



Harold W. Neighbors, PhD
Director, CRECH

Real Men Wear Blue

“ We men have a dilemma. How do we modify a self concept that on the one hand can be detrimental to our ability to ask for help, while at the same time hold on to the sense of efficacy, control, and self esteem we derive from our masculine identities? ”

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Associate Director, CRECH

Healthy Environments Partnership (HEP)

Amy Schulz
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Derek Griffith, Ph.D.
Assistant Director for
Research & Research Training, CRECH

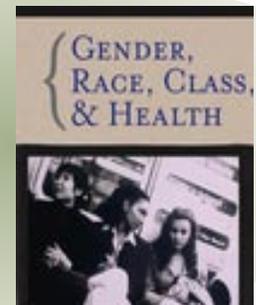
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WELCOME TO CRECH'S NEW ASSISTANT DIRECTOR



Derek Griffith

I was delighted to be named the Assistant Director for Research and Training for CRECH. This position will allow me to pursue a number of professional goals and to contribute to the Center in a number of ways. Among my principal goals as a public health professional is to train talented young scholars to conduct cutting-edge research on diverse aspects of racial and ethnic health disparities. I strive to teach students the art and science of designing rigorous studies and collecting quantitative and qualitative data, so that they may conduct innovative research that is congruent with their interests, not trying to fit their curiosities to a particular methodology. My primary role in CRECH is to coordinate the Master's and doctoral training programs in research on health disparities. In addition to matching students with mentors, I will be working with the other faculty and staff in CRECH to provide more opportunities for intellectual growth and exchange. I hope to facilitate CRECH being the social, emotional, and intellectual support necessary to help students efficiently matriculate through their respective programs.

This semester I am also teaching a doctoral seminar on Racial and Ethnic Health Disparities in the

Department of Health Behavior and Health Education. This course emphasizes social factors that influence the health of populations and their contributions to racial and ethnic health disparities. One of the primary aims of the course is to help students focus on changing the context in which unhealthy behavior and poor health outcomes occur, not just changing how people function in an unhealthy environment. These structural interventions locate the source of health outcomes in aspects of the social, economic, and political environments that shape and constrain individual, community, and societal health outcomes.

The primary objective of my research is to develop interventions to improve the health of African Americans and other people of color that are based on an understanding of contextual and structural determinants of health. My research is focused on social determinants of health (primarily institutional racism), health of men of color, and program development and program evaluation. Much of my research utilizes community-based participatory research principles and currently occurs in Flint, Michigan as part of the Prevention Research Center of Michigan. I do not do CBPR simply because I was trained in this approach, but I utilize this approach because I believe it gives me access to important insights into how, where, and with whom to intervene to address racial and ethnic health disparities. In an effort to

contribute to our collective efforts to eliminate racial and ethnic health disparities, my research goals are: (1) to move the discussion of historical and macro-social factors from the margins to the center of the research on health disparities; (2) to focus on the role of "place" and context in efforts to understand and eliminate disparities; and (3) to examine how institutional factors influence health services and health promotion.

I am trained as a community psychologist where I primarily studied social and political oppression. It is through this lens that I approach my work and encourage students to consider how these macro-social factors influence health. Because of my psychology background, I also believe it is critically important for researchers, evaluators, and practitioners to examine the values, biases, and perspectives we bring to our work. I believe these biases we hold as professionals are critical to address if we are indeed to eliminate health disparities since they are what dictates what we study and value.

This is a great time to be a public health professional. I am honored to be part of CRECH and look forward to working with the faculty and staff here to make the Center a place that the next generation of public health professionals develop and continue to work to promote health and social equity.

“Real Men” Wear Blue

At a recent research conference NIMH Deputy Director Dr. Richard Nakamura, in commenting on the extremely low suicide rates for Black women remarked, “African American women have a secret — more research is needed to uncover that secret.” Dr. Nakamura’s point was that we need to know more about what protects women, particularly Black women, from suicide. In taking a second look at the suicide rates by race and gender, it is clear that men, *both Black and White*, also have a secret. Four times as many men as women die by suicide. Clearly, more research is needed to uncover the “secret” that makes men more vulnerable to suicide.

