reframed “mother” from a biological construct into “mother” as a social construct, by defining mothering as a relationship in which a person's actions to nurture and care for another are based in a historical and cultural context.²⁰ Research exploring the experiences of women living with HIV has revealed that motherhood creates added challenges and higher levels of stress for women who must manage their own health care needs while simultaneously acting as caregivers to their children.²⁹ Mothers living with HIV also experience role conflicts as they attempt to carry out the daily activities of motherhood while experiencing profound fatigue and other physical limitations imposed by their disease.⁴² Finally, mothers living with HIV desire to protect their children from HIV-related stigma and experience stress in regard to disclosure of their HIV status to their children, significant others, and other family members, fearing that disclosure will make their children vulnerable to stigma.²⁸ As such, these mothers also have concerns about the care of their children in case they become ill and die, and paradoxically they cite motherhood and the desire to protect their children as a source of strength and a reason to live despite their infection.²⁸ The evidence as to whether motherhood plays a positive²⁸ or negative^{28,29,42} role in health outcomes for mothers living with HIV is conflicting; therefore, motherhood could be explored as both an axis of vulnerability and as a potential strength in an intersectional framework.

We argue that an intersectional approach is highly applicable to research on the impact of social determinants of health for African-American mothers living with HIV and a number of other populations experiencing disparate health outcomes. Modifiable health status in chronic illnesses such as HIV is largely determined by environmental, social, and behavioral factors;⁴³ in 2010, as part of the Patient Protection and Affordable Care Act, Congress authorized funding of the Patient-Centered Outcomes Research Trust Fund aimed at producing information from research that is guided by patients and other stakeholders in order to illuminate these factors. As the US moves toward more patient-centered care, understanding the role of social determinants in patients' health will be central to the design of interventions that will help to ameliorate those social determinants when they do not promote health.

Unlike a general intersectional approach, our model emphasizes access to quality health care, health outcomes, and potential health-promoting social determinants.³¹ It encourages understanding potential pathways and relationships social determinants have with health access, health quality, and health outcomes both at the individual and population level. Additionally, we argue that it is critical to examine health-promoting (or positive) social determinants of health that will move research from a deficit model to identify and capitalize on those patient and community attributes that enhance health.⁴³

Using an intersectional approach to investigate disparate health outcomes in HIV and other chronic illnesses could potentially address important questions such as: What mutually constituted social determinants contribute to the prevalence of a specified disease? How are

those social determinants related and how are they embedded in power structures for specific diseases or populations? What are some of the health-promoting social determinants, such as motherhood, that can enhance a patient's ability to self-manage a disease process? Can structural interventions and health policies be developed to improve the health disparity found in people with specific disease processes across gender, race, and class groups?

Implications of Using an Intersectional Approach

The methodological implications of using an intersectional approach, such as the one we have proposed above, are vast, and entire texts have been devoted primarily to this topic.^{16,18} Intersectional scholars have asserted that intersectional approaches *tend* to be less amenable to traditional biomedical, variable-oriented, or disaggregating methodologies such as multivariate, predictive models.¹⁸ Such methods seek to explain the relationship between independent, discrete variables but they do not explain *why* those relationships occur or illuminate their social and context-dependent constructions or the power structures within those relationships.¹⁸ Others have suggested that intersectional approaches have a closer alignment with or affinity with traditional qualitative methodological approaches such as ethnography or case study accounts.¹⁸ However, Kelly,⁹ a nurse scientist, moves the conversation forward for nursing by discrediting a strictly dichotomous intersectional versus biomedical paradigm and qualitative versus quantitative view and suggests that “the integration of feminist intersectionality and biomedical paradigm in research occurs in the selection of the research problems, design, and methods, as well as in the operationalization of the assumptions of each paradigm throughout the research process.” (p.E46) In other words, retreating to comparisons of the biomedical versus intersectional paradigms and their traditional affiliations with quantitative versus qualitative methods, respectively, simply reinforces a binary form of thinking that only one philosophical approach can address the complexity of health inequities and fails to acknowledge that philosophical or theoretical approaches are in no way tied to specific methodologies.⁴⁴ Integration of the intersectional and biomedical paradigm for the purpose of addressing health inequities will require an orientation toward the data, no matter the methodology with which it is collected, such that questions related to socially constructed categories of difference, power differentials, and mutually constituted social identities are considered. Scholars using the intersectional approach also have a long tradition of combining scholarship and activism in the pursuit of social justice; therefore, community-based participatory research is uniquely suited to intersectional approach because of its emphasis on participant-researcher collaboration and community engagement.^{9,16} Additionally, intersectional approaches may be served best by transdisciplinary groups of scholars engaging in collaborative research efforts. As McCall¹⁶ asserts, intersectional approaches cross disciplinary borders and such a “border-crossing concept suggests an interdisciplinary rigor that helps challenge traditional ways of framing research inquiries, questions and methods.”(p.7)

