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# Health Equity and Intersectionality: Women as a Special Population

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## Introduction

Health equity is the "attainment of the highest level of health for all people," according to the United States Office of Disease Prevention and Health Promotion, acknowledging both a particular standard of health and a recognized level of disparity for certain groups of people nationwide. Although health disparities exist at some level for every minoritized population, current policies continually dismiss the unique needs of women. Both health behaviors and health barriers limit the achievement of health equity for women, and legitimate recommendations for combating these inequalities require a look at historic disparities related to womanhood, as well as the problems associated with universal-fit healthcare policies that ignore marginalized populations with specific social determinants, which will collectively and continually inhibit a maximum level of health.

## A Look at Feminist Theory

Feminist theory can be used to understand gendered obstacles for women. In this paper, women will be a gender designation defined as not male, but will include any persons identifying as female, although there are many definitions and inclusions. However, current policies largely exclude other gender identifications, and a brief discussion on health disparities faced by LGBTQ persons will also be discussed herein. Having to outline a gender definition is already arguably setting forth one health equity problem, as social constructions of gender outside of the norm and not recognized in currently health policies create another extremely vulnerable population within the confines of other marginalization.

In Feminism without Borders, [23] many challenges for women, particularly heterosexism, misogyny, and racism, and one of her key concerns is the disconnect which exists between women. When women, as a minority group, are unable to achieve solidarity, particularly political, due to conflicts of sexual preference and practice, ideology, and other boundaries, the task of achieving equality or equity is difficult. How are women to have a voice against patriarchical privilege if they are at odds within their own sex? If we are calling for the next wave of feminism to dismantle structures of dominance, it must first start with the structures which inhibit equality between women.

In her text, Mohanty also discusses ways in which women in developing countries are stereotyped as powerless, emotional, and subordinate, particularly through religious oppression, victimized through violence, discounted through work in the home, and are financially dependent upon a partner. [23] There are barriers to understanding when career-driven women fail to acknowledge the free choice of women to also be married, rear children, enjoy domestic work, and adhere to religious modesty. It is not for women to decide which free choices are oppressive. There are also those whom believe that a career gives them financial freedom, as well as being single or childless, and that dressing uncovered demonstrates a lack of self-respect. When women stereotype and decide values for one another, including decisions which limit a woman's control over her body, from birth control to abortion, it only acts to support and strengthen the same patriarchical structure which ultimately dominates us all. [23].

When a privileged majority decides on policies or norms for the rest of the population, diversity is ignored. To this end, minority women, or women of color, as well as disabled women and those with alternate gender identities, are also further disadvantaged in additional structures of dominance, discrimination, classism, and perpetual cycles of poverty, often leading to complicit behaviors that limit their ability to break through barriers. Certain health and social behaviors, such as illicit economy or intentional servitude are definitely counterintuitive to the equality desired through feminism, but the intention of women in these groups also needs to be studied, as well as their need. Dominant structures are deeply engrained in colonialism and tied to economic models, in which women were historically part of domestic trade, sometimes in exchange for land or services, and their activities within their communities were strictly governed by a set of expectations, often religious, and without personal agency. In the past (and still in various places worldwide), women have been given as gifts, often with a dowry, which is a practice that now has more affectionate meaning for some, such as when a bride's parents pay for the wedding. It all still denotes some sort of bride-price or financial benefit to the groom in exchange for the woman.

In her essay, "'Introduction' to The Second Sex," Simone de Beauvoir, and in her work, "The Traffic in Women," [34] discuss how women are typically defined in relation to men. A woman may be defined as not male, thus so always in comparison to a male, lacking her own autonomy, being described as "contrary to," and dependent. [26] When considering personal economy, women are designated as relative to or dependent on someone else, taking care of the home and/or children so the husband can work, filling a sexual need in men (so they can blow off steam after work), and she is arguably oppressed in these circumstances, unable to make financial decisions without access to her own resources. [26] The irony here is that even if a woman desires her own financial autonomy, so that she may have the same net

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worth as a man, countless statistics support findings that women are paid less for the same work, so she still lacks equality.

In her work on Marxism, Heidi Hartmann relates the structural dominance of women, particularly in terms of resources and money, similar to a worker whom is lower in hierarchy to men. This is similar to the Marxist descriptions of bourgeoisie and proletariat, and Marx describes in his own works on capitalism, such as in "Das Capital," the role of women in economic structure was most importantly to mind her husband, his health, and his home, so that he remains able to labor to his fullest. She is only a conduit for his success.

There is an even deeper contrast for women of color, when, as described in The Combahee River Collective's "A Black Feminist Statement," racism is part of the heterosexual, patriarchical, class oppression, that it is historical and long-standing, and that change will only come in "conscious-raising" and solidarity. Black women face their own micro structures of dominance against black men, in addition to the macro struggles within the white structures of dominance against both white women and white men, and much like Nicholson and Mohanty recognize, the first waves of feminism largely excluded their additional structural obstacles. Women of color, the Collective's statement shares, have been left out of feminism [26].

In her work, "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," [5] shares that "ignoring differences within groups frequently contributes to tensions among groups," and that women of color fall behind the curve of feminism because of the additional burdens which particularly exist within their race. We cannot ignore that there are higher numbers of black women in shelters than white women, higher unemployment, and a higher prevalence of abuse. Obviously, aside from socioeconomic structures, there are additional hurdles for these women [5]. Explains that policies which may positively affect white women still do not reach women of color, and that policy and research structures largely ignore the unique needs of women whom have more complex intersectionality than white woman.

We find the same power struggles within Native American and Hispanic populations, where these women struggle in feminist progress. Their limitations include, among other issues, lacking autonomy within their traditional communities and families. It's the being invited to but still not getting to go to the ball. There is someone at home saying no.

In "The Master's Tools," [20] also shares that the work of feminism largely ignores the ultimate goal, which must be those which "dismantle oppression" and recognize intersectionality. "Difference is that raw and powerful connection from which our personal power is forged," she states, echoing the change that Mohanty suggests through "herstory," which is more than standing in solidarity, and instead standing out through individualism, in order to be heard, eventually, as a sex.