Paradoxically, epidemiologic studies show that women have higher rates of depression than men. However, national suicide rates tell a different and more tragic story. Some mental health experts

of depression among men. The higher male suicide rate is certainly consistent with this hypothesis. Even worse, men with depression are half as likely as women to seek professional help for symptoms of depression, and suicide is one major consequence of untreated depression.

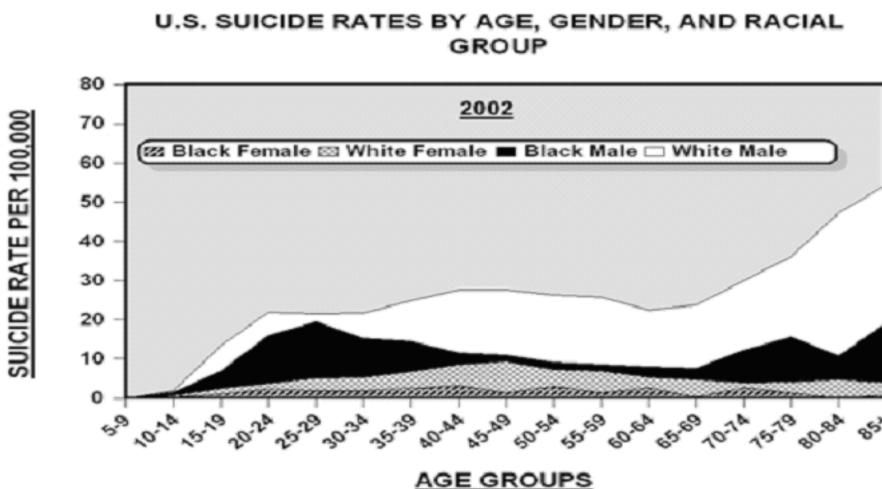
What is it that men are hiding? Some scholars think the secret lies in the concept of masculinity. Characteristics frequently attributed to the concept of masculinity include strength, power and control. Perhaps most important are independence and self-sufficiency. Society’s definition of masculinity is viewed by men as functional and adaptive. It allows men to be productive under all kinds of difficult conditions. In fact, the harder the challenge, the more men like it. The more it hurts, the more men “suck it up” and “do what has to be done.” “Real men” are tough. Most men would not want it any

“humiliating defeat.”

Despite the benefits, some men also know that masculinity can be a double-edged sword. Masculinity does not work as well when men are confronted with serious health problems. I am not talking about the cherished aches and pains that result from our weekend battles on the courts and ball fields. I am referring to chronic medical conditions that demand and deserve professional attention. Our quest for strength, independence and self-sufficiency and our unwillingness to reveal any sense of vulnerability are *not* adaptive when it comes to dealing with the pain of a disease like major depression. Here, being a “real man” prevents us from asking for the help we need.

We men have a dilemma. How do we modify a self concept that on the one hand can be detrimental to our ability to ask for help, while at the same time hold on to the sense of efficacy, control, and self esteem we derive from our masculine identities?

Gentlemen, the truth is that depression is a major risk factor for suicide. In short, *depression kills!* The inability to ask for help when needed is killing too many of us. If you are often angry and feeling overly irritable; if you are drinking more than usual or feeling a strong desire to increase control over every aspect of your life as well as the lives of your loved ones; and most important, if you are slowing down and having trouble handling your business, doing your work, and solving your problems, you may have more than a simple case of



Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics

suggest that men are, in actuality, depressed as often as women. In essence, the apparent gender difference in rates of depression results from the *under-diagnosis*

other way. As author and therapist Terrence Real explains, the essence of “manhood” is the ability to stand up to pain and discomfort; giving in to one’s distress is experienced as a

