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Gendered Racism

A Call for an Intersectional Approach

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Inequities in social determinants of health (SDOH) contribute to health disparities that outweigh an individual's ability to make healthy choices. SDOH refer to environmental conditions that affect a wide range of health, functioning, and quality of life outcomes and risks. They are complex, interdependent, and often grouped in five categories: economic stability, education access and quality, health care access and quality, neighborhood and the built environment, and social and community con- text. Within the social and community context, discrimination has increasingly received attention since the American Public Health Association established its National Campaign Against Racism (Jones, 2016a,b). Understanding, revealing, and redressing racism as a social and structural determinant of health may help eliminate racialized health disparities. Yet, for those who are at the inter- section of multiple oppressions, focusing on racism alone may not go far enough.

Gendered racism refers to the simultaneous experience of racism and sexism. Described by sociologist Phelomena Essed (1991), gendered racism represents the complexity of oppression specific to women of color based on gendered and classed forms of racism.

Gendered racism manifests through constructed ide- ologies and stereotypes (Collins, 1990). For example, Black women have been stereotyped as the Strong Black Woman (SBW). Although it might be culturally affirmed by some, it can also be under- stood as the super-human capacity to endure unconscionable amounts of stress and lead to essentialist notions that all Black women are inherently strong (Burton, 2017; Woods-Giscombé, 2010). Internalizing the stereotype is thought to lead to suppressed emotions and negative health effects that are specific to Black women (Collins, 1990; Mollow, 2006; Woods-Giscombé & Black, 2010). Collins (2000) theorizes that the SBW ideology was invented to endure hard- ship and thus Black women's existence justifies their own oppression.

Intersectionality provides the theoretical framework for gendered racism (Burton, 2017). Intersectionality de- scribes the simultaneous experiences of oppression, whereby race, class, gender, sexuality, ethnicity, nation, age, and dis- ability intersect and form mutually con- structing features of social organization (Bowleg, 2012; Collins, 2000; Erevelles & Minear, 2010). Feminist legal scholar, Kimberlé Crenshaw, coined the term intersectionality in 1989 to explain the nuances of race and gender. She argued that for women of color multiple marginalizations of race and gender intersect. Moreover, the experiences of women of color are not fully understood through any single lens, such as exploring race or gender. Women of color occupy a space where they are and have been silenced and dominated by the antiracist and feminist movements due to the movements' failures addressing those who are affected by both forms of oppression (Burton, 2017). For example, although Black women share some similar forms of oppression with their racial and gender counterparts, they also experience a type of racism that Black men cannot and they experience a form of sexism that White women cannot. Further,

White feminists regularly fail to interrogate racist practices just as antiracists fail to interrogate sexist practices (Crenshaw, 1991). These failures further relegate women of color to the margins.

In the renewed focus on racism, let us not forget the gendered aspects of oppression. Understanding gendered racism and applying intersectionality is critical to planning and implementing care that promotes optimal health outcomes. To reduce health disparities, an intersectional approach is needed and examining gendered racism as a social and structural determinant of health may impact the health of women of color more than focusing on racism alone.

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