In their work on multiracial feminism, Maxine Baca Zinn and Bonnie Thornton Dill also speak to the progress that could be made if the feminist movement recognized difference, such as structural barriers which more rigorously impede women of certain race and/or class from reaching measures of equality more often than a woman of privileged race and/or wealth. There are flaws in the universalizing of women. It is problematic when decisions are made for women, even by other women, either through a collective grouping, which diverts attention from the recognition of individuals, or through binary approaches which blatantly discount a variation of needs. Women whom challenge heteronormativity are often considered revolutionary or oppositional, being disdainfully labeled as a feminist, because challenges to dominant structures are a threat to the status quo. There are also paradoxes in feminism, such the opposition of sex work by those whom disdain it as the commodification of sex for the pleasure of men or used as a tool of self-objectification, while women whom freely choose sex work may use it as a catalyst for financial independence and, depending on her work, may feel empowered. In her work, The Aftermath of Feminism, [31] also attempts to differentiate this disempowerment and empowerment through choice, using these examples. That is, we can dislike pornography because it objectifies women, but a woman who chooses activities or occupations designed for the male gaze may still be empowered through her freedom of choice. This begs the question of how we judge whom can benefit from feminism, and whom, if anyone gets left out, and if we should applaud any entryway into female freedom, or only when it includes absolute autonomy from men. Women in certain religions also believe that subservience to their husbands, fathers, or brothers, is preferable to the pressures of making sole decisions, and many freely choose this belief system. This is, of course, unless we delve into the sociology of this choice and whether it came from cultural norms or a lack of exposure to additional options, and is it also feminist to make choices of her own volition which include those in subordination? [23]

In the introduction to her anthology of feminist work, The Second Wave, Linda Nicholson, remarks that feminist movements must evolve, and they must capture women previously left out of or who fall outside of the borders of other movements. Perhaps she is speaking of these uniquely oppressed women, and regardless of our own stereotypes, values, and norms, we truly must strive to understand the other. The most powerful component of this glance at feminist struggle is that women are failing each other when they do not appreciate difference, and that alone causes gender oppression, made worse when it is through other women. Again, one of the most important calls to action presented by Mohanty is to allow "her story," or the individual identity stories of women, to help us to "understand oppositional agency." [23] Health equity will begin here, as well, when we must take up the task of recognizing unique intersections of women and their specific and diverse needs, which requires a more complex set of tools than recognizing that women are simple different than men. Women are also different from one another, and our experiences make us unique.

## Acknowledging the Other

One of the obstacles of differentiating need is the chronic lack of recognition of any needs which exists outside of our own. This is more than ignoring, perhaps worse than disregarding, as it simply not seeing. It could be the lack of a lens to see differently or the inability to accept anomaly. In business, feedback, suggestions, and dissention are typically not actively sought for fear of having to make changes, which cost time and money. Lack of recognition of varied gender and sexual identification in policy, education, and within the medical community is a dehumanizing discrimination tactic against those in the LGBTQ community. Lack of universal building design or failure to allow pathways into mainstream office or school environments demonstrates disdainful discrimination for the disabled. In [31] chapter "Illegible Rage: Post-Feminist Disorders," she discusses the pressures placed on women to fit into approved, patriarchically-preferred feminine contexts, in order to be counted as real women. Anything else is considered farse, illusion, pathological, or masquerade. When someone's sexual identity or orientation sits outside of heteronormatives, they are aggressively judged and outcast, because again, they stand to upset and challenge

the status quo. Robbie mentions that commercial images of women are also often fractured, showing only fragments of their body, sometimes without a face, disembodied as if their names or individual identities are of no consequence. [31] Members of the LGBTQ population are also an extension of this fragmentation, often met with a backlash of alienation from support systems, subject to violence, and faced with a barrage of social media, news, and policies set out to discourage or erase.

The challenge of acknowledging the other may also lie within a growing lack of humanity or sensitivity. In her book, Regarding the Pain of Others, Susan Sontag discusses how we as a society have become desensitized through, among other things, a constant exposure to images, through art and photography, particularly in this information age, and certainly increased through technology, making it easier to view the historical materialism of war, trauma, despair, and suffering, quicker, more frequently, and with more intensity, than in previous eras. Whether it is through social media or press, images of misery and violence are graphic, plentiful, and vast, and studies have corroborated that the more we are exposed to these images, they become part of our norm and normalized within our psyche. We are also, for the most part, able to keep these images separate from those mental images of our own lives and our own stories. We live one reality and associate the foreign images with the pain of others. That happens to other people. Through this justification, we can quickly discard the image and upload the next, replacing it with a new one, over and over, never spending too much time unpacking the image before and understanding the why, just quickly clicking to the next.

Trauma and media expert, [21], in his book, Bio political Media: Catastrophe, Immunity and Bare Life, discusses that human suffering and catastrophe has become the norm, and that our natural reaction to images of destruction, unrest, and trauma is to engage in self-protection. We think only about how it will affect ourselves. He mentions that the images of particular events are so distressing to us, that we begin to feel a certain distant, disdainful, or stereotypical way about the subject of that image, due to self-preservation. He gives the example of 9/11 and how the images of the Twin Towers became synonymous with a terrorist act, and how an image of Osama Bin Laden became synonymous with terrorist, and we associated anyone with particular ethnic characteristics to also be a terrorist, regardless of individual ideology or identity. Fear takes over, and we simply do not want to spend too much time differentiating them from another. These images are powerful, and if self-protection is also reaction to images of people suffering from natural disasters or epidemic, we may begin to also understand the indifference of some to the suffering of women from violence, rape and assault. We are desensitized by the sheer volume of images, and particularly when the pictures are of women of a different ethnicity or nationality; it isn't one of us, so we simply click through. When trying to understand privileged justification, the disparities do not concern them. Those with recognizable privilege do not even have to hope that [it] doesn't happen to them. Their self-preserving actions mean that [it] never will. For "it," insert poverty, starvation, preventable disease, and so forth.

