

Discourse

Reflections on the Social Determinants of Women's Health Exploring Intersections: Does Racialization Matter?

Joan M. Anderson

Introduction

It is an honour to be invited to write the Discourse for this issue devoted to a social determinants perspective on women's health. It is especially gratifying to reread the call for papers and to see determinants conceptualized as inclusive of gender and culture. For me, the mention of culture as a determinant immediately raises a question: How/why is culture a determinant of health, and, if we examine culture as a determinant, what else should we include? I will return to this question later. Suffice it to say that writing this essay has given me an opportunity to reflect on the trends and funding support over the past 10 years that have contributed to our understanding of the social determinants of women's health. *CJNR* has provided ample opportunity for us to engage in a substantive dialogue. For example, in 1994 and 2001 it published issues devoted to Women's Health (Vol. 26, N° 4, and Vol. 33, N° 3). Other focus issues pertinent to the topic include Culture and Gender, in 1996 and 2003 (Vol. 28, N° 1, and Vol. 35, N° 2), and Diversity and Health, in 2004 (Vol. 36, N° 4). This is a good time to revisit some of the ideas that were highlighted over a decade ago as well as to pose some further questions: To what extent have these earlier discussions informed our understanding/conceptualization of social determinants? How far have we come? Where are we going?

Connecting Past Dialogues with a Social Determinants Perspective

Ellen Hodnett, in her guest editorial in the Winter 1994 issue of *CJNR* devoted to Women's Health, states, "I was an active participant at the local and national levels in the recent restructuring of the Medical Research

Council, and I remain optimistic that Canada's largest health research granting agency will one day fulfil its legislated mandate" (Hodnett, 1994, p. 8).

The launch of the Canadian Institutes of Health Research (CIHR) in 2000, with its broad, inclusive, transformative mandate, has been a watershed in Canadian health research, opening up opportunities for research on the social determinants of women's health. The CIHR is committed to four research themes (biomedical, clinical, health systems and services, and population and public health), all of which are reflected in its 13 institutes. This commitment has provided an enormous boost to research on women's health and on emerging conceptualizations of gender and health research. Miriam Stewart and her colleagues (Stewart, Kushner, & Spitzer, 2001) set out the research priorities conceptualized by the CIHR's Institute of Gender and Health, pointing the way to the inclusion of gender analysis across a wide spectrum of health research.

The discipline of nursing has benefited from new funding opportunities and new synergies in health research. Many nurse scholars, at different stages in their careers, have received CIHR awards and research grants. Yet, while we have good reason to celebrate our achievements, as we look to new horizons many questions remain, in terms of not only how to ensure stable funding for new generations of nurse researchers, but also how to address new questions and how to translate knowledge into policy and practice. How have the new opportunities in research funding affected the everyday lives of women and provided new insights into the determinants of their health?

Pat McKeever, in the Winter 1994 issue of *CJNR*, states, "I believe that women currently are bearing a disproportionate share of the costs that are associated with chronic illness and disability" (McKeever, 1994, p. 15). How far have we come since 1994? Are women still bearing a disproportionate share of the costs associated with chronic illness and disability? With all of the changes in health-care delivery systems over the past decade, one might argue that an even larger proportion of the cost of caring is being passed on to women (and men), who are the caretakers despite the resources being put into home-care management. Lynam and her colleagues (2003) argue, for example, that "In enacting the reform agenda, the importance of the home as a site for illness care has increased." There are consequences, most likely, for women's caretaking role in the home.

A cogent argument could be made for naming the allocation of resources to health-care delivery systems a social determinant of women's health, since it shapes women's lives in significant ways. One is struck by the complexity of the determinants, the multiplicity of intersecting factors, and the shallowness of our understanding of the issues. For

example, impoverished women seem more vulnerable than affluent women when they have to assume a caretaker role, as caregiving can drain their scarce resources. But can one leave it at that? One might argue that the support networks of some poor women mitigate their lack of economic resources. What are some of the sociopolitical conditions that condemn women to a life of poverty or to a life of social isolation? Are some women positioned in such a way that they are “at greater risk” for a life of poverty or social isolation? In mulling over these questions, I have found it necessary to sift through the many concepts that have been making their way into the health-care literature over the past decade or so. It is to these concepts that I now turn.

