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Foregrounding intersectionality in public health: A commentary on Giubilini, Gur-Arie and Jamrozik

– Richard Matthews –

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Giubilini, Gur-Arie and Jamrozik's[1] "Expertise, Disagreement, and Trust in Vaccine Science and Policy" explores how "failures of transparency in the acknowledgement of scientific uncertainty, absence of knowledge, and expert disagreement about scientific knowledge" undermine expert status and authority and thereby damage vaccination programs. To avoid these problems, the authors argue that public health experts need to

1. publicly acknowledge relevant uncertainties about knowledge claims; and
2. publicly acknowledge that disagreements between experts can exist due to either epistemic uncertainties or differences in value judgements.

Such acknowledgements are important, in their view, to establish and maintain epistemological and moral trust. The former is the reliance of an individual or a group on "an expert, considered to possess knowledge or skills that are relevant to specific goals in which we have some stakes". Moral trust is the ability of an individual or a group to trust that a public health official has good intentions, genuine commitment to moral principles, or the capacity for moral judgements. Trust, in turn, is a condition of expert authority, which is "the extent to which experts are trusted in their field of expertise to provide reliable information." Expertise itself involves both meeting relevant epistemic conditions that sometimes include knowledge, and a capacity to recognize how individual and society interests will be affected.

These are important considerations. However, I do not believe that they are likely, by themselves, to make much difference to the building and maintenance of trust in vaccination other than for those privileged populations already equipped and predisposed to receive such information. This is because the essay does not foreground the material conditions for the implementation of public health measures. To be effective, such acknowledgements need to first account and compensate for the ways in which inequities shape and distort the possibility of trust by marginalized and oppressed populations. That is, the recommendations need to take intersectionality seriously.

Richard Matthews
Bond University
email: rmatthew@bond.edu.au

[1] Giubilini et al. (2025).

For Shannon et al.,[2] intersectional analysis requires thinkers, practitioners and activists to take seriously the ways in which different forms of power shape individual human life. According to Hill-Collins and Bilge,[3] intersectionality is an account of human being that is essentially relational, emphasizing the ecological, economic, political and cultural conditions of life – for example, the eco-social determinants of health – and the ways these advantage certain groups while disadvantaging others. The main divisions are along economic class, gender, sexuality, race/ethnicity, disability/ability and age lines, although further subdivision is not uncommon.

Following Peggy McIntosh,[4] privilege is defined as unearned or unmerited advantage, and oppression as unearned or unmerited disadvantage. Privilege and oppression are concerned with the unjust distributions of power, mediated through intersectional differentiation, that ensure that certain groups and their members unfairly benefit from a given socio-economic order, while other groups and their members are unfairly harmed. Typically, there is a small dominant group that only enjoys the advantages of intersectionality and a significantly larger group that only experiences disadvantages. However, most people enjoy at least some privileges while suffering at least some oppression. In a capitalist, masculinist and white-privileging society, the dominant group will consist primarily of white, wealthy, able men. Multiple groups may occupy the most highly marginalized positions, but examples include women, LGBTQI or First Peoples who are unhoused, and asylum seekers or undocumented individuals who also experience gender oppressions.

In societies marked by privilege, good choices, merit, intelligence and other individual traits are irrelevant to problems of privilege and oppression. On the crucial causal factors that govern socio-economic positioning, they make little to no difference. Much more important are the violent and exploitative ways that dominant groups interact with subordinated ones. This means that – for any intervention they might plan – public health officials need to consider the realities of state and non-state violence in the lives of the populations that they seek to support.

A crucial starting point is the ambiguities of law. It is important above all to pay careful attention to the status and use of law, as law in part defines the structure of privilege in any intersectionally defined community. In these societies, law – including health law – is manifestly beneficial for dominant groups, while simultaneously becoming increasingly harmful for oppressed groups the greater the burdens arising from their intersectional oppression. In extreme cases, state law is designed to be exclusionary and therefore harmful to those at its margins. Asylum seekers and undocumented people are obvious examples since they are commonly deliberately excluded in law, policy and resource allocation. But these problems are also true for First Peoples in settler colonial states.[5]

Taking an intersectional approach to the problem of trust in public health generally, and vaccination in particular, requires us to consider the inequitable ways in which capitalist economics structurally distributes wealth through the exploitation of the poor

[2] Shannon et al. (2022).
[3] Hill-Collins and Bilge (2020).
[4] McIntosh (2009).
[5] Matthews (2019).

and marginalized. These populations are required to be poor for the sake of the overall functioning of the economic system. Such exclusions intensify the more health systems are marked by privatization: those who cannot pay for health care cannot get access to private systems without a lucky gift from a benefactor. In addition to accounting for the structural inequalities in contemporary health economics, public health officials also need to bear in mind the violent history of public health – especially for specific populations such as First Peoples. Vaccination research and the residential nutrition experiments in Canada's residential schools are two historical examples that are strongly remembered by First Nations people in contemporary Canada. Historical exploitation and victimization by public health measures increases population-level and individual distrust in the present. If public health officials wish to be trusted, they need to recognize how their predecessors have historically harmed certain populations, that such a history remains alive in the consciousness of some groups, and that therefore they may be perceived as carrying on such violent legacies regardless of their current actions.