Of course, this rationale does not fit every facet of the population, but self-preservation is a powerful reaction. In his book, Pathologies of Power: Health, Human Rights, and The New War on the Poor, Paul Farmer discusses how we differentiate levels of suffering. Is it "painful illnesses, say, as well as torture and rape," or is it "assaults on dignity, such as institutionalized racism and gender inequality"? (Farmer 29) He notes that "suffering is a fact" but policies acknowledge a "hierarchy of suffering," so how are we to decide what constitutes health equity or equality, whom sets the standards, and will the standard be the same for all people? (Farmer 30) Farmer mentions this because policymakers, or those in power, as well as others in positions of leadership, may also believe that suffering and structural violence are a byproduct of choice, and the right to health and equality exclude those whom have made health behavior choices different than their own or the standard for health, such as AIDS due to unprotected, homosexual intercourse or through intravenous drug use. We make justifications for suffering, based on the stereotyping of others. Even when intersectionality is acknowledged, irresponsible health behaviors can be used to justify lack of outreach. Those on the periphery of recognized, acceptable health and appropriate healthy behaviors become the surplus population.

As outlined in previous papers, there is arguably the existence of biopolitics. In his lectures at the College de France, "Society Must is defended" and "The Birth of Biopolitics," [13] presents the theory that when certain populations in a society are considered to be useless or weak, they can be discarded. There can be a let die (versus the imperialistic make die) of those persons not adequately contributing to the economy, as they are considered to be stressing valuable resources and a burden to the system. This let die is gradual, almost calculated, Foucault argues, through lapses of accessible health care, lack of affordable resources, decreased subsidized medications, and decreased equal opportunity, creating for policymakers a parasitic population in need of handouts. There is an indifference to their perishing, as the state is primarily in the business of making money and growing power. This is a harsh concept, but one that [16] also argues in her book, Death Beyond Disavowel, as she describes ways in which marginalized populations, such as black women, Latinx, and queer, are "existentially surplus" and that "political protections of life" exclude disenfranchised populations, such as prostitutes and drug addicts. [16] Hong also mentions Lorde's "Master's Tools" speech, where Lorde challenges us to reach deep "inside [ourselves] and touch that terror and loathing of any difference that lives there," acknowledging our hatred of the unfamiliar and our fear of the different [16].

## Different Women

The problem is that women are already, arguably, by physiology, emotionally, and psychologically, different. Since we have already acknowledged that our standards, economy to values, and likely health, is also based on the heterosexual male, women are even more so othered. Men are aware of this difference, but based on policy remarks earlier this year, for example, many have decided that women should not be entitled to anything different than men, specifically birth control. Men have decided, however, that women's labor is not as valuable as theirs, and the main reason why the salary gap exists is simply because women allow it. Thus, the system is rather hypocritical at how it arrives at decisions of equality.

The earlier wave of feminism only asked that women be allowed access to the same jobs as men, but it did not negotiate pay, and a fairly significant percentage of men would meet a women's wage protest with expressing a lack of need for women in the workplace anyway. They have the same argument regarding immigrant jobs, yet we can also locate the irony when we must either increase the cost of manufacturing to meet the minimum (or higher) wage demands of white earners or we are unable to fill lower income jobs because no one else wants to do them. There is definitely a disconnect. While there is no real concrete explanation for the gendered wage gap, other than deeply embedded familial structural tradition, there have been times, particularly in

U.S. history when women were considered invaluable players in the workforce. During World War II, women were considered important surplus labor, as men were drafted to war, and the war effort required factory laborers at home. However, many employers may believe that women should be paid less to account for distractions and absences due to parental commitments, even though fathers may also be a part of the family structure, and the paradox is worse for women of color.

As Hong mentions in her book, and as was also discussed by Butler, certain types of women have become invisible, whether due to disability, sexual orientation, gender identification, or ethnicity, and this invisibility leads to further marginalization due to this discounting. In her book, Citizen, [33] paints a powerful picture of black men and women whom have been disproportionately victimized by, in particular, police violence, due to criminalization tactics, believing that they must appear to be faceless and disembodied, lumped together as a whole, as the statistics for the killing of black persons is considered racially endemic in the United States. As is also described by Sontag and Meek, the image of the black hoodie, shown on the cover of Rankine's book, requires no face, because it has become synonymous with murderer, rapist, and thief. It may just only be a kid in a hoodie, on his way home to his family after running an errand, but he gets shot anyway. There are many works on the disembodiment of black women, as well as their invisibility due to the structures of dominance within her community or country.

In his book, Infections and Inequalities, Paul Farmer discusses the HIV/AIDS epidemic in the U.S. and Haiti and the stereotypes and religious systems which surround the health literacy regarding the disease. HIV was historically considered a largely homosexual male disease, particularly in the United States, until the first female cases appeared. Female infection cases were considered to be isolated, associated with contaminated needles in drug use, but then HIV/AIDS among women began to become prevalent in some major cities, through sex with infected male partners. In Haiti, AIDS was expected to also be relatively confined to certain groups, such as homosexuals and drug users, and it was thought to be only contracted sexually through anal intercourse. When monogamous, married women began showing symptoms of the disease, particularly when routinely tested during pregnancy, the disease was also traced to infected men whom were engaging in extramarital sexual relationships or intravenous drug use, and then bringing the infection back to their wives. Incidentally, these infected women were treated like pariahs in society. Community members whom lacked health knowledge regarding the communicability of the disease feared that their children would be infected playing with children of HIV-infected parents, and they did not want those children in schools or HIV-infected women active in society. The women began lives of invisibility in plain sight. Even with readily-available information regarding the transmission of HIV/AIDS, this visceral reaction is common, and there have been incidents in which parents in the U.S. have also threatened to sue a school board or take their children out of school if an HIV-infected child attends.