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Angela Glover Blackwell Lecture — October 19, 2005



Angela Glover Blackwell presented a talk to an overflowing audience on October 19, 2005 at the Michigan League titled, “Healthy Places, Healthy People: The Impact of Community on Health and Well-Being.” Ms. Blackwell is founder and chief executive officer of PolicyLink, a national nonprofit research, communications, capacity-building, and advocacy organization. Glover Blackwell’s lecture focused on studies published by PolicyLink demonstrating the influence of community conditions on the health of individuals and families

(“Reducing Health Disparities Through a Focus on Communities”). “Regional Development and Physical Activity: Issues and Strategies for Promoting Health Equity,” explores the connection between development patterns, physical activity, and poor health. The report makes recommendations for facilitating increased physical activity by improving community design and suggesting new goals for community organizing. PolicyLink is an organization committed to Lifting Up What Works,[©] with a mission of advancing a new generation of policies to achieve economic and social equity, based

on the wisdom, voice, and experience of local leaders who are shaping successful solutions to national problems.

Co-sponsors of this lecture included CRECH, Detroit Community-Academic Urban Research Center, the Community Health Scholars Program, the Center for Social Epidemiology and Population Health, the Taubman College of Architecture and Urban Planning, the Department of Health Behavior & Health Education, and the Gerald Ford School of Public Policy.

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the “blues.” Going it alone is not always the “manly” thing to do. Ask for help. See your doctor.

In the 1980s and early 1990s the Oakland Raiders, whose team colors are black and silver, had the reputation for being one of the meanest, toughest, hardest hitting teams in the National Football League. They showed no fear and no weaknesses. As a result, the Raiders were considered to be “real men.” To promote the team, they

developed the slogan, “Real men wear black.” But the secret’s out. Sometimes, “real men” wear blue.

ⁱ Terrence Real (1997). *I Don't Want to Talk About It: Overcoming the Secret Legacy of Male Depression*. New York: Scribner.

— Harold W. Neighbors, Director

Depression: The Public Health Dimensions

In the latest issue (fall/winter 2005) of the School of Public Health’s *Findings*, “depression” and how public health researchers are finding new ways to diagnose, treat, and ultimately prevent this disabling disease, is analyzed.

Read more on this mental disorder which Dr. Harold Neighbors terms “one of the largest and most pervasive racial disparities in public health.” [Click here!](#)

Walters Lectures on Colonial Trauma Response in Native Americans

On November 17th and 18th, CRECH had the privilege of co-sponsoring talks by Dr. Karina Walters with the U-M School of Social Work. Dr. Walters is an Associate Professor with the School of Social Work, University of Washington, Seattle. She is co-founder of the Native Wellness Research Center and the newly-formed Institute for International Indigenous Health and Child Welfare Research. Dr. Walters is currently running a study on what she calls Colonial Trauma Response in Native Americans. Dr. Walters, who is of the Choctaw Nation of Oklahoma, is studying ways in which cultural identity, HIV, and alcohol use are impacted by the historic and current social status of Native American tribes as a subaltern class. In her Thursday talk, she related that the subjects of the study are urban Native Americans, who have higher rates of the most communicable diseases than any other ethnic group. Dr. Walters' findings are that the colonialization perpetrated by the hegemony has not only affected past generations, but that the stress and emotional trauma has been passed down through generations and is currently affecting health and wellness in the Native American population today.

On Friday, Dr. Walters spoke about the political ramifications as a researcher whose HIV-prevention project was marked for cancellation by a congressional amendment and the importance of fighting for scientific freedom. Her targeted research was a health survey of Native American "two-spirit" people. The term two spirit, she noted, includes gay, lesbian, bisexual and transgendered Native Americans, but also goes beyond those terms to embrace the fluidity of gender identities in indigenous communities and to honor the social, ceremonial and spiritual roles two-spirit people originally played in those communities. This success story (since she was indeed funded) was a welcome eye opener for all of us, as we come to terms with the fact that only in a perfect world can we do science just for science's sake!



