An Expanded Definition of Intersectional Stigma for Public Health Research and Praxis

Kirsty M. Sievwright, MHS, Anne L. Stangl, PhD, MPH, Laura Nyblade, PhD, MA, Sheri A. Lippman, PhD, MPH, Carmen H. Logie, PhD, MSW, Maria Amélia de Sousa Mascena Veras, MD, PhD, MPH, Sophia Zamudio-Haas, DrPH, MSc, Tonia Poteat, PhD, PA-C, MPH, Deepa Rao, PhD, MA, John E. Pachankis, PhD, MA, M. Kumi Smith, PhD, MPIA, Sheri D. Weiser, MD, MPH, MA, Ronald A. Brooks, PhD, and Jae M. Sevelius, PhD, MA

ABOUT THE AUTHORS

Kirsty M. Sievwright and Anne Stangl are with the Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD. Laura Nyblade is with the Global Health Division, International Development Group, RTI International, Washington, DC. Sheri A. Lippman, Sophia Zamudio-Haas, Sheri Weiser, and Jae M. Sevelius are with the Department of Medicine, University of California, San Francisco. Carmen H. Logie is with the Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Canada. Maria Amélia Veras is with the Collective Health, Faculdade de Ciências Médicas da Santa Casa de São Paulo, São Paulo, Brazil. Tonia Poteat is with the Department of Social Medicine, University of North Carolina School of Medicine, Chapel Hill. Deepa Rao is with the Department of Global Health, University of Washington, Seattle. John E. Pachankis is with the Department of Social and Behavioral Sciences, Yale School of Public Health, New Haven, CT. M. Kumi Smith is with the Department of Epidemiology & Community Health, University of Minnesota Twin Cities, Minneapolis. Ronald Brooks is with the Department of Family Medicine, David Geffen School of Medicine, University of California, Los Angeles.

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Intersectionality—an analytic tool that enables researchers and historically marginalized communities to investigate how "intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life"[1(p2)]—is becoming a prominent lens through which to conduct social and behavioral science research, particularly within the field of public health.[1–3] Intersectionality is now recognized as critical to ending the HIV epidemic, as well as addressing other public health priorities.[2,4] Stigma researchers are applying an intersectional lens to understand and address health inequities among groups at the most marginalized intersectional positions, as stigma reduction cannot be fully achieved without centering the structures and systems that drive stigma and discrimination.[2,5,6] For example, without understanding how racism and homophobia mutually shape the experiences and opportunities of sexual minority people of color, we cannot fully understand or address the stigma and discrimination they experience.

To realize its full potential for improving health equity, a closer look at the concept of intersectional stigma and how it is operationalized in research and practice is warranted. Berger defined intersectional stigma as the "total synchronistic influence of various forms of oppression which combine and overlap to form a distinct positionality."[7(p24)] Logie et al. defined intersectional stigma as the "interdependent and mutually constitutive relationship between social identities and structural inequities."[5(p9)] Considering these definitions, the next logical step in understanding and addressing public health inequities is to deliberately integrate intersectional stigma frameworks into interventions to improve health outcomes.

To address intersectional stigma and its sequalae, it is important to consider what it means for a stigma reduction intervention to be "intersectional." We recommend that an intersectional stigma reduction intervention should hold the following principles: (1) recognize and name how systems of power, privilege, and oppression intersect to affect individual experiences and fuel stigma; (2) aim to dismantle systems of power, privilege, and oppression, and mitigate the harms caused by those systems; (3) ensure community leadership and meaningful engagement; and (4) support collective action, cohesion, and resistance to address the intersecting axes of inequities. We explore these principles to guide progress toward achieving health equity.

(1) *Recognize and name how systems of power, privilege, and oppression intersect to impact individual experiences and fuel stigma*

Within this burgeoning area of public health praxis, it is important for researchers and community practitioners to be explicit about how an intervention is informed by the concept of intersectionality and how it will address intersectional stigma. Systems of power perpetuate intersectional stigma[5,7]; therefore, the conceptual underpinnings of intersectional stigma interventions and subsequent phases of development, implementation, and dissemination should clearly name systems of power and oppression and clarify their role in perpetuating oppression.[8] For example, this can be accomplished through statements of purpose and conceptual models that explicitly note which systems of oppression are being addressed and how.

Stigma reduction interventions that simply consider co-occurring stigmas are not truly intersectional without recognizing the contexts that drive and mutually shape these stigmas. This is upheld by Rao et al., who note in their editorial on HIV stigma among Black women in the United States, "[o]ur understanding of the factors that have an impact on the health of Black women is limited when we regard these categories as distinct or static identities and add or subtract them from concepts of interest."[9(pp446–447)] The authors go on to convey how understanding the experiences of Black women as "mutually constructed and fluid, continually shaping and shaped by dynamics of power"[9(p447)] offered insights to inform impactful intervention—in this case, to explore resilience strategies as an intervention to reduce internalized stigma.[9]

(2) *Aim to dismantle systems of power, privilege, and oppression, and mitigate the harms caused by those systems*

