in which intersectional theory (Williams and Wall, 2001; Weber) as well as research on health disparities have focused. We focus on the intersection of race, gender, and socioeconomic status (SES) and consider how these factors interact to influence health outcomes. Researchers have identified a number of health disparities that are associated with race, gender, and SES. For example, African American women are at a higher risk for breast cancer and prostate cancer than their white counterparts (Finney et al., 2005). Similarly, women with lower SES have higher rates of obesity and related chronic diseases such as diabetes (Bauld et al., 2006). In this chapter, we explore how race, gender, and SES intersect to influence health outcomes.

David R. Williams
Pamela Braboy Jackson

Health Paradoxes

And SES

Of Race, Gender,

The Intersection

Chapter Five
The United States routinely reports health statistics by race. However, members of the major racial/ethnic groups are divided over whether to report preferred terminologies for certain groups. In this paper, we use the preferred terms for each group interchangeably.

Table 5.1 illustrates the magnitude and pervasiveness of racial disparities in health across different diseases by considering the top fifteen causes of death for whites and other races. We refer to American Indians, African Americans, and Hispanic populations for our analyses. For example, the national study found that 62 percent of whites prefer "white", "American Indian", and 50 percent prefer "black" (Tukey and others, 1990). In an effort to recognize individual differences, we use the preferred terms for each group interchangeably.

Table 5.1: Age-Adjusted Death Rates for White Men and Women for the Fifteen Leading Causes of Death and the Racial and Gender Differences in the United States, 1999

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Whites</th>
<th>Racial Differences, Black/White Ratios</th>
<th>Gender Differences, Male/Female Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Blacks</td>
</tr>
<tr>
<td>1. Heart disease</td>
<td>324.7</td>
<td>215.5</td>
<td>1.23</td>
</tr>
<tr>
<td>2. Cancer</td>
<td>246.5</td>
<td>168.6</td>
<td>1.38</td>
</tr>
<tr>
<td>3. Cerebrovascular disease (stroke)</td>
<td>60.0</td>
<td>58.7</td>
<td>1.46</td>
</tr>
<tr>
<td>4. Pulmonary disease</td>
<td>59.6</td>
<td>40.2</td>
<td>0.84</td>
</tr>
<tr>
<td>5. Accidents</td>
<td>50.0</td>
<td>22.7</td>
<td>1.24</td>
</tr>
<tr>
<td>6. Diabetes mellitus</td>
<td>25.8</td>
<td>20.5</td>
<td>1.88</td>
</tr>
<tr>
<td>7. Pneumonia and influenza</td>
<td>27.7</td>
<td>20.8</td>
<td>1.17</td>
</tr>
<tr>
<td>8. Alzheimer's disease</td>
<td>14.7</td>
<td>18.4</td>
<td>0.66</td>
</tr>
<tr>
<td>9. Nephritis</td>
<td>14.8</td>
<td>9.7</td>
<td>2.22</td>
</tr>
<tr>
<td>10. Septicemia</td>
<td>11.0</td>
<td>9.4</td>
<td>2.56</td>
</tr>
<tr>
<td>11. Suicide</td>
<td>19.4</td>
<td>4.4</td>
<td>0.54</td>
</tr>
<tr>
<td>12. Liver disease and cirrhosis</td>
<td>13.7</td>
<td>6.1</td>
<td>1.10</td>
</tr>
<tr>
<td>13. Hypertension</td>
<td>5.1</td>
<td>5.3</td>
<td>3.31</td>
</tr>
<tr>
<td>14. Homicide</td>
<td>5.5</td>
<td>2.2</td>
<td>6.35</td>
</tr>
<tr>
<td>15. Aortic aneurysm and dissection</td>
<td>9.0</td>
<td>3.8</td>
<td>0.76</td>
</tr>
</tbody>
</table>

Source: National Vital Statistics Reports (2001), per 100,000 population.
the distribution of health is not easy to explain, other than economic status can powerfully shape health outcomes. Additional factors, such as access to medical care, education, and social support, also play a role. Women and men, for example, may have different levels of access to healthcare services that can affect their health outcomes. Understanding these factors is crucial in developing strategies to improve health equity. Additionally, differences in social and economic resources available to men and women can contribute to disparities in health outcomes, with women often facing greater challenges in accessing healthcare services and opportunities.取り入れる。
The Intersection of Race, Gender, and SES

Intersection of Race/BiHegy

[Data and charts related to race, gender, and SES]

Health care arrangements and practices also respond differently to the needs of men and women with respect to their social, economic, and political status. These differences can be seen in the various ways health care professionals interact with patients. Men and women often receive different levels of care and treatment, which can affect their health outcomes. For example, women are more likely to be hospitalized than men, which may lead to different health outcomes.

