Intersectionality, Inequality and Maternal Health

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Scholarship on intersectionality is generally considered to have begun with the contributions of Kimberlé Crenshaw (1991, 1998) and Patricia Hill Collins (1997, 1998, 2000). Discussions are rooted, as a result, in the fundamentally important intersections of race, gender and social class, and are methodologically committed to both philosophical inquiry and empirical analysis. Over the past twenty years, however, intersectionality has evolved in many directions; number and type of relevant intersecting sources of disadvantage have increased to include ethnicity, sexual orientation and disability. As such, the discourse has served to further "de-center the subject" by placing her in various positions relative to multiple sources of disadvantage, rather than placing her, for example, as a woman at the center of discussion of marginalization (and assuming gender to be the primary source of disadvantage with race and class and sexual orientation and disability as factors of secondary importance). In addition, the focus on identity as constitutive of difference has given way to more deliberate and sophisticated analyses of power imbalances. According to Ange-Marie Hancock, it is of little value, in both theoretical and practical terms, to continue to pursue intersectionality as content specialization (2007a, 2007b). Greater understanding of identity as a socio-culturally determined position will not lead to improved analysis of social standing and political marginalization nor the policy prerogatives and implications of this standing.

This admonition represents perhaps the primary point of departure of intersectionality research from identity politics. The arguments of Will Kymlicka (2004, 1995, 1989), Charles Taylor (1994) and others who contribute to the latter debates are dependent on content-based understandings of the subject. They also privilege cultural identity over other forms of identity, which might prove just as critical to the identity of the subject, such as sexual orientation or disability (see Lee 2006). Furthermore, their primary analytical purpose is to center the subject in order that political claims can be made and strengthened. Kymlicka's work demonstrates these differences in a paradigmatic way. He has argued not only for the primacy of culture, which is, in this formulation, based on territorial-temporal properties and not on ascriptive characteristics, but for the primacy of certain cultures (national minorities) over other (immigrant) cultures. In his analysis, the Quebecois and the Aboriginal peoples in Canada are the unrivaled winners of the "oppression Olympics" (Martinez quoted in Hancock 2007a: 250).

Most of the current scholarship on intersectionality seeks to do exactly the opposite. It seeks to eliminate competition among oppressed groups and levels of oppression. Scholars speak not of hierarchies of power but of systems, matrices, and grids. This complicates analyses of identity, oppression and compensation, yet allows for more fully engaged political and policy discussions. Furthermore, intersectional approaches are not bound by national or sub-national contexts; they allow for and invite investigations of transnational, North-South, and global relationships of power. By way of contrast, Kymlicka's analyses fail to resonate beyond their intended national borders.

Increasingly, intersectionality is offered not simply as a discursive or explanatory remedy to "mainstream" cultural or political narratives, but as a method of inquiry that could be, and ought to be, applied to analyses of political institutions, patterns of representation, public policy, international relations, and so on. This recognizes the

normative and methodological dimensions of the approach, which are overlapping and mutually reinforcing. To approach a policy problem (related to reproductive rights, for example) with an intersectional design (in order to ask questions about differences in constructions and experiences of reproductive freedoms according to race, sexual orientation and disability) is to declare that reproductive rights ought to be examined for their differential, contradictory and contested entitlements and burdens.

Thus, possibilities exist within this analytic for the examination of the ontological and/ or teleological phenomena of identity and the consequentialist phenomena of inequality (among others). In other words, it is possible to conceive of intersectionality as the study of the nature of various intersecting vectors (such as race, class, sexual orientation, disability) which create or contribute to a subject's identity. These intersections can construct identities and positions that are both liberating and oppressive. Intersectionality also entails the investigation of purposeful engagement or action that is connected to identity. Subjects mobilize "particular aspects of their identities in particular circumstances" (Nash 2008:11) in order to resist, claim or negotiate political issues and spaces. In addition, intersectionality provides for the interrogation of the problems of inequality (and the consequences of identity as markers of relative privilege and disadvantage). The purpose of this paper is twofold: 1. to consider the theoretical and methodological terrain that is shared by social determinants of health and intersectional approaches; and 2. to effectively conceptualize various elements of the shared terrain.