Intersectional stigma interventions must expand beyond an emphasis on individual attributes (i.e., stigmatized identities or health conditions) by including components that both (a) seek to dismantle the systems of privilege and power that drive intersectional stigma and (b) mitigate the harms caused by those systems. For example, the Manas por Manas intervention in Brazil is designed to mitigate the harms of intersectional stigma experienced by transgender women while navigating stigmatizing health care and other social service environments. Working with peer navigators, transgender women acquire critical skills and tools to manage and address anticipated and enacted stigma experienced when seeking services (e.g., using role play to navigate situations where their correct pronouns or chosen name are not used).[10]

Additionally, structural solutions that address the factors underpinning interlocking systems of oppression are needed to affect long-term, systemic change and prevent intersectional stigma from moving forward. For example, the aforementioned Manas por Manas study also advocates for and supports transgender women to step into positions of power, visibility, and influence within universities, clinics, and communities.[10] Ensuring that transgender women are visible in staff positions and leadership roles within the organizations that serve these communities—and have a voice in shaping the policies and practices of these organizations—is an initial step toward dismantling some of the structural barriers and stigma that perpetuate health inequities.

(3) *Ensure community leadership and meaningful engagement*

Communities experiencing intersectional stigma are uniquely positioned to identify and facilitate effective interventions to address intersectional stigma. As such, the development and implementation of interventions to address intersectional stigma should include leadership and engagement of communities experiencing the type of intersectional stigma addressed by the intervention. Community leadership and engagement should go beyond community members simply serving on a community advisory board or serving as "gatekeepers." Community members must be recognized and engaged as codevelopers, coimplementers, and coevaluators wherever possible.

Depending on the community and context, the form of community leadership and engagement may vary, ranging from community organizations leading efforts, to community organizations and public health researchers and practitioners connecting and forming mutual partnerships, to public health researchers and practitioners leveraging their resources and skills to bolster the infrastructure and capacity of a community organization if needed. Furthermore, an often overlooked but critical factor for ensuring community leadership is the availability of core funding to support the infrastructure of community organizations, not just funding for activities or services they provide as part of a research study. For example, in the Encontros intervention, local sex workers worked to establish their own organization to support local HIV prevention efforts through community building, integration, and social cohesion. The research team and national network of sex workers partnered to secure a training for the nascent sex worker advocacy group that addressed how to establish an association, write an organizational charter, and manage grants and finances.[11–13] Organizational support is a means to ensure that community organizations can engage as equal or lead partners without relying on university structures to receive donor funds, which inherently contributes to a power imbalance.

(4) *Support collective action, cohesion, and resistance to address the intersecting axes of inequities*

Public health researchers and practitioners who focus on stigma must move away from emphasizing deficits in communities, as has been the tendency. Crenshaw, who first coined the term "intersectionality" in 1989, maintains that intersectionality does not problematize social identities; rather, it recognizes the power of collective action, cohesion, and resistance that exists in the face of oppression: "The social power in delineating difference need not be the power of domination; it can instead be the source of social empowerment and reconstruction."[14(p1242)] Furthermore, Logie et al. assert that intersectional stigma research and praxis would benefit from greater focus on the radical potential of intersectionality to leverage collective efficacy, solidarity, and liberation in efforts to dismantle systems of oppression.[3]

There has long been debate about intersectionality's focus on inequity and empowerment; as Davis inquired more than a decade ago, "Should it be deployed primarily for uncovering vulnerabilities or exclusions or should we be examining it as a resource, a source of empowerment?"[15(p75)] Empowerment, in this context, should not be interpreted as the paternalistic conferral of power, but rather the inherent resilience of communities facing intersectional stigma that leads to action, such as coalition building, community mobilization, and political activism.[16] As such, public health researchers and practitioners should not simply document these strengths and assets, but become part of the solution by working alongside and joining the ongoing, collective action of communities experiencing intersectional stigma to advance social and health equity.

INTERSECTIONAL STIGMA REDUCTION INTERVENTIONS

We offer four additional examples of intersectional stigma reduction interventions that reflect the principles outlined in this editorial.

- The Karnataka Health Promotion Trust developed a series of integrated structural interventions in collaboration with female sex workers, policymakers, and other stakeholders "to address context-specific factors (social inequity, violence and harassment, and stigma and discrimination) contributing to HIV vulnerability"[17] in South India. This program simultaneously worked to mitigate harms and risk for female sex workers, as well as the structural drivers of stigma. The community-level activities were observed to increase female sex worker's membership in community-based organizations and support referrals to social benefits and redressal of violence and harassment.[17]
- Project Advocacy and Other Community Tactics (ACT) was designed to "eliminate barriers to HIV care for gay and bisexual men and transgender women in five African and two Caribbean countries."[18(p2251)] This project entailed a "coordinated set of community-led advocacy initiatives targeting structural changes,"[18(p2251)] including community mobilization and sensitization workshops.[18] Project ACT was observed to improve access and availability of affirming care and resources, and highlighted "the vital role community-led advocacy plays in addressing stigma and discrimination as structural barriers to HIV care."[18(p2251)]
- Sheroes was a community-driven, group-level HIV intervention for transgender women in the United States; it entailed five weekly, peer-led group sessions and sought to decrease risk for HIV acquisition and transmission as well as increase access to gender affirmation.[19] Sheroes centered the voices of transgender women, through collaboration and engagement with transgender community members and stakeholders. Sheroes also fostered "alliances between transgender women through community building and empowering relationships via creation of a 'sisterhood' of transgender women who had completed the intervention."[19] The pilot indicated an increase in such social support and a reduction in sexual risk behavior, as compared with the control group.[19]
- Positively Trans is a Transgender Law Center program led by trans women of color living with HIV in the United States. Through "community-driven research, leadership development, and storytelling,"[20] Positively Trans makes the case that "trans voices, needs, and leadership must be centered in [the HIV] response, and that the HIV response is a key strategy for trans health and liberation."[20] This program serves as an important reminder that within community settings there are existing, effective community-led efforts to reduce and mitigate the harms of intersectional stigma.