In [8] work, The Beginning and End of Rape, she analyzes the testimonials of women whom have felt disavowal from both the government and tribal leaders, particularly in terms of persistent violence and rape, powerless to report abuse and assault to leaders, for fear of retaliation or repeated abuse. Assault in this population is often at the hands of a male relative or close friend, and reporting can lead to fracturing from family relationships and financial support, as many Native women are stay-at-home mothers and dependent upon not only male family members but on the unique tribal systems which exist on Native lands. Assaults on tribal lands are typically dealt with by tribal councils, often requiring the assailant to offer only a verbal apology or monetary fine. Native women whom have been victims of rape and/or battery often feel isolation and shame, often using coping mechanisms like substance abuse to deal with the physical and psychological trauma of assault. They often do not seek help for this substance abuse; for fear that their children could be taken away. The perpetual cycles of poverty, powerlessness, and victimization of Native women have deep roots in colonialism, and their population remains one of the most vulnerable in the U.S. to prostitution, human trafficking, and violence, and these effects extend to subsequent generations, as there is a lack of resources for either gender violence or substance abuse, and low role modeling to teach children differently. They do what they see, creating unhealthy and often dangerous environments in Native schools and in the Native communities, stemming from adolescent assault and rape, teen pregnancy, and early alcoholism.

In her important work, Death without Weeping, Nancy [35] also shares ethnography of normalized violence among Brazilian women, and the hardships they face in a patriarchical, Catholic, and machismo society, powerless to make choices regarding birth control. This lack of choice means that the poorest women in Brazil are forced to have large families, even if they are unable to feed or adequately care for them. The title of the book describes the tragedy of death within these households, particularly of the weakest, sickest, and most malnourished children. These Brazilian women are no less family-oriented and warm-natured than their wealthier counterparts, but "death without weeping" speaks to the implied relief that the death of that child in a poor family is one less mouth to feed, and the strongest of the children have survived. Brazilian women in these circumstances are also no less emotionally affected by this loss as other women whom have outlived their children, but herein exists a moral justification, based on their dire socioeconomic circumstances, which allows them to try and see the death for the better. [35] also shares stories of Brazilian women, most often Afro-Brazilian in the lowest socioeconomic tier, whom leaves their children in the care of others, so that they can travel into the city to work as housekeepers and nannies for wealthier women. Some literally leave their children behind to raise themselves, so that they can raise someone else's child (ren), for the financial betterment of their family. It is yet another paradox.

While engaging in field study in Brazil for a 2010 Masters of Interdisciplinary Studies thesis, Access to Water, Sanitation, and Public Health Services among Urban Poor in Maceio, Brazil, it was not uncommon in many areas of Brazil to see children from impoverished communities working at fruit stands alone, often in remote locations, typically a girl between the ages of nine and eleven with a small group of younger siblings, to earn nominal wages while their mother was also at work. However, this also means a disproportionate number of young girls in Brazil are vulnerable to rape, molestation, and other sexual assault, not uncommon among the poor.

In their work, Fields and Barbara Fields, trace the inequalities faced by the American black population, deeply engrained in racism and the systemic dehumanization of the black body. In the early to mid-Century, erroneous rumors stated that the black person was less intelligent than a white person, and their bodies were more prone to disease, creating ethical nightmares like Tuskegee in which black men in Alabama were used in unethical clinical experiments and denied treatment in order to understand the affects of syphilis on the body. In addition, Rebecca Skloot's work, The Immortal Life of Henrietta Lacks, also describes how Ms. Lack's cells were used for prolific medical

experiments, due to the unique replication abilities of her cells, leading to various advancements in medicine, particularly vaccines for HPV and polio, yet her African-American family was not informed of the use of her cells, nor did they receive any compensation for these life-saving and profitable discoveries, when many others did.

Sojourner Truth spoke of her own experiences as a black woman being excluded from the same chivalry extended to white woman. Her race made her invisible to these opportunities. These circumstances describe disenfranchised people whom are considered to have little to no inalienable rights, and this problem is also prevalent in other vulnerable populations, such as incarcerated women, Latina women, and others. Disabled-bodied women, those with LGBTQ-identity, and any complex intersections of many social categorizations and/or multiple vulnerabilities, such as black, disabled, and queer, further limit the scope of access to health, care, rights, and recognition, among uniquely othered groups of women. Some of these categories overlay or interlock, and some sit on their own, and each contain their own facets of discrimination, thus needing to each be individually studied and summarily included when deciding on policy standards.

In their American Journal of Public Health article, "Persons with Disabilities as an Unrecognized Health Disparity Population," [20] outline that "adults with disabilities are four times more likely to [self-report poor health than those] with no disabilities," and that many of the adverse health outcomes may be preventable, particularly when accompanied by additional compounding variables such as low socioeconomic status, gender, or race, and that the lumping of all disabled persons into a catch-all disability category means that healthcare and programs are not differentiated by cognitive disabilities, physical disabilities, injuries, and so forth. When access, in particular, assumes physical disability, other subsets of the disabled population are excluded, again meaning their life years are adjusted for this determinant. The Krahn article presents a particular Center for Disease Control (CDC) Behavioral Risk Factor Surveillance System (BRFSS) survey which demonstrates the difference between people with disabilities and those without, adjusted by additional social determinants, with fairly significant statistical outcomes. Their findings showed that people with disabilities were twice as likely (or more) than able-bodied persons to a) not have seen a doctor in the past year, even when they needed to, b) not engage in any "leisure-time physical activity", c) be obese, d) have heart disease, e) be unemployed or have a poverty-level (or below) income, and f) have lack of transportation. Without argument, we need to develop public health initiatives aimed at narrowing these gaps, particularly when doing so could prevent early death or additional disabilities and health problems in this population [20].

LGBTQ research such as "Sexual Orientation Identity in Relation to Minority Stress and Mental Health in Sexual Minority Women" by [29] and "Hispanic Lesbians and Bisexual Women at Heightened Risk or Health Disparities" by [19]. Acknowledge that in addition to existing disparities due to both structures of dominance and racial discrimination, women belonging to complex intersections face health problems more often. When cultural norms typically mean that a Hispanic family is traditionally a male husband head of household in a heterosexual relationship with a female wife, lesbian, gay, and bisexual women challenge the "nuclear family" status quo. Hispanic LGBTQ women may find themselves alienated from previous support structures, which creates additional stress factors, particularly if language, familial connections, immigration status, and acculturation are also compounding variables related to mental health. Women whom already experience racial discrimination now also report varying degrees of homophobia, stigma, and victimization, in addition to the adverse mental health conditions associated with just racial barriers alone [29].