In this paper, I propose the recategorization and examination of theories and methods of intersectionality according to this framework (ontological (nature of identities), teleological (purposeful, directed action through the mobilization of identities), and consequentialist (inequality as reinforcing ascriptive identities)). In the final section I consider deontological (duty and social justice focused) possibilities. I offer this not as a corrective to existing and ongoing attempts to understand and define intersectionality's qualities, boundaries and merits, but as an additional way of clarifying the multiple contributions of intersectionality scholars and indicating new possibilities for development and application of the theories. It is important to examine the collaborative potential of intersectionality and social determinants of health literatures because they purport to address the same sorts of issues (related to inequality and group differentiation), and problems (disparities in health status), yet they have developed, and are employed, in isolation from one another.

Consequentialist formulation

I am going to begin with the empirical and work toward the theoretical. The data show that in the United States there are serious disparities in maternal health for different groups of women.

Table 2: Maternal Mortality Ratios in the United States

Population	MMR
Overall (all origins)	12.1
African American (non-Hispanic black)	31.2
Hispanic	10.1
White	8.1

Source: Hoyert 2007:10

The Maternal Mortality Ratio (MMR) indicates the number of maternal deaths per 100, 000 live births. Overall, the rates are low (by global standards) for all populations. However, there are significant differences among populations. The rate for white women is well below the American average, at 8.1. For African American women, the rate is almost four times as high, at 31.2. Hispanic women have an MMR that falls below the national average, but exceeds the rate for white women.

Some of the difference can be explained simply by widely variant patterns of access to health services. In the United States, racialized women tend to be socio-economically disadvantaged as well. Therefore, while race and gender are relevant intersecting identities, the determinative vector is socio-economic status (SES). Women who can afford high quality private health insurance have better access to medical services than women who have no health insurance or have to rely on Medicaid, which explains differences in health outcomes. This conclusion is supported by public health research which is unequivocal in its claim that maternal death can best be prevented by better medical care and equipment at time of delivery (Yamin and Maine 2005). However, a closer look at the indicators reveals a much more complicated public health, and interstitial, picture.

When the variable of SES is controlled in all populations, the differences persist (see Hoyert et al 2000: 10; Nazroo and Williams 2006: 238). Affluent African American women have higher rates of maternal death (and infant mortality, a corresponding indicator) than their white and Hispanic counterparts. The reasons for these disparities have been the focus of the social determinants of health (SDH) research movement (Farmer 1999; Wilkinson 2006; Evans, Barer, Marmor 1994; Daniels, Kennedy, Kawachi 2000; Marmot and Wilkinson 2006; Heymann, Hertzman, Barer, Evans 2006; Levy and Sidel 2006). Clearly, this is a problem that demands attention from public health researchers and policy analysts. Understanding the ways in which inequality affects health status is important for achieving goals (set by domestic governments and through international agencies) and alleviating the pain and suffering of individuals, families, and communities. Improving the health of populations is also related to other policy goals, such as containing public health expenditures, enhancing economic productivity, and ensuring military preparedness. Policies that address racial or socio-economic inequality,

therefore, are also de facto health care and/ or public health policies and have the potential to improve a range of health indicators.

Maternal health is also a matter for intersectional inquiry. Ange-Marie Hancock asserts that "intersectionality, as a body of research, is concerned even in its theoretical voice about the practical implications of its arguments," (2007b: 71) and creates new opportunities for the resolution of "intractable political problems" (74). Therefore, it is possible to begin with a problem, like MMR differentials, and then apply intersectional methods and theories, rather than begin with an abstract determination of the approach or paradigm and then analyze policy accordingly. Such an approach is particularly fruitful because it remedies one of intersectionality's most serious shortcomings: its expansive and seemingly unbounded orientation. As Leslie McCall states; "in a nutshell, research practice mirrors the complexity of social life, calling up unique methodological demands" (2005: 1772). The narrowness of the problem, expressed as various dimensions of a single indicator, affords wide intersectional analysis. Answers to the obvious questions: Why do white women of all socio-economic levels and ages have better maternal and reproductive health status than African American and Hispanic women? What other social, political and economic vectors (in addition to race, SES, age, health status) are relevant to maternal and reproductive health? are complex and evasive. Speculation about intersecting sources of disadvantage provides a way forward in the debate but does not lead to definitive answers.