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IMPLICATIONS FOR IMPLEMENTATION AND EVALUATION

To inform the development of interventions in line with the principles that we have outlined, and to assess the impact of these interventions on health outcomes relevant to populations affected by intersectional stigma, the concept of "evidence" needs to be broadened. At present, funders and peer-reviewed journals tend to have a narrow conceptualization of evidence. Randomized controlled trials (RCTs) are considered the gold standard of evaluation, and biomedical outcomes are often prioritized over socio-structural and community-level outcomes valued by communities. In addition, intervention implementation typically must accommodate three- to five-year funding cycles, thereby constraining the outcomes an intervention can reasonably affect in such a short time. Current standards constrain our ability to maximize impacts that reflect community priorities, evaluate the success of interventions, and study the reduction of intersectional stigma over time. In addition, narrow conceptualizations of evidence limit the potential for community-derived solutions to be optimally evaluated and scaled.

Study Design

When evaluating intersectional stigma reduction interventions, evidence from programmatic efforts using real-world implementation strategies and designs should be valued alongside RCTs. RCTs are limited in their ability to assess social and structural change. For example, employing an RCT design to evaluate an intersectional stigma intervention is often impractical, as it would likely require randomizing communities to social or community change interventions, which would be expensive and could take much longer to evaluate than the typical five-year funding cycle allows. We must support study designs without experimental assignments, such as rigorous observational research and implementation science methods. Furthermore, we need to acknowledge the value of qualitative and mixed methods for evaluation research.

Outcomes

To effectively evaluate intersectional stigma reduction interventions, it is necessary to employ a wider range of proximal markers (e.g., mobilization and solidarity), implementation outcome measures (e.g., acceptability, feasibility), and structural outcome measures (e.g., changes in laws and policies, community representation) alongside clinical outcomes. Existing measures have been validated for this purpose (e.g., cohesion,[21,22] community mobilization[23]). Where needed, measures may be adapted or additional measures developed and validated to capture other latent constructs to support the generalizability of findings.[24]

Timelines

Extended evaluation timelines can allow more meaningful observation and assessment of the impact of intersectional stigma interventions that seek to effect systemic change. For example, traditional National Institutes of Health R01 grants could be extended from five to seven years for interventions that address structural drivers of stigma. Similarly, funders could release calls for supplemental grants to allow for additional data collection two years after the intervention ends to assess longer-term changes and policy-level effects. Such extended timelines are necessary, as policy and institutional-level changes often do not manifest within traditional study timelines.

Structural Interventions

Beyond study design, outcomes, and timelines, there is a need for greater development, implementation, and evaluation of structural interventions, which work by altering the societal, legal, and economic contexts that influence individual, community, and societal health outcomes. For example, legalizing and making widely available needle exchange programs at a state or country level is an example of a structural intervention to minimize harms, such as HIV and hepatitis C exposure, for people who inject drugs. At present, few intersectional stigma interventions have included structural components to dismantle systems of power, privilege, and oppression.

Research Coordination

Recognizing that multiple interventions across levels are necessary to dismantle systems of power, coordinated approaches that create opportunities to build on prior and ongoing research and praxis are needed. For example, alongside the provision of harm reduction services for people who use drugs, legal changes, such as decriminalizing possession of multiple syringes, are required so programs can operate safely and legally.[25] Such coordination may occur among public health researchers and practitioners, community organizations and members, or local officials. This may also be accomplished through the creation of dedicated research consortiums. Supporting the dissemination of intersectional stigma reduction efforts also supports opportunities for continued or complementary interventions by other study teams.

This editorial offers a close look at the implications of intersectional stigma from an intervention standpoint as well as more broadly within public health. Employing an intersectional lens and approach to stigma reduction is critical to advancing public health and achieving health equity. To fully realize this goal, public health communities must support and facilitate action to dismantle and mitigate the interlocking power dynamics that drive health inequities. To meaningfully do so, we must expand our approaches and reassess values placed on various modalities of intersectional research and praxis.

CORRESPONDENCE

Correspondence should be sent to Kirsty M. Sievwright, Johns Hopkins Bloomberg School of Public Health, Department of International Health, 615 N Wolfe St, Baltimore, MD 21205 (e-mail: ksievwright@jhu.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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