In her article, "Triple jeopardy? Mental health at the intersection of gender, race, and class," [32] discusses unique risk factors within minoritized populations which lead to an increased prevalence of mental health disorders and illness, such as depression, often worsened by feelings of despair due to their economic circumstances and discrimination experiences, and then further exacerbated by lack of affordable care options or cultural barriers to seeking help. In their article, "Rethinking gender and mental health: A critical analysis of three propositions," [15] discuss the tendency of research to pathologies women with certain mental health disorders and do the same for men, such as stereotyping that it is mostly women who exhibit signs of depression, or assert that a mental health disorder is effeminate or masculine. It has also been suggested that men and women cope differently to stressful situations, along with the gendered expectations for behaving a certain way when either depressed or anxious. This sets up men for the unrealistic expectation that they should "man up" as to not appear weak, stigmatizing any feminized depression behaviors, while women, whom may be expected to cry when depressed, for example, may exhibit alternative response behaviors, such as suppressing her feelings. Hill and Needham list a number of recommendations for these barriers to mental health, while we await additional and more intersectional research, which include "refrain[ing] from overstating empirical support for gendered responsively" and shedding expectations of gendered disorder responses, among others [15].

We also have to be careful about setting guidelines based on our own expectations or practices. One example relates to current events on the reporting of sexual assault, violence and rape in Hollywood, which cases are often ten or more years old. Common questions are why now and why wait so long to report, or question the integrity of the victim, such as did the assault really happen or is there an ulterior motive for reporting the incident now? There is arguably no set standard of time in which a woman (or man) may be ready to share her or his story of assault, and although some do report immediately, others out of shame, retaliation, ridicule, or fear of being blackballed in their professional, hide the incident(s) until such a time as they feel empowered to share. Her story would look deeper into these testimonials in order to build a better understanding of victimization and how to better advocate for and increase success in the prevention of additional violence.

## Socially-determined Obstacles to Healthy Equity

In a paper entitled "Gender as a social determinant of health: Gender analysis of the health in Cambodia," presented by [22] at the 2011 World Health Organization (WHO) for the World Conference on Social Determinants of Health in Rio de Janeiro, they first acknowledge that sexual identity and gender identity are social determinants, as both men and women worldwide struggle to seek sociopolitical recognition. This recognition, whether it is as a lesbian woman or a female to male Trans, etc. is crucial before we can move forward with solutions seeking to narrow health disparities for special populations. When there are professional and academic barriers to health knowledge, lack of training, and low competencies, stigmas exist, or likewise, vulnerable populations are turned away from care that can be life-saving and life-sustaining. Like many countries in the world, Cambodia has a higher percentage of women in the population than men, yet there are, as also exists in many other of the world, "unbalanced power relations

between men and women [which affect health risk]." [22] Leading causes of death in Cambodia include "acute respiratory infection, diarrhea [(typically from waterborne diseases)], malaria, [infant and maternal mortality], tuberculosis, measles, and dengue fever." [22] Immediately, this list highlights socioeconomic determinants of disease, particularly when we look at infant and maternal mortality and what lack of resources, education, and healthcare can mean to a woman during prenatal care and childbirth. Measles is considered to be, as was also studied by Paul Farmer, one of the "diseases of poverty" in underdeveloped countries, which is defined as any disease which would be preventable or have a vaccine for or a cure, or a positive-outcome treatment plan, if the person were in a higher income bracket. Tuberculosis, dengue, and malaria are all diseases often associated with tropical climates but are also most prevalent among the poor, particularly those living in rural environments where access (including transportation) to medical treatments is challenging, and are often found in living environments where there may be an increased number of family members residing in a single household, or when community members live in such close proximity that one sick person can quickly infect a large group of people. Lack of public health knowledge is also scarce, so life-saving prevention protocol is often unknown, again due to socioeconomic level, geographic location (such as living rurally), and low health literacy has a significant effect on morbidity. Understanding that standing water, for example, can attract the mosquitoes which carry vector-borne diseases, such yellow and dengue fevers, means that people are not taking simple precautions, like filling in water puddles with dirt or dumping out containers after rain, to reduce the chance of disease. Diarrhoeal disease also has varied causes, often a byproduct of other diseases, such as cholera and malaria, but it also affects a disproportionate number of children in countries where both water scarcity and sanitation problems exist. When there is a lack of potable water or where sanitation solutions are in decline, there is a higher probability of wastewater and waterborne pathogens, such as E.coli, salmonella, and giardia, which all have diarrhoeal implications. When there is a lack of clean water to help rehydrate an affected person, then the disease persists until the death is not necessarily caused by the pathogen itself, but instead by dehydration.

In the WHO study, important statistics on HIV prevalence were outlined to remark that although the overall disease has decreased in Cambodia, particularly among high-risk populations, such as "commercial sex workers," as with Farmer's Haitian study, [22] found that a "sharp increase in prevalence among low-risk heterosexual women" attributed to married men who engage in unprotected sexual activity with prostitutes and then bring HIV and sexually-transmitted diseases (STDs) into the home. [22] As is seen in studies regarding the increase of STDs and sexually-transmitted infections (STIs) and HIV/AIDS among Hispanic women, a man's refusal to wear condoms has greatly increased the occurrence of the disease among heterosexual, monogamous women. Here too, the power struggles which exist between men and women in this culture mean that women are unable to control their own health outcomes.

One of the most significant overviews in the Cambodia paper is the objective outline for the Cambodian Ministry of Health and Ministry of Women's Affairs, similar to the United Nations Millennium Goals for all countries, to research and review current policies and programs, analyze shortcomings, and design a sustainable plan for health equity. In their policy review, they use the WHO Gender-Responsible Assessment Scale (GRAS) to question which "level each policy [falls] into: gender-unequal, gender-blind, gender-responsible, gender-sensitive and gender-blind" with the intention of the eventual achievement of either gender-specific or gender-transformative policy. One of the goals of gender-transformative policy "addresses the causes of gender-based health inequalities" and also works to "foster progressive change in power relationships between men and women." It does not seek to make men and women equal, as with one potential goal of feminism, but to find ways to ensure that Cambodians with a strong adherence to cultural norms and traditions can have both culture in praxis and healthful outcomes [22].