Karina Walters, PhD

Kudos Korner!

Congratulations to Rashid Njai and Kai Bullard who successfully advanced to candidacy status!

CRECH is pleased to announce that Miller is on board as our new research secretary!

Center for Research on Ethnicity, Culture and Health (CRECH)

611 Church Street - Room 207
Ann Arbor, Michigan
48104-3028

Phone: (734) 647-6665

Fax: (734) 998-6908

www.sph.umich.edu/crech/

Editor: Lynda Fuerstnau
ljfirsti@umich.edu

This newsletter is published to inform the public about educational, research and training activities of the Center for Research on Ethnicity, Culture and Health at the University of Michigan School of Public Health.

CRECH ALUMNI UPDATES!



Edna Amparo Viruell-Fuentes

Edna Amparo Viruell-Fuentes received her PhD in Health Behavior and Health Education from the University of Michigan in 2005. As a Yerby Fellow and a W. K. Kellogg Scholar in Health Disparities in the Department of Society, Human Development and Health, at the Harvard School of Public Health, Viruell-Fuentes continues her research on the structural and social determinants of health with particular attention to the intersections of race, ethnicity, immigration, class, and gender, and their impacts on health disparities. Although most of her time has been devoted to submitting manuscripts, Viruell-Fuentes has given lectures at the David Rockefeller Center for Latin American Studies and across campus. *Identities: Global Studies in Culture and Power* will soon publish Viruell-Fuentes article titled, "My Heart is Always There: The Transnational Practices of First-generation Mexican Immigrant and Second-generation Mexican American Women." Articles in preparation will seek to build an expanded theoretical base for examining Mexican immigrant health together with issues of racial and ethnic identity, as well as those

related to immigrant and social embeddedness in local neighborhood environments and transnational social networks.

With 15 years of research and policy experience, Viruell-Fuentes' future plans entail building a transnational research project (a Latino/a health agenda that ties together the experiences of Mexican immigrants in the U.S. to those of their non-immigrant counterparts in Mexico), finalizing publications and seeking an interdisciplinary academic position that would enable her to put her research and teaching interests into practice.



Jacqueline Two Feathers

Jacqueline Two Feathers is graduating in December 2005 with her Ph.D from the School of Public Health, Department of Health Behavior and Health Education. Her dissertation research at the University of Michigan included the development of a culturally tailored diabetes lifestyle intervention for African Americans and Latinos residing in Detroit and participating in the REACH project. The intervention materials were adapted from a

previously evaluated intervention with Native Americans. REACH participants made significant positive improvements in knowledge, behavioral, and clinical outcomes. The results paper was published in the September issue of the *American Journal of Public Health*.

Two Feathers returned to Albuquerque, New Mexico after she finished her coursework and research, and completed her dissertation there. She is currently teaching an introductory nutrition course and a survey of health careers course at the Southwestern Indian Polytechnic Institute, a Native American community college. Two Feathers is also a research scientist at the University of New Mexico's Cancer Center where she is partnering with two Native American tribes to develop a survey to assess cancer screening behaviors and an intervention to improve cancer screening behaviors. Her future plans include seeking a faculty position to continue intervention research that addresses health disparities.

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**To All CRECH
Scholars:**

**Please keep CRECH Staff
informed
of any change in address or
other contact details!**

CRECH ALUMNI

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Debbie Barrington

Tis the season to be thankful and I have much to be grateful for! This August 2005, I fulfilled all the requirements for my PhD, and by September was back in my hometown of New York as a Robert Wood Johnson Health and Society Scholar at Columbia University. This prestigious post-doctoral fellowship provides me with two years to lay the groundwork for an academic and research career in population health. The course ahead consists of publishing papers from my dissertation, establishing my research agenda, and securing a