Finally, this approach is particularly powerful for the design and implementation of interventions. Structural interventions, which focus on changing the “environment or context within which people act for the purpose of influencing individual health behaviors,”⁴⁵ (p.S46) attempt to target the social determinants associated with negative population health

outcomes.¹ Social determinants include not only socially constructed categories such as race, gender, and class,¹⁸ but also built environment such as actual neighborhoods and community spaces or trusted and reciprocal social networks.⁴⁶ By illuminating the social determinants negatively and positively impacting health and how those social determinants interact, we can assess which, if any, of those structural influences may be amenable to intervention via health policy and advocacy. As related to our example of African-American mothers living with HIV, inquiry framed with an intersectional approach may produce evidence substantiating the nuances of how macrolevel power differentials create their disparate health outcomes. For example, does one social determinant such as class inequality consistently trump other determinants such as gender or race in producing negative health outcomes? Can the intersection of the racism, classism, gender inequality, and stigma be mitigated by motherhood? How does whiteness operate to shape the health experiences of these mothers? Research using an intersectional approach and our proposed model can unveil such nuances. The evidence could then be used to advocate for structural interventions aimed at altering imbalances of power, such as the provision of micro-financing programs to reduce economic inequality¹ or antiracist education to challenge and change the unmarked white privilege of the US healthcare system.⁴⁷

Process interventions are nested within structures and aimed at impacting individual health and health behaviors through specific healthcare processes such as evidence-based care, behavior change management, and the patient-provider relationship.^{43,48,49} For example, exploring the ways in which the unique social identity of African-American mothers living with HIV influences their health-related experiences and creating empirically-driven typologies of vulnerability, researchers have a potential means for assessing vulnerability that may be clinically relevant for clinicians.⁴⁸ Being able to adequately assess vulnerability gives clinicians a greater understanding of social forces influencing a patient's health care decisions and will allow for a greater congruence or shared understanding between the provider and patient regarding "realistically attainable health care goals."⁴⁸ (p.384) Such an assessment literally gives the provider a sense of what it is like for the mother as she stands in the middle of the intersection of social determinants and the potential "trade-off" decisions she must make regarding her health care, such as whether to buy her medications or clothing for her child.⁴⁸ This kind of evidence could be used to develop HIV-specific, evidence-based guidelines for mothers that: 1) consider how a mother's assessed vulnerability changes certain health care recommendations, 2) provide a patient-provider decision making tool for trade-off decisions, and 3) suggest ways providers can adapt their health practice in caring for mothers living with HIV.^{43,48} Few guidelines such as these exist, but an excellent example is the guidelines provided by the Health Care for Homeless Clinicians Network called *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS*.⁵⁰

Conclusion

To date, the acknowledgement of the role of social determinants in producing health inequities by the scientific community has failed to translate into significant progress toward interventions that ameliorate disparate health outcomes among populations. As healthcare scientists, we urgently need to expand our understanding of health inequities and the means

with which we investigate them. An intersectional approach offers a complexity of inquiry matching the complexity of social forces shaping those inequities. Our model of Motherhood and HIV: An Intersectional Approach, while specific to African-American mothers living with HIV, can be modified to reflect the social determinants of health relevant to a multitude of other populations and offers a framework for this future work.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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FIGURE 1.