Low socioeconomic status was another determinant associated with maternal and infant health outcomes. When poor women are also demonstrating a higher prevalence of a) chronic diseases, such as diabetes and hypertension, b) mental health problems, such as depression, c) spousal or partner abuse, d) STDs, and e) and substance abuse, as well as a rampant lack of resources for 1) safe and adequate housing, 2) locations for exercise, and 3) nutritious food, these are also compounding high-risk factors for maternal and infant mortality. (Healthy People 2020) An Iranian Journal of Public Health study focused on determinants of location, such as urban versus rural living, education, ethnicity, income, occupation, marital status, and age, as factors in reproductive health for women in Iran. The report demonstrated findings that people living in poverty and unemployment "are more likely to have poor health" and those factors also increased the likelihood of "crowding" in family dwellings, with additional adverse health effects stemming from population pressure and highly communicable disease indicators, and that as a result, single women were found to have better physical and mental health outcomes than those whom were married. Differences in "married" outcomes were attributed to poor health behaviors, such as "limited physical activity, unhealthy diets, and lack of attention to personal health," and due to strong cultural traditions, married women are often taking care of extended family members, living in large or crowded households, and must place their own health needs last [1].

A WHO survey comparing men and women from 57 countries also looked at some of the same determinants, such as income and marital status, to understand disparities between genders, and found that men and women indicated that they more easily found paid employment opportunities in Europe versus a lack of opportunities for those living in African regions, as an example, which gainful opportunities had statistically greater physical and mental health outcomes. Obviously, employment relates to income and thus health conditions fare better for those whom are also insured or able to pay out-of-pocket medical expenses and can afford transportation, and employment has also been shown to be an important determinant for health for women. Women with occupations also had a higher likelihood of being unmarried, and per the Iranian study, this marital status is associated with favorable health outcomes, likely because women are able to solely focus on their own health, nutrition, and care needs. Widowed men and women also had poorer health outcomes compared to those whom were married:

"[m]en and women who were married or cohabitating or divorced, separated or widowed, had significantly worse health than those who had never married and this was particularly true for women." [17]

In her American Medical Association Journal of Ethics policy forum paper, "Social Determinants of HIV Risk in Women," Claire Pomeroy discusses the "disproportion [lately] high risk of Hispanic and African American women" for contracting HIV and developing AIDS, worldwide. The stereotypical victim of this disease no longer exists. "[H]eterosexual transmission is the chief cause," and reasons

for this include, among other conflicts, the powerlessness of women in heterosexual relations, when non-monogamous male partners refuse to wear condoms. This may be due to cultural norms in which perpetual power struggles between men and women exist, as was also mentioned previously, but also due to societal values, when sex education is considered taboo or is not in-depth enough to cover various facets of disease prevention, or women and young girls in many countries receive no information at all, due to lack of any education. [28] Poverty is another important marker when women "have no choice but to become sex workers or to trade sex for necessities such a food and housing," which can increase the likelihood of infection if, here again, there is a lack of control of one's own protection during sexual intercourse. [28] Pomeroy does mention the development of the female condom as one method of both empowerment and risk reduction, but she theorizes that this will have a limited scope for lowering prevalence, since the female condom is "more expensive, less widely available, and more difficult to use than the male condom." Research has shown that women often do not understand how to use the female prophylactic, meaning that its use would only improve or increase "if paired with outreach and education," as well as cost-effectiveness and availability, and only then succeed in becoming a valuable protection against sexually-transmitted diseases [28].

The Ontario Women's Health Equity report defines female low-income populations, immigrant, and minority groups as additionally vulnerable women. Other social determinants for Ontario women are "education, employment, [single-parent households], and food insecurity." (POWER 1) There were additional vulnerabilities for each determinant, as also segregated by race. For example, Aboriginal women had the lowest level of education. Women had lower self-reporting of employment than men, and those in single-parent, female-led households "were twice as likely to have lower incomes as those headed by men (46% versus 22%, respectively)." (POWER 2) The determinants were also used to measure self-reported health status, physical fitness or activity, access to health services, and acute and chronic health conditions among women with lower socioeconomic status, particularly when compounded by variables of race and education, reporting, for example, a 2x additional likelihood of "having diabetes or cardiovascular disease" than higher-income women. East and Southeast Asian women self-reported the best health outcomes, while again, Aboriginal women had higher reported adverse outcomes and risk factors, such as, and "39% of Aboriginal women reported smoking." (POWER 2-3) There were additional factors, such as acculturation, language, transportation, rural and urban geography, difficulty in understanding health systems, and lack of health coverage for services, particularly among immigrant women. The report also offers a Power Health Equity Road Map of key steps necessary to achieve health for all, which includes making equity a priority for Ontario and addressing socially-determined "root causes of disease." (POWER 5)

## Finding Solutions

When we look at studies regarding health disparities, they often outline barriers to care, such as lack of access, such as transportation, native language, and affordability, as well as low outreach effort to certain populations. There are stereotypes of bias preventing healthcare professionals from seeking out those in marginalized groups, as well as lack of training in cultural competencies to bridge understanding and provide effective solutions which are both culturally-acceptable but also health-viable. We must also acknowledge that there are uncontrollable circumstances, such as migration patterns, but there are also those which can be controlled with careful study and appropriated intervention, such as encouraging healthy sexual and reproductive behaviors. Certain belief systems, including stigma, also influence the trajectory of disease, and universal solutions do not work, particularly for groups in which tradition is deeply engrained or for those whom common measures do not fully encompass. As outlined in the section above, there are many opportunities for improvement, and researchers have developed detailed plans for how solutions can be implemented, but the plan is often where it stops. Funding obstacles, lack of viable programs, low commitment to strategic and sustainable planning, refusal to acknowledge redundancy in or, likewise, an inability to create strategic partnerships with others in the field of health to share information and expertise, means that funding could go farther and cast a wider net. There is far too little collaboration in the fields of public health, social services, and policymaking, a great deal of reinventing the wheel and the results are ineffective and narrow in scope.