tenure-track faculty position for a life-long engagement of research and teaching in social and reproductive epidemiology. Though I expect to stumble along the way I shall not fall, for I am surrounded and supported by the love of family and friends, and I walk with a metaphorical cane filled with tips and lessons, many of which were learned from my CRECH peers and mentors. So thank you to members of CRECH Cohort 1, Naima Wong, Edna Viruell-Fuentes, Darian Tarver and Jay Pearson who have passionately debated with me for years on the state of marginalized America. Thank you to Amy Schulz for your distinctive ability to not only give, but elicit from others remarkable insight into the complexities of race, ethnicity, gender, class and culture. Thank you to Cleo Caldwell, for being such a great role model for African-American women in academia that all I had to do was watch and listen for instruction in combining

spiritual power with intellect. Thank you to David Williams for your guidance and encouragement which I carry with me to this day as I attempt to turn my vulnerabilities into strengths. Thank you to Lynda Fuerstnau for embracing not only the CRECH program, but the students within the program. Thank you to George Kaplan for being the master of resource and opportunity, and to Trivellore Raghunathan for imparting great methodological knowledge. Thank you to Harold Neighbors who is unsurpassed in his dedication towards increasing the representation of minority research investigators. And finally thank you to Sherman James, the founder of CRECH, who had the vision that it takes the formation of institutions comprised of individuals with a lived experience of embracing equity, diversity and solidarity to eradicate discrimination and its inequalities at the institutional level.

“Workshop — Connecting Social and Environmental Factors to Measure and Track Environmental Health Disparities” — The Follow Up!

Community members, scientists, and policymakers convened at the University of Michigan in May 2005 to discuss how environmental conditions may promote health disparities. Although research suggests that environmental conditions can cause gaps in illness between disadvantaged and advantaged groups, there is yet no systematic effort to track these conditions over time. Without attention to trends, it is difficult to assess whether progress is indeed being made by policy actions and regulations.

Participants of this workshop sought

to build a base from which to set future tracking efforts. One unusual aspect about this workshop was the attention paid to broader social factors, including residential segregation, the distribution of power, the presence of institutionalized racism, and the production of health from multiple levels.

That is, the tracking of environmental health disparities does not simply mean the tracking of mortality rates, specific illnesses or of particular environmental hazards (e.g. soil lead). Rather, participants suggested that the tracking of illness and physical and

environmental toxins must occur alongside the tracking of social conditions, including residential segregation, poverty, and social attitudes. Race/ethnicity and economic status are fundamental and critical factors to consider in tracking both physical and social environmental conditions.

Click here to view the Power Point presentations that were given at the workshop: www.sph.umich.edu/crech/whatsnew/wn_HDW_2005.htm

Interventions to Address the Built Environment to Reduce Obesity in Detroit: The Healthy Environments Partnership!

Addressing racial, ethnic and socioeconomic differences in obesity and overweight are among the most important health challenges of our time. Obesity, a major risk factor for four of the ten leading causes of death (cardiovascular disease, diabetes, dietary cancers, and stroke), has increased dramatically over the past 20 years in the United States. By 1999-2000, 64% of the adult population in the United States was overweight and 31% was obese. Nationally, rates are even higher among African American and Hispanic women, with 72% of Hispanic and 77% of African American women overweight or obese. Obesity-related diseases, such as cardiovascular disease, contribute substantially to racial disparities in mortality in the United States. These patterns are clearly evident in the city of Detroit where data collected between 1998-2002 found 70% of the adult population to be overweight or obese, and where mortality rates due to cardiovascular disease in 2000 were nearly double those experienced by the nation as a whole.

The Healthy Environments Partnership (HEP), made up of representatives from community-based organizations, health service providers, and researchers from the University of Michigan, has been working together since 2000 to understand the relationships between the built and social environments and risk factors for cardiovascular disease, including obesity, in three areas of Detroit. Baseline data from HEP (2002-2003) found that 72-85% of adults aged 25 and over living in eastside, northwest and southwest Detroit were overweight or obese, depending on the race and ethnicity of participants.