Exploring Emerging Directions in the Social Determinants of Women’s Health

In 1996 I was invited to serve as guest editor of the *CJNR* focus issue on Culture and Gender. In reviewing the papers that were to be published in that issue, I observed that one of them provided “the lenses through which we might begin to grasp the simultaneity of oppressions at the intersectionality of gender, class, and race relations” (Anderson, 1996, p. 18). How and to what extent should these concepts be woven into the social determinants of women’s health? I would argue that if we name culture as a determinant of health, we must, of necessity, include other concepts that have become conflated with culture. It is only by grappling with these complexities that we will be able to pursue a meaningful and insightful analysis.

In reflecting on how far we have come in our understanding of the “simultaneity of oppressions” since I wrote that editorial in 1996, I have thought about my own struggles with the complexity of this kind of analysis and some of the concepts that have been surfacing in my own research and that of my colleagues. Many scholars in Canada and elsewhere are conducting research into women’s health and are exploring various intersections in their work, including the intersections of gender, race, class, and other social relations. But despite the work that is being done, I believe, much remains to be unmasked; we have to make transparent the complexities of these intersections and how they are *played out in everyday life to determine women’s health*. We might assume we know what “race” means, but how can we use the concept as an analytic category in trying to comprehend the social determinants of women’s health? What are the *processes* by which *race* is played out in everyday life that makes it worthy of mention, and how do these processes intersect with class and gender? I suspect that there is no single way to tackle these questions — our paradigms of inquiry will, to some extent, organize how

such questions are approached — but I want to reflect on one tack we might take as we analyze these complex issues as social determinants of women's health.

In her groundbreaking doctoral dissertation research (for which she won the Governor General's Gold Medal at the University of British Columbia), Sheryl Reimer Kirkham (2000) offers a convincing analysis of racialization in health-care settings. It is to this concept that I now turn. Before discussing some of Reimer Kirkham's insights, I would like to direct the reader to a definition of *racialization*. Although not as widely used as *race*, the word racialization could offer a handle on how we might begin to unpack the concept of race in our research. Ahmad (1994) tells us that "racialization assumes that 'race' is the primary, natural and neutral means of categorization, and that the groups are distinct also in behavioural characteristics, which result from their 'race'" (p. 18). I take it that Ahmad is drawing our attention to the assumptions we make about people based on the racial categories we put them in. He goes on to tell us that "a major issue in the racialization of health research is that it is assumed that the populations can only be meaningfully divided into 'ethnic' or 'racial' groups, taking these as primary categories and using these categories for explanatory purposes" (p. 19). The problem with this, Ahmad warns, is that "issues of institutional and individual racism as determinants of health status or health care become peripheral at best" (p. 19).

For me, Ahmad's observation raises many questions about the conduct of health research and the conundrum that faces the health researcher. For example, I am mindful of the ways in which the very research we do to address inequities in women's health might reinforce the inequities, since we assign people to "ethnic" categories that could carry connotations about people's behaviour. Such research, though well-intentioned, could eventually feed into racialized categories. For this reason, I believe, the concept of racialization *as process*, as opposed to race *as category*, may hold promise as an analytic strategy: instead of categorizing people by race, we would be examining how racial categories are constructed and how the *constructions are used* in everyday social encounters to *categorize* people in order to interpret what they do and say.