Environmental conditions are also barriers to health, when women who live in impoverished neighborhoods often reside in unhealthy buildings, lack access to healthy foods, may lack access to affordable and adequate transportation, and are often victimized in both circumstances of structural violence and situations due to place. Poverty maps often overlay additional mapping of water scarcity, food scarcity, higher prevalence of cancer, HIV, obesity, and STDs, and, once again, due to lack of personal or economic power, political representation, or individualized recognition, results in these populations being exploited or subject to harms due to their invisibility, such as in the dumping of chemotherapy waste in West Chester, Pennsylvania, and the prevalence of lead in drinking water in Flint, Michigan, both of which are largely black communities.

In their manuscript, "Understanding Racial/ethnic Disparities in health: Sociological Contributions," David Williams and Michelle Sternthal, share the 19th century findings of W.E.B. DuBois which studied racialized difference in disability adjusted life years (DALY) for especially poor blacks in Philadelphia, whose prevalence of tuberculosis was largely due to inadequate housing and lack of nutrition, common in their communities. These are circumstances which still exist today, from mental health effects of discrimination to the economic disparities which segregate the poor from higher education and income opportunities which are more easily accessible to the wealthy.

When considering intersectionality, we also need to be specific about the issue. If we are speaking about physical abuse, is it intimate partner abuse, male to female abuse, female to female abuse, and so forth. There can no longer be stereotypical face of violence. We also need to be specific about statistics. When we look at gun violence, why are we not recognizing the higher number of deaths attributed to suicide than to massacres, and why is the conversation not focused on greater access to mental health resources without consequences, such as losing one's job, during or after treatment, paving the way for solutions rather than ineffective policy. Stigma accounts for much of the lack of seeking mental health treatment, and fear can account for lack of both medical and punitive assistance after abuse, all with devastating effects when symptoms are prolonged.

For each health outcome, the focus cannot be binary, as it oversimplifies difference. Singular approaches ignore the many social categories that fall within inequality. There are too few studies on the causes of heart disease in women as compared to men, for example. Many studies on breast cancer focus on the universal aggregate of woman versus unique populations, such as African American women,

who have a high prevalence of this disease.

Sexually-transmitted disease prevention often focuses on heterosexual behaviors and lacks the greatly needed public health information which particularly lags for lesbian women. Physicians responsible for beneficence and inclusion are also still navigating the unfamiliarity of transgendered care, often with stereotypes and personal judgments attached. When gender identity lacks a checkbox in the doctor's office, those individuals feel invisible and surplus and the prejudices which may exist among some medical professionals cause barriers to care and perpetuate feelings of alienation and self-loathing in the LGBTQ population, which lead to additional adverse health effects, such as depression and suicide.

A goal of not creating additional harms is imperative in public health, since social and economic disparities include those obstacles already, as explained in the analysis, "Where Health Disparities Begin: The Role of Social and Economic Determinants – and Why Current Policies May Make Matters Worse." Steven Woolf and Paula Braveman assert that reduction of spending and narrow-reaching policies leave certain populations vulnerable to "magnify [ied] disease burden." They outline solutions that are precursor to disease prevention or disability care, such as interventions which may make the prevalence of disease lower in minoritized populations. Creating "education reform to help [poor] students finish high school and obtain college degrees" and pathways to learning "marketable skills" and accessing jobs, as well as programs that provide free or affordable nutritious foods and fitness programs, in addition to resources to improve residential conditions, will all lead to better health. [42].

If policymakers are stuck on the idea that equity is a health handout for populations they believe are responsible for their own negative health consequences, perhaps they can instead agree that structural improvements may also have a positive economic outcome, with the added benefit of positive health byproduct. Perhaps it is all in how we frame the solution, particularly within this administration, which is arguably focused on economic success versus population health.

Reaching unique intersections of women does not necessarily require specialized innovation. Although cutting-edge research and technology is needed in the genres of breast cancer or STD-prevention in female, same-sex relationships, what most prevention only requires is thoughtful approach, which starts with placing health advocates at the forefront of policy decisions, not career politicians. Dinosaurs in the political systems whose standards for health are measured against a very old, traditional, conservative, white, male, heterosexual, patriarchical scale, no longer work. Our diverse populations, made up of hundreds, if not thousands, of micro-minorities, need prevention and treatment protocols which especially consider any limitations to access. The U.S. National Institutes of Health (NIH) demonstrates this problem through many of their published studies which lump minorities together. The NIH is nationally recognized as a leading authority on health reporting and recommendations, yet underreporting in certain populations, and lack of funding to reach every variable of personhood, often limits the scope of study to a general sample of the problem, population, or disease.

In the opinion article, "Sex bias in trials and treatment must end", [19] itemize the lack of equity in biomedical research, remarking that studies that focus on women are largely within single-sex acute disease research, such as "breast, cervical or uterine" cancer. Studies also lack in understanding that genetically, men and women have unique pathology, biomarkers, and physiology which "affect the way men and women respond to medications and therapeutics." Recognizing that most pharmaceuticals lack "sex-specific dosage recommendations on their labels," we continue to merge together extremely important subsections of the population, here being chromosomal or other DNA differentials, which could have DALY effects. [19]

Experts in the field of social sciences and medicine do acknowledge these limitations in research. In her article, "Gender and health: Relational, intersectional, and biosocial approaches,"[4] discusses the social construction of gender and the acknowledgment that "sex/gender differences research need not reify the binary," and although there is interdisciplinary recognition of "the importance of diversity… health research is limited to considering categories such as sex and gender…" [4]

There are numerous corroborating studies which present that an intersectional framework would greatly benefit women's health. In her American Journal of Public Health article, "The Problem with the Phrase Women and Minorities: Intersectionality – an Important Theoretical Framework for Public Health," [2] explains that "health policy and prevention messages [are exclusively] from the perspective of white middle-class populations" and largely leave everyone else out of the mitigation plan. She outlines those intersections of "race, ethnicity, gender, sexual orientation, SES, disability, and immigration and acculturation status," as well as "microlevel and macrolevel experiences," including structural dominance within these intersections, "complicates everything," but that, as with Mohanty's recommendation, taking a storied approach which considers:

The "experiences of historically oppressed or marginalized populations as its vantage point; [it] can facilitate and inform the development of well-targeted and cost-effective health promotion messages, interventions, and policies." [2]

Without this deep, ethnographical, rehistorical approach, we are only acknowledging the health inequities of a binary global population.

