Advances in Nursing Science
Vol. 28, No. 3, pp. 194–202

Examining the Margins
A Concept Analysis of Marginalization

Elyssa B. Vasas, MPH, RN

The aim of this analysis is to explore the concept of social marginalization for the purpose of concept development. Specifically, the article intends to clarify the relationship between health disparities and marginalization and generate knowledge about working with people who are socially marginalized. Concept development evolved from the critical analysis of relevant literature generated through searches of nursing and social science databases. Literature was organized thematically and themes related to marginalization as a social process were included and analyzed. The article explores the challenges of using marginalization as an independent concept and suggests areas for future inquiry and research. **Key words:** *concept analysis*, *health disparities*, *marginalization*

MARGINALIZATION is a widely used descriptive term in the social sciences, applied to various people, locations, and events. The word conveys a vague sense of disadvantage and injustice, but writers generally do not describe what they mean when they label a group or place "marginalized." Furthermore, marginalization is rarely used as an independent concept, one which could help researchers understand the experience of those they describe.

The discipline of nursing has been utilizing the concept of marginalization for the past decade to guide knowledge development and inform nursing research and practice, particularly in the realm of women's health.[1,2] It is defined as the process through which individuals or groups are peripheralized on the basis of their identities, associations, experiences, and environments.[1] The concept was initially analyzed in 1994 and has been revisited 3 times since by the same scholar.[1,3,4]

The concept of marginalization is particularly salient to the study of health disparities. Being on the periphery of society exposes groups and individuals to environments that potentially threaten their health and well-being.[5] Marginalization thus creates vulnerable populations; social groups who have an increased relative risk or susceptibility to adverse health outcomes.[6] Health disparities result from this differential risk between vulnerable groups and nonvulnerable, advantaged groups.[7] By exploring the concept of marginalization, we can gain insights into how vulnerable groups are created and situated along the periphery of mainstream society, and begin to analyze the role of nurses in reducing health disparities created through marginalization.

Despite the seeming utility of the concept, and the ability of the concept to guide nurses working in health disparities, marginalization remains a "descriptor" rather than a "concept" in the majority of nursing literature. The purpose of this article is to explore the concept of marginalization, specifically its relation to health disparities. By revisiting the concept, new knowledge is generated about working with people who are described as "marginalized." Further clarification and development

From the International Center of Research for Women, Children and Families, University of Pennsylvania School of Nursing, Philadelphia.

This work was supported by the NIH grant to the University of Pennsylvania School of Nursing, International Center of Research for Women, Children and Families (T32-NR-07100). The author acknowledges the help and support of Dr Julie Fairman.

Corresponding author: Elyssa B. Vasas, MPH, RN, Center for Health Disparities Research, University of Pennsylvania School of Nursing, 420 Guardian Dr, Philadelphia, PA 19104 (e-mail: evasas@nursing.upenn.edu).

of the concept also leads to a more rich understanding of how the concept can guide and inform future nursing research and practice.[8]

METHODS

This analysis evolved out of a critical review of literature that created linkages between thinkers discussing the phenomenon involved in marginalization. The perspective of the author is reflected in the feminist and postcolonial methods applied to the analysis. To begin, the previous concept analyses of marginalization were reviewed, and a search through ISI Citation Index was performed to find authors who used the concept in their work. Key word searches were performed in the search engines CINAHL and PubMed for the terms "marginalization," "marginalized," and "marginal," with no limitations on year of publication. Literature referenced in these articles was also reviewed for relevance to the concept. Key word searches were also performed in PsychINFO, PsychARTICLES, Sociological Abstracts, Social Services Abstracts, Genderwatch, and the Anthropological Index Online, for the terms "marginalization," "marginalized," and "marginal." The 40 articles and books included for review described or referred directly to the process or experience of marginalization, or its seemingly parallel concept social exclusion. Social exclusion refers to the norms and processes that prevent certain groups from equal and effective participation in the social, economic, cultural, and political life of societies.[9]

INTRODUCTION TO THE CONCEPT

The concept of *marginalization* is discussed in relation to marginalized epistemologies and marginalized populations. Marginalized ontologies include those that are not widely accepted, and those not meeting privileged, Western, empirical, standards.[10] An example of marginalized knowledge is the bodily and spiritual knowledge of women experiencing the psychosocial stressors of living with HIV.[11] Marginalized populations, on the other hand, are groups of people who are socially excluded and experience inequalities in the distribution of resources and power. The focus of this article is social marginalization, in an effort to examine marginalization within the context of populations experiencing health disparities.

Social marginalization can be constructed in terms of geography: people and groups who are positioned in places that are far away from the resources they need such as hospitals, food and water, and schools.[5] Incarceration is an example of geographic marginalization. Marginalized people in this situation interact with their environment on the basis of the concrete margins that define the boundaries between and around people.