[Table 2: Prevalence of Men and Women Reporting Poor Health]

<table>
<thead>
<tr>
<th>Income</th>
<th>Percentage of Men</th>
<th>Percentage of Women</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>4.2</td>
<td>6.7</td>
<td>2.5</td>
</tr>
<tr>
<td>Middle</td>
<td>9.1</td>
<td>11.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Poor</td>
<td>24.3</td>
<td>26.6</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Note: Higher income = better health care; lower income = worse health care.

[Graph showing trends in health care access and outcomes by race, gender, and SES]

[Discussion on the implications of these findings for health policy and practice]
The Intersection of Race, Class, and SES.
MIDDLE-CLASS BLACK WOMEN

Affirmative action programs have provided many opportunities for qualified women to gain access to professional fields they would otherwise have been denied. For example, IBM's affirmative action program resulted in an increase in the proportion of female engineers from 1.8 percent in 1980 to 2.5 percent in 1994 (Pathways to Progress, 1996). Similarly, the 100 corporate boards increased from 122 in 1992 to 232 by 1996 (Norman, 2002). Nonetheless, 90 percent of all engineers were only 10 percent of all engineers in 1996 (Pathways to Progress, 1996).

One of the ways in which women confront work problems is by seeking corporate workplaces, from African Americans (Collins, 1990, p. 27). However, women are also accused of overly “sensitive” (Kanter, 1977), and women of color are often treated as “mothers” by their male colleagues. These stereotypes persist even in the workplace. For example, in a study of black women in management (Collins, 1990, p. 27), women were often accused of being “sensitive,” and women of color were often treated as “mothers.” These stereotypes are reinforced by the cultural stereotypes of “black” and “female” that are often used to describe women of color.

Other evidence suggests that workplaces from African Americans face additional challenges. For example, women who are often competing (Bell and Kram, 1990), and women who are often competing (Sokoloff, 1980, p. 216). Nonetheless, women who occupy positions of authority (Kanter, 1977) and are identified by other group members as “leaders” (Bale and Bales, 1957) are more likely to be successful in their careers.

In summary, affirmative action programs have provided many opportunities for qualified women to gain access to professional fields they would otherwise have been denied. However, women continue to face challenges in the workplace, and stereotypes of “black” and “female” persist.

cared non-Hispanic white woman, American women have a higher infant mortality rate than less educated black women. The paradox of infant mortality occurs when we consider how race/ethnicity, gender, and SES influence data. These concerns are central to the understanding of how infant mortality is affected by education and race.

The black-white difference in infant mortality has been linked to a lack of support systems available to middle-class African American women. A lack of support systems available to middle-class African American women can lead to increased rates of infant mortality. The black-white difference in infant mortality can be explained by the lack of support systems available to middle-class African American women.

<table>
<thead>
<tr>
<th>Years of College</th>
<th>Infant Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-11</td>
<td>11.4</td>
</tr>
<tr>
<td>12-13</td>
<td>9.7</td>
</tr>
<tr>
<td>14-15</td>
<td>8.5</td>
</tr>
<tr>
<td>16-17</td>
<td>7.3</td>
</tr>
<tr>
<td>18-19</td>
<td>6.9</td>
</tr>
</tbody>
</table>

The black-white difference in infant mortality has been linked to a lack of support systems available to middle-class African American women. The black-white difference in infant mortality can be explained by the lack of support systems available to middle-class African American women.
United States, race of marriage is positively related to waistline among African American men and women. However, the effect of race of marriage is not significant for African American men. This finding may be due to the fact that African American men are more likely to marry within their own race than African American women. Moreover, African American women are more likely to marry outside their own race than African American men.