What is compelling about Reimer Kirkham's (2000) work is that she draws our attention to *how racialization operates*, showing us how the nurses of colour in her study experienced racialization. Reimer Kirkham explicates how *processes actually worked in day-to-day interactions to construct people in particular ways*. As she points out, "While much health care literature focuses on encounters between White health care providers and recipients of Colour, there are a whole range of other relations, often along various intersecting axes of power differentials, that illustrate the

nefarious and shifting ways in which *race* is constructed and negotiated in health care settings” (p. 203). What is implicit here is that constructions of race (*racializing processes*) are not neutral; they have implications for people’s lives. I am reminded of an incident from one of our research studies. A nurse, a woman of colour, related her experience of working with a patient who had undergone eye surgery. Before the patient’s eye patches were removed — before he could see the nurse — the conversation was cordial. Once he could see her, his tone changed. The nurse felt that she could no longer do anything right; her competence was questioned. Such racialized assumptions about competence are historically located and socially reproduced in everyday interactions, sometimes in ways that are “hidden.” They make up the substratum of the taken for granted and often go unquestioned and unchallenged.

Let me be swift in pointing out that it is not only people of colour who are racialized. The processes of racialization apply to everyone. For example, we might assume that white middle-class people are able to “manage” without home-care services because they have the resources to care for themselves; we related such a case in one of our research papers (Anderson et al., 2003). Or we might assume that people from some “ethnic groups” will go home from hospital to an extended-family situation when, in fact, they may have no one to help them out at home. Although racializing processes can affect anyone, they are most detrimental in situations of unequal power relations, when people from some racialized categories are constructed as *inferior, therefore lacking in authority and unable to fulfil some roles, or when people from some groups are constructed as needy or as expecting too much from the “system,”* as some of the findings from our individual research projects (which form the basis for a knowledge translation study) are now showing.¹ These racialized assumptions, when acted upon, can put people at a disadvantage, with dire consequences for their health and their lives. In such instances, “race” can play out as a determinant of health.

Reimer Kirkham (2003) takes up this point when she argues that “there is mounting evidence of inequities in both health outcomes and health care experiences that fall along lines of race, class and gender.... The health discrepancies experienced by women and those who are impoverished are further complicated by the intersectionality of disadvantages” (p. 2).

¹Cultural Safety and Knowledge Uptake in Clinical Settings: A Model for Practice in Culturally Diverse Populations (J. Anderson, A. Browne, J. Lynam, S. Reimer Kirkham, P. Rodney, P. Semeniuk, and others — 2005–08). RFA funded by the Canadian Institutes of Health Research. (A knowledge translation project in the Culture, Gender, and Health Research Unit.)

What we might take from all of this is that the determinant of health is not race as a fixed or biological category but, rather, *the social process of racialization, how people are constructed based on assumptions about race*. That I am brown is not the issue — the issue is how brownness is constructed. *These are the constructions that intersect with relations of power to disadvantage some groups and to ultimately determine and maintain class position*. It is this complex interaction between racialization, gender, and class relations that we need to explore if we are to get a handle on the determinants of women's health that are inclusive of all women who make up the Canadian mosaic. We have a rich research literature on ethnic inequalities and how ethnicity positions people in terms of occupational opportunities and income (see, for example, Li, 1988). In order to determine the mental and physical health of women (and men), we need to understand and further analyze the processes (e.g., racialization) and various intersections with gender and other social relations that operate in everyday interactions.

Earlier, I asked how and why “culture” is a determinant of health and, if we examine “culture” as a determinant, what else we need to include in the discourse. I would suggest that, first of all, we must be clear about what we mean by culture and how it becomes a determinant of health. To what extent might we unwittingly conflate “culture” with “racialized categories”? As Ahmad (1994) tells us, “Racialization takes place in terms of notions of cultures being static and homogeneous and having a biological basis” (p. 19). While, for analytic purposes, the concept of culture needs to be threaded through the discourse on social determinants, we need to monitor our use of the term — is it being used as a static concept or as a fluid, dynamic concept, constructed within highly charged socio-economic-political contexts?

As we unmask the complex processes and intersections that form the social determinants of health, I would like to turn to one further issue. If our analysis is gendered, can we continue to focus our attention solely on women's health? I raise this question not to shift the spotlight from the concerns of women but, rather, in the spirit of analysis. I contend that we can understand women's issues only through rigorous gender analysis, examining the socio-economic-political-historical-racialized contexts of women's lives and comparing them to the lives of men in similar contexts. It is comparison, I argue, that strengthens our analyses, as it is only through comparison that some inequalities can be understood. By comparing the lives of poor women with those of affluent women, for example, and the lives of white women with these of women of colour, we can see how racialization serves to position women in different ways. We need to remain cognizant of the fact that all women do not share the same social reality and the fact that “privilege” operates along different,

socially determined, axes of power. We need to tease out the various social and historical locations in order to understand how they function as social determinants of health.