The SDH approach is similar to intersectional analysis in design and intent. In a discussion of inequality and education reform, Hancock suggests that "instead of merely using income as a proxy for class, an intersectional approach might define membership in a particular class based on a series of questions that… reflect not simply quantitative differences but theoretically relevant qualitative differences" (2007b:72). The SDH approach does consider "class" to include various elements of social standing to be relevant to health. Another advantage of the SDH approach is that it theorizes and operationalizes *relative* disparities. In intersectional approaches, a subject's identity is absolute, and all components of the mobilized identity are relevant to the inquiry. For example, in Crenshaw's explication of the unique and precarious position of black women vis-à-vis the law, the categories of "black" and "woman" are both combined within the subject and irreducible. However, for SDH scholars, what matters most is relative social position and not identity. SDH research does not rely on a conception of identity in its interrogation of inequality, which is substantially different from intersectional approaches. Therefore, the SDH approach might be combined with intersectional research to move scholarship forward on inequality and difference.

Arline T. Geronimus argues for the superiority of a "weathering" approach/ framework for understanding and addressing racial inequality and health in the United States. She explains that "weathering suggests that African-American women experience early health deterioration as a consequence of the cumulative impact of repeated experience with social, economic, or political exclusion" (2001:1). In order to address underlying inequalities that affect health, it is necessary to "get political," (Cohen and Northridge in Geronimus 2001: 10), which requires the recognition that "racial stereotypes have a powerful impact on health as well as politics" (Geronimus 2001:10). She provides the following example of the effects of marginalization on health:

…contrary to popular perceptions [prenatal health risks] … are more prevalent among "older" black women (in their 20s and 30s) in poor communities than they are among teens. Research has suggested that older black women are more likely than teens to smoke, drink, use illicit drugs, be hypertensive, and have dangerously high levels of circulating blood lead during pregnancy, and that they may be less likely then teens to breastfeed their infants or bring them to clinics for well-child medical attention, including immunizations. They have higher rates of maternal mortality, and… their infant mortality rates are worse (2001: 9).

These observations, which are generated through public health research, require political analysis. This is suggested by Geronimus, as noted, although she does not call for an intersectional approach, as such. Intersectionality combines the political/ policy analysis, and also explicitly looks for intersecting vectors relevant to inequality. The example of the prenatal health risks, cited above, implicates sex, race, SES, and age as critical intersecting vectors. The public health project becomes determining how these vectors interact to affect health. But the intersectional, political project becomes the analysis of the locations of disadvantage, of situated inequality, regardless of how various sources of inequality actually combine. Both projects investigate particular groups (such as older African-American women) in relation to other groups (white women, younger African-American women, African-American men, and so on). They seek to understand and analyze public health or political problems and in so doing illuminate possibilities for policy progress.

Robert Aronowitz identifies this emerging area of research, which investigates "the mechanism by which social factors lead to health and disease in the bodies of individuals," the "shorthand" for which might be, "how does culture get under the skin?", as a new paradigm (2008: 1). Previous SDH approaches involved individual risk assessment or population level dynamics. In this new era researchers seek to "understand and influence… [the] *contextual* factors "above" the level of the individual" (1-2). As a contributor to this new research paradigm, Aronowitz proposes the examination of the *framing* of disease states and their purported causes as a way of better "understanding the social patterning of disease." In order to justify his own approach, he explains:

I want to point out that while I evoke "how culture gets under the skin" to situate my argument about framing as mechanism, I do so only because it is the most common shorthand that epidemiologists and clinicians use to map social conditions to biological phenomena. Epidemiologists and clinicians use this shorthand because they cannot precisely or even imprecisely define the interface they intuitively want to capture – what exactly is inside or outside the body or culture, or what culture is and is not. In other words, I am using and existing and problematic term of reference. Yet, by arguing for the inclusion of framing phenomena I want to challenge **medicine's and epidemiology's everyday if poorly articulated assumptions about the location and meaning of this culture/body interface** (2008:2 my emphasis).