When race of marriage is controlled, race of social class of mother is not significant for either gender. However, race of social class of father is significant for African American men. This suggests that African American men may be more likely to marry someone from a different race of social class than African American women.

To further explore the relationship between race of marriage and waistline, we conducted a mediation analysis. The results showed that race of marriage indirectly affects waistline through race of social class. This suggests that race of social class may mediate the effect of race of marriage on waistline.

The results of this study have several implications. First, African American women are more likely to marry within their own race than African American men. This may contribute to the higher waistline among African American men. Second, race of social class may mediate the effect of race of marriage on waistline. Third, further research is needed to understand the mechanisms behind these findings.

References:
Middle-class African American men may be an underestimated group with multi-directional expectations becoming primary focuses.

Middle-class African American women (Columbia, 1999), College-educated African American women (Columbia, 1999), and Jackson, 1999).

The inter-connection of race, class, and SES (Sibley, 1999; Jackson, 1999). These are often associated with perceptions of discrimination and educational attainment. African American women report higher levels of social status and race discrimination, and report higher levels of discrimination and educational attainment (Jackson, 1999). There is a strong association between perceptions of discrimination and educational attainment. African American women face real challenges (Jackson, 1999).

Middle-class African American women face real challenges (Jackson, 1999). There is a strong association between perceptions of discrimination and educational attainment. African American women report higher levels of social status and race discrimination, and report higher levels of discrimination and educational attainment. African American women face real challenges.
Moreover, while the level of residential segregation has markedly lower levels of segregation than African Americans (Vass, 1974), there are great racial/ethnic minority groups in the United States. This is in part because segregation in particular, are unique in the United States, as they are the only two major racial groups that are not seen as whites. Again, segregation appears to preclude an elevated risk of homicide. Again, segregation appears to preclude an elevated risk of homicide. Again, segregation appears to preclude an elevated risk of homicide. Again, segregation appears to preclude an elevated risk of homicide.
CONCLUSION

Those who live in underserved neighborhoods, where there is a higher cost of living and fewer resources, have a higher risk of poor health outcomes. The intersection of race, class, and health is a critical issue that affects the well-being of African American individuals. Improved health outcomes can be achieved through policies that address the root causes of health inequalities and promote equitable access to healthcare services. This intersection highlights the need for comprehensive strategies that address both the social and economic determinants of health.

In conclusion, the intersection of race, class, and health is a complex and multifaceted issue that requires a holistic approach to understand and address. Future research and policy interventions should focus on identifying and addressing the underlying causes of health disparities to improve overall health outcomes for African Americans.
women are socialized to protect
health and well-being. This, in turn, fosters
healthy habits and behaviors that
influence a woman's health throughout
her life course. These habits and
behaviors may, in turn, influence
certain physiological factors that
contribute to heart disease.

In a race-conscious world, where
race and ethnicity intersect, it is
important to consider how these
factors may influence a woman's
decisions about her health. It is
important to recognize that, even
in a race-conscious world, certain
differences in health outcomes may be
systematically related to health
care disparities. As such, it is
important to consider how these
differences may influence a woman's
decisions about her health.

In conclusion, heart disease risks
are influenced by a variety of factors,
both individual and societal. While
race and ethnicity are important
determinants of heart disease risk,
other factors, such as socioeconomic
status and access to healthcare,
also play a significant role. It is
important to continue to study these
factors and their impact on heart
disease risk in order to better
understand and address these
disparities.
Bulitt E and Nunoa S. One or two workplace: formal or informal. Cambridge, Mass: Harvard.

Reference

The Intersections of Race, Class, and Health

Groups will use their power to maintain their privileged position

Conclusion

Gender discrimination (Williams, 1997) suggests that the dominant working in female-dominated work settings do not experience

However, men who hand themselves in token positions (1994) are not

Professional women are also subject to other similar
differences (Brown, 1996) and features of their own, according to

Health care is a form of personal power and privilege. The

Women who work with women workers dominate the field are

Gender, class, and poverty. The Intersections of Race, Class, and

The chapter has focused heavily on the African American


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and to avoid any expression of emotion or manipulation that could

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