Concluding Comments

When one looks towards the health research of the future and its conceptualizations of the social determinants of health, the opportunities for pushing the boundaries of theorizing seem greater than ever — and the complexities that confront us more daunting than ever. We now have a national funding body that makes it possible for us to do innovative research. Nurse researchers are positioned as never before to engage in research that can influence practice as well as health and social policy. Nurse researchers are in positions of influence. But it is not only the availability of research funding that will make possible the kind of analysis I am suggesting. Nurses have a social and moral responsibility to conduct research that is inclusive of all of Canada's populations. However, we must conduct this research in ways that do not reproduce racialized categories but that, instead, challenge the categories and assumptions that result in the demeaning of people. We need to question the taken for granted and expose the processes through which social reality is constructed and maintained. This issue is not just a theoretical one. It is also a moral issue, with implications for people's lives. It seems reasonable to argue that being demeaned and disempowered is a potent determinant of one's mental and physical health. Nurses should be aware of the processes through which a climate of despair is created. The choice is ours to make. Will we take up the challenge of conducting research that pushes us to a new level in understanding the social determinants of health? Such research may well provide new insights into how we might work towards a more just society.

References

- Ahmad, W. I. U. (Ed.). (1994). *'Race' and health in contemporary Britain*. Buckingham, UK, and Philadelphia: Open University Press.
- Anderson, J. M. (1996). Guest Editorial: Constructing culture and gender. *Canadian Journal of Nursing Research*, 28(1), 17–19.
- Anderson, J., Perry, J., Blue, C., Browne, C., Henderson, A., Khan, K., et al. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, 26(3), 196–214.
- Hodnett, E. (1994). Guest Editorial: Women's health. *Canadian Journal of Nursing Research*, 26(4), 7–9.
- Li, P. S. (1988). *Ethnic inequality in a class society*. Toronto:Thompson Educational.

- Lynam, M. J., Henderson, A., Browne, A., Smye, V., Semeniuk, P., Blue, C., et al. (2003). Health care restructuring with a view to equity and efficiency: Reflections on unintended consequences. *Canadian Journal of Nursing Leadership, 16*(1), 112–140.
- McKeever, P. (1994). Discourse: Between women: Nurses and family caregivers. *Canadian Journal of Nursing Research, 26*(4), 15–21.
- Reimer Kirkham, S. (2000). “Making sense of difference”: *The social organization of intergroup relations in health care provision*. Unpublished doctoral dissertation, University of British Columbia.
- Reimer Kirkham, S. (2003). The politics of belonging and intercultural health care. *Western Journal of Nursing Research, 25*(7), 762–780.
- Stewart, M., Kushner, K., & Spitzer, D. (2001). Discourse: Research priorities in gender and health. *Canadian Journal of Nursing Research, 33*(3), 5–15.

Author’s Note

I thank Dr. Sheryl Reimer Kirkham, Associate Professor, Trinity Western University, for reading and commenting on this paper. I have appreciated my discussions with her and with my other colleagues in the Culture, Gender and Health Research Unit as we have grappled, over the years, with some of these theoretical and moral issues. I also wish to thank the Canadian Institutes of Health Research for funding my program of research, which has made this kind of theorizing possible.

Comments or queries may be directed to Dr. Joan M. Anderson, School of Nursing, University of British Columbia, T201 – 2211 Wesbrook Mall, Vancouver, British Columbia V6T 2B5 Canada. Telephone: 604-822-7455. E-mail: anderson@nursing.ubc.ca

Joan M. Anderson is Health Research Coordinator, Office of the Vice President Research, University of British Columbia, Vancouver, Canada.