Intersectional analysis is well designed and well equipped to examine the "location and meaning of the culture/body interface," and can therefore provide, in analytical terms, what is missing from the new SDH paradigm. Some SDH scholars naturally align with

intersectional inquiries (Farmer 1999, 2005; Hertzman and Frank in Heymann, 2006: 35-57; Raphael 2000 and 2008; Culhane and Elo 2005; Stewart 2007; Torres-Arreola et al 2005; Wilkinson and Marmot 2003; Wilkinson 2006; Nazroo and Williams 2006; Rees and Chavkin 2006; Morrow and Hankivsky 2007; Chibber et al 2008), although they do not engage with the ever-expanding research on intersectionality. However, SDH and intersectional approaches do share a considerable amount of common ground, which creates possibilities for philosophical and analytical collaboration (some of these possibilities have been considered by Weber and Parra-Medina 2003).

As explained in this section, the starting point for consequentialist analysis (concerning the example of maternal health) is categorical differences in maternal mortality ratios, and intersections are considered only as vectors of inequality, not as intrinsically valuable identities. Therefore, it can be concluded that these formulations of intersectionality attend well to policy problems and the effects of inequality. The approach does not, however, directly recognize or empower subjects. It is also mostly unconcerned with power relations beyond the extent to which they produce particular health disparities (see Weber and Parra-Medina 2003).   This approach most closely approximates what McCall labels the "intercategorical complexity" of intersectionality. The main premise for these investigations is that "there are relationships of inequality among already constituted social groups, as imperfect and ever changing as they are, and takes those relationships as the center of the analysis" (1785). Inevitably, however, the consequentialist formulation must interact and compete with the other formulations.

Teleological formulation
This formulation represents the logical next step from consequentialist analysis. It entails mobilizations of certain aspects of identity in order to effect change. In McCall's typology, his formulation approximates "intracategorical complexity," in which "categories have an ambivalent status" (1783), in that

> traditional categories are used initially to name previously unstudied
> groups at various points of intersection, but the researcher is equally
> interested in revealing – and indeed cannot avoid – the range of diversity
> and difference *within* the group. Although broad racial, national, class,
> and gender structures of inequality have an impact and must be discussed,
> they do not determine the complex texture of day-to-day life for individual
> members of the social group under study, no matter how detailed the level
> of disaggregation (2005: 1782).

Therefore, the purpose of intracategorical analysis is not merely to identify and analyze the sources of complex inequality, but to operationalize identities in order to resist the socio-political dynamics that contribute to inequality. Within this approach, "complexity derives from the analysis of a social location at the intersection of single dimensions of multiple categories, rather than at the intersection of the full range of dimensions of a full range of categories" (1781). But identities and inequalities share center stage, whereas in the first approach identities or categories are only relevant insofar as they operate as sources of relative advantage or disadvantage.

As explained in the previous section, maternal health is determined, in large part, by many factors (both material and symbolic) related to inequality. Therefore, in order to

improve maternal health and reduce rates of maternal and infant death, it is necessary to identify and address inequality, which entails the complex interrogation of the ways in which culture "gets under the skin". But the public health outcome (fewer deaths and better overall health) might not be the only relevant goal. For example, the traditions of midwifery in Aboriginal communities in Canada or in African American communities in the US are important to broad dimensions of health (physical, mental and emotional), but they are also critical to identity. These traditions are symbolically and politically meaningful beyond their connections to health indicators. Patterns of care are not simply instrumentally valuable, but are intrinsically important, identity creating and affirming. Purposeful policy change might include improving health indicators or validating certain aspects of identity (such as traditional knowledge sharing by and with midwives).