Several recent studies highlight pathways through which aspects of the built environment may influence food intake and energy expenditure, key modifiable risk factors for obesity. Access to grocery stores or public green spaces, land use patterns, street layout, and the condition of the built environment may facilitate or hinder healthy behaviors and influence weight.

Based on these findings, HEP is pursuing further research to understand the contributions of area socioeconomic characteristics and environmental conditions such as access to safe spaces for physical activity, to the risk of obesity among residents. Through the newly

funded "Lean and Green in Motown" (LGM) project, HEP will be working to better understand relationships between the built environment, physical activity and dietary practices, and to assess the potential for interventions that include environmental change efforts to increase physical activity and promote healthy diets.

Relationships between the Built Environment and Obesity

A number of aspects of the built environment have been hypothesized to influence obesity through their effects on physical activity and dietary patterns. These include land use patterns, with higher densities and mixed use development postulated to be associated with decreased automobile use and increased pedestrian travel. However, in contrast to the hypothesized direction of these relationships, physical activity declines among less economically advantaged groups, many of whom live in urban communities with relatively high densities and mixed land uses. Other dimensions of the built environment that have been hypothesized to influence obesity include the accessibility of healthy foods or exposures to unhealthy food, and access to places for physical activity. Socioeconomically disadvantaged communities may have reduced access to places in which to be physically active, and may also encounter inadequate access to healthy foods through limited retail outlets or limited availability of healthy foods in the retail outlets that are present in local areas. Finally, characteristics of street layout and neighborhood conditions (for example, condition of sidewalks) may also influence residents' ability to be physically active in their neighborhoods.

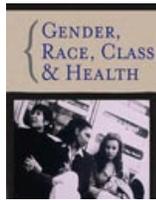
Intervention in the Built Environment

There are important questions about the effects of interventions which modify aspects of the built environment. There is some evidence that increased access to spaces in which to be physically active, in conjunction with informational outreach efforts to promote physical activity, can increase physical activity. There are, however, many unanswered questions, including whether enhanced access to places for physical activity is

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Intersectional Approaches to Understanding Gender, Race, Class and Health

(Excerpt adapted from *Intersectionality and Health: An Introduction*, by L. Mullings and A. Schulz. In [Gender, Race, Class and Health: Intersectional Approaches](#), A. Schulz and L. Mullings, editors. Jossey-Bass Publishers: San Francisco, CA. 2005)



Theoretical and empirical efforts to understand and address disparities in health have emerged in multiple arenas and among scholars and practitioners working within public health, as well as scholars located in the social sciences and humanities. While these scholars all focus on understanding and eliminating health disparities, they bring diverse perspectives and insights to an understanding of the topic and to potential solutions. Yet there are relatively few opportunities for dialogue and mutual exchange across the disciplines and paradigms that inform this work. The just released volume [Gender, Race, Class and Health: Intersectional Approaches](#), emerged out of efforts by the Institute for Research on Women and Gender and the Center for Research on Ethnicity, Culture and Health, to bring together scholars from the social sciences and public health to examine the ways that gender, race, and class are mutually constituted and interconnected, with the goal of informing theory, research, and practice focused on the elimination of health disparities.

The chapter authors examine the processes through which unequal structuring of life chances based on race/racism, class, and gender/sexism produce inequalities in health and illness. Together, the contributors to this book examine the malleability of race, gender, and class as socially constructed categories as well as the obdurate nature of inequalities structured around these concepts in the United States. In keeping with paradigms that emphasize that race is socially constructed, rather than a biological or genetic characteristic of individuals, race is conceptualized in this book as relations between groups rather than as something that people of color “have” and whites do not. Similarly, the chapter authors examine gender as a set of social relations rather than an attribute of individuals.