Intersectionality offers a way of situating public health decision making within the eco-social determinants of health at individual, intermediate and distal levels. These determine what public policy is possible and shape who is most likely to benefit. For example, Gopichandran[6] in an analysis of vaccination programs in India describes the impacts of the lack of access to quality education upon vaccine hesitancy. It is noted that those harmed by structural inequities, if they participate in vaccination programs at all, are likely to do so through passive conformism rather than the exercise of informed choice. The transparency of public health officials can play no significant role. Bajos et al[7] describe how scientists are rendered less trustworthy by the harms that social and economic forces inflict on the populations they marginalize. This has little to do with the epistemological or moral trustworthiness of public health officials and everything to do with how they are positioned vis-a-vis more or less marginalized and oppressed groups.

It is not just a matter of the history and contemporary reality of state violence within a state. International interstate behavior is also influential. Public health officials should also be mindful of the impacts on public health decision making, and of whether they are trusted, arising from the violence of internationally aggressive states – including the United States and other liberal countries as well as China and Russia.[8] As an example, the assassination of Osama bin Laden was conducted under the cover of a vaccination program. This generates a powerful distrust of public health programs for obvious reasons, not to mention undermining all of the classic principles of healthcare ethics. A vaccination program – mandatory or otherwise – may meet with a violent response under these conditions.

At the population level, asylum seekers, undocumented workers and trafficked persons sit in a grey zone between international state violence and internal state violence.[9] Their marginality makes any encounter with a public health official potentially dangerous – if they are noticed at all – and not uncommonly they have traumatic experiences

[6] Gopichandran (2017).
[7] Bajos et al. (2022a).
[8] Kobayashi et al. (2022).
[9] Ingram et al. (2011).

with public officials in their backgrounds.[10] Trust in these cases – whether epistemic or moral – is unlikely to emerge without considerable other work.

These considerations show why any discussion of trust in public health has to take Maya Goldenberg's[11] work seriously. There is too little reflection on the ways in which public health officials exacerbate vaccine hesitancy. Goldenberg describes the deployment of the language of a war on science as a way of dehumanizing the vaccine hesitant and assuming their hostility. She reminds us that the history of medical research and practice has been exploitative and caused considerable suffering for many populations – Black Americans, First Nations individuals, those with physical and mental disabilities, the unhoused, among many. In addition she notes the impacts of growing wealth inequalities and the increasing re-organization of healthcare for the sake of profit rather than the public good on social and economic forces contributing to the loss of trust in public health officials and the resulting vaccine hesitancy. In addition, Quinn et al[12] note the "early and ongoing evidence of racial discrimination and bias in the testing and treatment of COVID-19." Structural racism is a powerful driver of vaccine hesitancy and medical mistrust among marginalized populations.

The question that has to be asked, then, is: What impact – if any – could the recommended commitments to transparency and acknowledgements of uncertainty have in the absence of an intersectional foundation? It is conceivable that they will make a meaningful difference for the privileged groups for whom public health systems are primarily designed, and therefore for those who are already most likely to benefit. Such groups are also threatened by problems of vaccine hesitancy and refusal, for example through misinformation and disinformation on the internet and elsewhere. But if this is all that public health officials are to aim at, then the measures will inadvertently reinforce already existing health inequities.

In that regard I am skeptical that the measures proposed in the paper will make much difference with more marginalized groups in the absence of serious efforts towards redistributions of power, redefinitions of expertise, and reflexive and knowledgeable engagement with marginalized communities and their leaders. The problems with trust here have little to do with the expertise, personal virtue, or good decision making of public health officials. Above all, acknowledgements of expert disagreement and uncertainties about knowledge are unlikely ever to even reach such communities, let alone be trusted by them. For less marginalized populations, it is unclear whether transparency and accountability of an official can reduce hesitancy given the fear with which some community members may regard *any* public official; rather, redistributions of power to the relevant communities, accompanied by cooperative interaction on the part of public health officials, seems a more plausible approach. The recommendations about epistemic uncertainty and transparency are likely to have enhanced value then.

[10] Bajos et al. (2022a).
[11] Goldenberg (2021).
[12] Quinn et al. (2023).

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