   According to Aboriginal midwife Katsi Cook, "in my community, we've been organizing the families and the women to recover birth as the way to keep our people strong, to give our children a sense of continuity" (2000). The reclaiming of pregnancy and childbirth is connected to liberation and decolonization movements, and often involves reverence for tradition and resistance to the modern, regardless of empirical evidence (Anderson (Kim) 2006; Simpson 2006; Whitty-Rogers, Etowa and Evans 2006). The cultural requirements of the birthing process compete for significance with the public health requirements, and respect for cultural protocols are considered to be endemic to the health of mothers and babies. Leanne Simpson insists that:

> In order to heal our nations, our communities, and our families, we need to reclaim this ceremony. By reclaiming pregnancy and birth, we are not only physically decolonizing ourselves but we are also providing a decolonized pathway into this world. It is our responsibility to the next generation. In my role as an academic, I often speak about sovereignty and self-determination, re-building our Nations, and re-gaining jurisdiction over our lands because colonialism is the root cause of all of the major environmental problems we face. Patricia Monture-Angus writes that self-determination begins at home. I like to take that one step further – that self-determination begins in the womb (2006:28-29).

The complexity of balancing cultural and public health imperatives is captured by Cook:

> I'm not against hospitals. I am for the ability of the women to make their own choices. Peter Hawken told a beautiful fairy tale… about an almost "toad" woman who asked a prince to choose whether she would be beautiful at night and ugly in the day, or ugly at night and beautiful in the day. The prince's answer to her was, "You choose." Paul Hawken said, that's the way our culture has to go: to allow the woman to choose. In our community, our Mohawk culture and our very belief system have been denigrated, have been made against the law, have been the objects of government policies directed at them to eliminate them, to serve the interests of a production-based industrial economy (2000).

The intersection of health and culture in this formulation implicates many sources, and requires more than the investigation of the health and disease related pathologies of the "culture/body interface." The consequentialist formulations and applications of

intersectionality are insufficient and ultimately unable to analyze and understand the identity-based dimensions of health and wellbeing. A teleological approach theorizes the mobilization of certain aspects of identity for multiple purposes. In this formulation, health outcome might be secondary to cultural preservation or decolonization.

Similarly, for African American women, midwives have played cultural roles that extend beyond the value of their skills. The traditional African American midwife connected individuals to families, and families to communities, and "crossed other boundaries – racial, professional, and class-based ones – those that divided life and death, and those that supposedly marked the divide between tradition and modernity in the South" (Fraser 1998: 43).   The medicalization of childbirth (in the first half of the twentieth century) is complex and contradictory; considered to be tantamount to the gendered and racialized regulation of African American women, and at the same time recognized as an important moment of racial inclusion. Fraser explains:

> Interest in the African American midwife and her history is connected to the emergence of theoretical and practical critiques of the hospital-centered, medicalized obstetrics that have dominated and continue to dominate reproductive health care in the United States. The responses in Green River [Virginia] suggest that the crucial issue had not revolved around resisting medicalization. Instead, reproductive change signaled African Americans' symbolic, if not fully realized, inclusion in the field of vision of a health care bureaucracy that had up until then largely ignored their health needs. If this meant giving up the much-valued midwife, it could also lead to being a part of the "public" in public health. Our own enthusiasm for the recuperation for the midwifery arts should not obscure the race and class issues that led African Americans to welcome modern bodies and modern minds even at the expense of the traditional values and knowledge that they had so respected and valued (1998: 178).

Therefore, African Americans had the same choices that were open to the toad-woman: choosing something objectively positive (beauty/ access to modern medical care) would inevitably bring about something negative (ugliness/ further denigration of tradition). These examples reveal 1. that inequality and its consequences are complex and contradictory; and 2. the nature of inequality is inextricable from identity.

The teleological formulation, therefore, provides avenues for addressing "causal complexity" in public policy (Hancock 2007a: 251) and the problem of "complex inequality" (McCall 2005: 1795). At the same time, this formulation invites interrogation of identity as a source of relative advantage/ disadvantage and a purpose/ goal of policy development. It mobilizes aspects of identity as a means of resisting inequality and injustice, as well as a means of staking a claim to valued experiences and positions. Further, unlike the consequentialist formulation, the primary goal of this approach is not necessarily to extricate the effects of inequality, but to understand the nature of that inequality and create policy space for complex explanations and remedies.