Survey methods are also important, from capture to recapture surveys which decrease the margin of error and participant observations that witness occurrence, among others, as there is also no one-size-fits-all approach to research methodology. Studies have shown that in some Latinx communities, for example, research which requires paperwork may mean a very minimal sample or response, as there may be fear among potential participants that sharing personal information can lead to deportation.

Lack of cultural, gender, intersectionality intelligence, or these competencies also leads to a gross generalization about funding, programs, resources and populations. The conflicts over the defunding of Planned Parenthood in this political administration plays upon conservative morality and a specific focus on the role of the organization in abortions, and discounts the needs of over a million, particularly impoverished urban women, on the services of Planned Parenthood for their sexual and reproductive health needs.

[25] a report outlining what "health care access [would look] like without the Affordable Care Act (ACA) or Planned Parenthood," currently under attack in the United States, acknowledging that a significant portion of women would be priced out of quality health care due to low income. The analysis looks at access to birth control options, annual gynecological exams, and trans-related health care, to name a few, and outlines that over nine million women fall within the needs scale for ACA, in particular, "including a disproportionate number of women of color." (NWLC 1-3) This report uses a qualitative

methodology to share case studies important to the understanding of how impoverished women use ACA and Planned Parenthood due to their socioeconomic status. If defunded, many women would go without testing for STDs and STIs, be unable to afford sustainable birth control methods (from the monthly pill or IUD implantation, as well as the replacement of these implants), meaning that women will be forced to have children in already strained financial and environmental conditions, when they would otherwise have a choice. (NWLC 4) This is separate from the controversy of abortion and only includes women with unplanned pregnancy due to lack of affordable birth control, including those circumstances in which it is not a choice to engage in sexual behaviors.

Medicaid expansion, prevention services like annual well-women exams, which can be an important measure for chronic diseases like high blood pressure and diabetes, and acute care such as pap smears as a cancer-monitoring method, are all part of the equation if policies eradicate ACA. These programs also exist with the relative assurance of non-discriminatory health professionals to provide care for LGBTQ patients, as well as those stigmatized by diseases such as AIDS, especially when these patients have felt discriminated against or stereotyped elsewhere.

To this end, there seems to be a rampant lack of focus in Washington, DC on any gendered outcomes related to healthcare policy, particularly in the current Senate health bill. In addition to Medicaid and Planned Parenthood defunding, it is imperative that we place emphasis on the portion of the bill that seeks to threaten "maternity care, prescription drugs, and ambulances." [27] The alienation of citizens whom are both low-income and of reproductive age means that hospital childbirth could become unaffordable for most, and even if we are pessimistic enough to believe this is a flagrant effort to disavowal, it may force more women to use alternative locations for childbearing, such as at home, and skip prenatal care, further increasing both maternal and infant mortality in the U.S. Affordable emergency transportation services, which are also on the chopping block, affects people of every socioeconomic strata, but for those without any transportation to regular health services, the inability to reach urgent medical care is a particularly disproportionate determinant for non-drivers due to age, immigration status, legal limitations, and disabilities.

As a mitigation effort, [24] report on state policy options focuses on improving women's health, and offers bipartisan health advocacy recommendations for U.S. legislators. Aimed at acknowledging both the needs of their constituents and current administrative and legislative policy goals, the NCSL creates a recipe for improvement upon the provisions of the current health care proposals. Their plan seeks to give options which either improve upon the ACA or work with an amended version thereof, and outlines very strategically that it cannot be ignored that chronic diseases, such as heart disease, diabetes, and osteoporosis transcend all income brackets, race and ethnicity, and even sexual identity. Chronic disease affects all American women. The advocacy piece emphasizes that women have historically acted as a gateway to the rest of their families, whether as a spouse or caregiver. Therefore, women's health behaviors and outcomes can have a profound effect on those around them. (NCSL) Perhaps the mothers and wives of the most vehemently opposed legislators of ACA and Planned Parenthood can share their own her stories as a way to hit home the important and unequal figureheads whom women are to our nation, regardless of political ideology. Whether symbolic or tangible, these shared experiences put a face on national healthcare policy changes and other currently introduced and/or embattled legislation which affect all women today.

Finally the importance of education, particularly early education, for both girls and boys is unparalleled in the prevention of future diseases worldwide. As in all countries, prevention education in the United States can greatly affect outcomes for teen pregnancy, intimate partner abuse, STIs, HIV, and birth control. Recognizing determinants such as age and logistical access to care reaches across all income levels, and U.S. policymakers can look to countries with highly accessible public transportation systems and those with safe, walkable, healthy communities, such as those in Europe, particularly Denmark and Austria, as well as in Japan, as solutions for our inadequate publicly-available transportation nationwide, particularly for low-income and disabled persons, in an effort to prevent additional disabilities and DALY.

As with women, wholly or as a social construct, healthcare solutions cannot be progressive and far-reaching if they are set up as universal. Women need to be at the table for planning, and implementation needs to include programs that, even if they vary from the political, moral, or traditional values of some, still need to encompass those whom live on the periphery of heteronormative privilege. It is difficult to explain conservative female politicians whom do not believe they are beholden to the representation of their sex or have the responsibility to be a voice for the disparities which exist for all women, or those of any ideology whom do not support victims of discrimination, violence, and inequity, and but they may be inadvertently caught up in the type of privilege that forgets and discounts the other.

Health equity will need to begin with grassroots advocacy, at least until there is administrative and legislative representation that aligns with health policy which recognizes broader and multiple social determinants. Right now, it will not come from the top down. Clearly, without women's reproductive power, which, as is asserted by Mohanty, her only true source of power, the human race would cease to exist, evolve, and populate. Globally, we cannot survive without physically and mentally healthy women. To this end, it is also apparent that each woman must, to best of her own personal power and agency, position, or belief, be her own best advocate and continue to voice her needs and determined obstacles, until someone hears herstory and healthy equity is finally achieved.

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