The resulting volume, rather than being organized around the health status and concerns of particular racially or ethnically defined groups, or genders, seek to contribute to our understanding how gender, race, and class structure social relationships in ways that produce differentials in health and disease. The volume challenges cultural, genetic or lifestyle explanatory paradigms for explaining differences between racial groups, and instead examine the ways that disparities in health are produced through unequal social relationships. Authors of the chapters in this volume are particularly concerned with probing the manner in which class and race

intersect with gender to produce variations in health.

Intersectionality theory, developed by black feminist social scientists in response to the essentialism of early feminist frameworks (see Mullings, 1997, for a discussion of the intersectional tradition among black feminist scholars) moves beyond simple additive models of race and gender to argue that we need to examine the ways in which race and gender are mutually defining (see Fine, Powell, Weis, and Wong, 1997; Ferber, 1998; Hermann and Stewart, 2000).

The scholars who have contributed to this book have been at the forefront of theorizing the intersections of gender, race, and class and those who have engaged in efforts to understand and address (dare we say eliminate) persistent racial, socio-economic, and gender disparities in health in the United States. The goal in assembling this diverse group of contributors has been to engage scholars in a critical dialogue that informs social science theorizing and empirical research, to bridge gaps between theory and practice, and to inform and enhance continued efforts to eliminate the social inequalities that drive persistent disparities in health.

To consider how analyses might be transformed by considering the health effects of racial/ethnic, gendered, and class-based inequality, the book takes up four overarching questions. First, we consider the ways that historical and

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Interventions

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sufficient, in and of itself, to promote greater physical activity, or whether such efforts must be combined with other activities, such as informational outreach, or living wages that afford residents the leisure time to be physically active. There are also questions about specifically which neighborhood features (e.g., sidewalks, parks, traffic flow) are most critical in shaping ease and frequency of use.

Modifications of the Built Environment in Detroit

With funding from NIEHS (R01 ES014234) the LGM project will assess multiple indicators of the built environment (e.g., land use patterns, accessibility of resources) and physical activity. As a longitudinal study, LGM will also track changes over time in physical activity, diet, and the built environment.

With funding from the Community Foundation of Southeast Michigan, several local groups in Detroit have designed and are now building greenways throughout the city. Urban planners involved with LGM will work closely with those groups, and with other organizations and residents of the city, to design features of these greenways intended to enhance their use by, for example, increasing visibility and thus safety. Simultaneously, LGM will be working with local organizations to promote physical activity through, for example, walking groups using the greenways. The study design allows for comparison of groups exposed to changes in the built environment only, and those who are exposed to other health promotion efforts in addition to the changes in their built environments. In documenting these changes over time, LGM intends to contribute to our understanding of the role of the

segregation of African American and Latino residents in older urban environments such as Detroit as a contributor to racial and ethnic disparities in obesity, and to improve our understanding of which built and social environmental features are most critical. In documenting the effects of changes in the built environment alone and in combination with other health promotional activities among predominantly African American and Latino communities in Detroit, the LGM project intends to improve our understanding of potential interventions to improve the health of residents of older urban environments. Because those residents are disproportionately African American and Latino, such an understanding can contribute to efforts to address persistent racial and ethnic disparities in health in the United States.

— *By Amy Schulz*

Intersectional Approaches

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and institutional contexts shape knowledge and thus how we understand illness, health, and inequality. Second, we consider how race, class, gender, and health inequalities are produced within particular social contexts, in order to gain a better understanding of commonalities as well as differences in these patterns as they emerge in various locations. Third, we consider the ways that institutions differentially structure health care and access to health care on the basis of race, class, and gender. Finally, we consider the question of the potential for the reduction or elimination of inequalities in health outcomes through day-to-day resistance,

planned intervention, and organized social movements. Ultimately, the chapters in this book attempt to shift our gaze from those most negatively affected by inequalities toward the broad structures that maintain those inequalities. A critical, intersectional analysis can provide a framework for analyzing the health effects of racial/ethnic, gendered, and class-based inequalities in the United States and help provide a theoretical foundation for claiming health as a human right.

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