Ontological formulation

The intellectual origins of intersectionality research are often considered to fall within this formulation (see McCall 2005; Hancock 2007a, 2007b), and deal primarily with the lived experiences of groups and individuals at the intersections of various social locations (see Crenshaw 1991, 1998; Collins 1997, 1998, 2000). The ontological formulation is concerned with understanding the complexities of multiple components of identity. It asks such questions as: What does it mean to be an Aboriginal woman? An African American woman? A poor African American woman? A disabled white woman? A lesbian mother?; and What does it mean to be *this particular* Aboriginal woman? *That particular* African American woman? *This particular* poor African American woman? Or *that particular* disabled white woman, or lesbian mother? The first set of questions pull in the direction of essentialist answers (because it seeks to explore and identify complex group identities), and the second falls into McCall's anti-categorical classification (because it seeks to explore and identify individual identities) (2005). Both sets of questions deal primarily with content specialization, which has its proponents (Jordan-Zachery 2007; Simien 2007) and detractors (Hancock 2007a, 2007b; Nash 2008).

The project of intersectional research, as initiated by Crenshaw, can be explained as follows:

> Although racism and sexism readily intersect in the lives of real people,
> they seldom do in feminist and antiracist practices. And so, when the
> practices expound identity as woman or person of color as an either/or
> proposition, they relegate the identity of women of color to a location that
> resists telling… My objective… is to advance the telling of that location
> by exploring the race and gender dimensions of violence against women
> of color (Crenshaw 1991: 242).

While Crenshaw's analysis focuses on public policy and legal problems (the politics of domestic violence), her main purpose is to create new categories, "Black women," and "immigrant women" and to describe the identities of those uniquely positioned social groups. This is not to say that she is working to construct a fixed identity for Black women or immigrant women. She makes clear that: "my focus on the intersections of race and gender only highlights the need to account for multiple grounds of identity when considering how the social world is constructed" (1991:1245). The subject, therefore, is ontologically indeterminate (Zack 2007), and understanding positionality and the burdens of particular social positions, are central to the inquiry. The problems of domestic violence and rape are used to demonstrate these positions, which exist independently of the particular problems (yet are also reinforced by them).

The work of Crenshaw is formidably nuanced and multifocal, and is captured by all of the formulations proposed in this paper. However, much of the literature that has followed from Crenshaw does seem to result in a preoccupation with content specialization (Collins 1997, 1998, 2000; Jordan-Zachery 2007; Simien 2007). For example, Patricia Hill Collins states that: "one can use the framework of intersectionality to think through social institutions, organizational structures, patterns of social interactions and other social interactions on all levels of social organization… African American, women, for example, can be seen… as a group that occupies a distinctive social location within power relations of intersectionality" (quoted in Ringrose 2007: 264). Therefore, these contributions add more to debates about identity than to debates

about inequality; they are cultural analyses first and foremost, and political analyses (concerning power imbalances and distributional equity) are related but secondary concerns.

To continue with the example of maternal health, in this formulation, the nature and meaning of "mother" and "birth" would dominate, if not render completely irrelevant, discussions of health. In the ontological formulation, intersectionality is not necessarily connected to specific problems (such as disparities in rates of maternal mortality or the precarious status of Aboriginal or African American midwifery). Andrea O'Reilly declares that, "the dominant definition of childbirth as a medical event empties birth as a signifier of its multiple and diverse meanings… [Yet] the political liberation of birth promised by the counter-discourse is also compromised by its discursive inscription of birth as "natural" experience" (2006: 54, 58). What is important in this analysis is not the availability of services or inequality in health outcomes, but the meaning of motherhood and birth. The identity of the mother and the value of the birthing experience might in fact be compromised by the availability of services that would reduce inequalities and lower maternal and infant mortality rates. The very *ideas* of maternal health and mortality become contentious (de Koninck 1998). Explication of social position is paramount and can expand discussions of care and well-being, but this type of inquiry does not address the consequences of inequality, not does it seek to mobilize identity in order to effect specific policy change. Disparities and intersections are relevant only insofar as they limit or facilitate full realization of a particular identity.

Deontological formulation
Naomi Zack states that, "the exclusion of non-white and poor women from establishment feminism… is partly a legacy and ongoing mechanism of broader social injustice…" (2007: 199). Intersectionality was developed in response to this problem of exclusion. However, it does not, as either normative or empirical enterprise, direct itself toward the broader problem of social injustice. It is dedicated, in all formulations considered thus far, to examining intersecting sources of disadvantage for either: addressing political and policy problems; determining and explaining identity; or both. It does not lend itself to deontological inquiry; it does not ask general, ethical questions about society-level imperatives.

Iris Marion Young helps to clarify the deontological approach (what should we do as a society to address structural inequality?) by separating social difference from identity. According to Young, "political theory would do well to disengage social group difference from a logic of identity, in two ways. First, we should conceptualize social groups according to a relational rather than a substanstialist logic. Secondly, we should affirm that groups do not have identities as such, but rather that individuals construct their own identities on the basis of social group positioning" (2000:82). She continues, "by conceiving social group differentiation in relational rather than substantial terms, we can retain a description of social group differentiation, but without fixing or reifying groups" (2000:89). Therefore, what is relevant to normative and empirical analysis, and, ultimately, to questions of justice, is relative social group positioning (i.e. inequality). Identity is another matter completely:

> Historically excluded or dominated groups all have organized discourses
> and cultural expressions aimed at reversing the stereotypes and

deprecations with which they claim dominant society has described them… [For example,] where dominant understandings of femininity equate it with relative weakness and selfless nurturing, some feminists have reinterpreted typically womanly activities and relationships as expressions of intelligence and strength. Interpretations and reinterpretations of typical experiences and activities of group members in response to deprecating stereotypes can rightly be called 'identity politics'… Often they are explicit projects that individual persons take up as an affirmation of their own personal identities in relation to group meaning and affinity with others identified with the group. Their function is partly to encourage solidarity among those with a group affinity, and a sense of political agency in making justice claims to the wider society (2000:103).

The subject matter of intersectional analysis includes both social group differentiation and identity politics. Often, the claims for these (somewhat) distinct categories are conflated, which contributes to complexity and confusion. It might not be possible to separate identity from social position in all instances, but the effort to do so might provide greater theoretical clarity.

Similarly, S. Laurel Weldon argues for the superiority of structural analysis which focuses on inequality and intersecting vectors of disadvantage (Weldon 2006). The philosophical predicates of this approach (as articulated by Young and Weldon) are shared by the SDH approach, as is the enduring concern with justice. Norman Daniels, Bruce Kennedy, and Ichiro Kawachi claim that "to act justly in health policy, we must have knowledge about the causal pathways through which socioeconomic (and other) inequalities work to produce differential health outcomes" (2000: 19). What should a just society do to reduce (maternal health) disparities? What does fairness require? What is our responsibility as democratic citizens? What are our moral obligations to those who are relatively disadvantaged (within societies and around the globe)? These questions necessitate intersectional inquiries, but they are not essential to intersectional analysis as currently constituted. Intersectionality, in all of its formulations, is divorced from larger, structural, and deontological inquiries. However, its relevance to social justice, broadly conceived, is undeniable.

Conclusion

Intersectional and SDH approaches share a significant amount of philosophical and political terrain. The consequentialist formulation (which is outcome/ inequality focused and directed toward specific policy solutions) and the teleological formulation (which is inequality and identity focused and directed toward policy solutions and identity recognition) account for the greatest amount of conceptual overlap and collaborative explanatory potential. The ontological formulation (which is identity focused and is directed toward identity construction and recognition) is the exclusive domain of intersectionality, whereas deontological matters are primarily within the ambit of the SDH approach. The complex problem of disparities in maternal health requires the sophistication that is afforded with the combination of both intersectional and SDH analyses.

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