While health disparities may occur in populations experiencing geographic social marginalization, the discipline of nursing uses the concept of marginalization to refer to an abstract process; one that results in certain people having limited access to social power, being barred from physical or nonphysical resources, and being subject to differential treatment. Hall and colleagues[1] describe it as a social process that results in groups having limited access to needed resources and being peripheralized on the basis of their identities, associations, experiences, and environments.[1]

The emphasis on the *process* of marginalization is contained in several definitions of marginalization besides the one given by Hall and colleagues. Ferguson describes marginalization as ". . . the process through which margins are created, defined, and enforced."[12] Tucker refers to it as "that complex and disputatious process by means of which certain people and ideas are privileged over others at any given time," and ". . . the process by which, through shifts in position, any given group can be ignored, trivialized, rendered invisible and unheard, perceived as inconsequential, de-authorized, 'other', or threatening, while others are valorized."[13] Despite this emphasis on *process* in the definitions of marginalization, previous concept analyses

of marginalization focus largely on the *experience* of being a marginalized person, including the feelings, reflections, perceptions, and physical outcomes associated with experiencing marginalization.[1,4]

The following concept development of marginalization distinguishes the process of marginalization from the experience of marginalization. Included is the introduction of several ideas that emerged during this analysis of the concept: that both the process and the experience of marginalization occur at various social layers, that the process of marginalization creates invisibility among marginalized people, and that there are frequently multiple sources of marginalization occurring in an individual's life.

MARGINALIZATION AS A PROCESS

Marginalization can occur only in relation to a margin. Margins provide the physical (concrete) and psychological (perceived) constructs around which marginalized people reside. They are the boundary-determining aspects of persons, social networks, communities, and environments.[1] Frequently, margins are defined or described in contrast to a central point. In this way, the central point (Center) defines the margins, and everyone who does not fit that description falls outside of the margin or becomes "marginalized."

The consequence of approaching the concept with this perspective is that it reduces marginalization to sets of binaries or dichotomies: the Center versus the non-Center, the Center versus the periphery, the majority versus minority, or inclusion versus exclusion.[1,13] The prevailing binary associated with marginalization is the distinction between the Center versus the Other. The distinctions are made through "othering," a process of identifying those that are different from oneself of the mainstream.[14,15] Hall described this phenomenon as the property of differentiation.[4] The process of othering is then used to reinforce and reproduce positions of domination and subordination, creating and maintaining margins.[12,15]

It is difficult to clarify who is in the Center, responsible for creating and maintaining the margins. The Center is determined by the majority and populated by powerful mainstream people.[3] However, the Centers are frequently invisible,[12,16] with their power coming from a hidden place. Conversely, marginalized people are invisible to those in the Center because they are not present in their immediate environments, and may live in secret or hidden places like street alleys, homeless shelters, ghettos, and slums.[1,17] Therefore, their needs and voices are often not heard by those in the Center.[3] Mohanty suggests that this is because privilege nurtures blindness toward those without the same privilege.[18] When their voices are brought to the attention of the Center, their demands often seem irrational or incomprehensible to those in the Center. This speaks to the Center's inability to understand the experience, process, or consequences of marginalization. In reality, the needs of marginalized people are generally not inappropriate or outrageous: they are asking to be respected, humanized, and have their basic survival needs met.[3]

Despite their invisibility to those in the Center, marginalized people are identified in the literature very clearly. This is particularly true in work regarding populations who experience health disparities. They are identified as being poor; people who are homeless; children; women; those belonging to a particular caste, ethnic, gender, or age group; victims of abuse; people with HIV/AIDS; racial and ethnic minorities; street children; immigrant women who are ignored and devalued because they are at both the margins of society and the margins of their ethnic group; homeworkers/domestic workers; commercial sex workers; confused elderly; disabled; mentally ill; gay/lesbian/bisexual or transgendered; unemployed; women of color; chronically ill children; those who exhibit gendered behaviors that do not blend within their ethnic groups; overweight children, who are socially isolated on the basis of their physical

characteristics; exiles; communities and nations; those who exhibit visible differentiations such as those related to appearance, identities, associations, political affiliations, national origins, addictions, and economic statuses; ragpickers, people belonging to low castes, migrant communities, demon possessed, adulterers, thieves, witches, unmarried, childless, beggars, state pensioners, people living in areas known for high crime and violence rates.[1,4,11,18–25]

MARGINALIZATION AND POWER

The process of marginalization is more complex than merely the creation of the Other, and the consequential fall out of being barred from resources. There is a powerful interplay between the forces involved in marginalization, although very few resources examined for this analysis describe this phenomenon. Dear and Moos employ Gidden's Theory of Structuration for the purposes of examining social inequalities, and their description of the theory provides a helpful framework for understanding the forces involved in the process of marginalization.[26] They describe the process of marginalization as occurring through the creation of conditions that determine social outcomes. These conditions are the result of an interplay between the social structures that exist in society and the agency of individuals. Social structures, determined by the powerful Center, consist of the organized rules and resources that individuals draw on and reconstitute in their daily activities. These structures are the medium upon which individuals interact, and they influence the way people communicate, negotiate interpersonal power, and apply the norms of society. Individuals are active, knowledgeable, and reasoning agents, interacting with these social structures to create and reenforce societal "norms."[26]

Within this framework, the Center exerts power over society by influencing the social structures upon which individuals act. The Center differentiates between the Center and the Other and then communicates this differentiation through society using vertical (or hierarchical) power.[1] The power at the Center is usually not contested, while the power of the periphery is constantly contested.[27] This power is dynamic, moving through the web-like social networks in which we live and interact with others.[4] An example of this type of power is symbolic violence, the creation of language and symbols that contributes to the marginalization of social groups.[3] These symbols are transformed and transmitted to the general public, conveying meanings that disparage and damage targeted groups. Symbolic violence is a subtle, but effective, way for the powerful Center to change public opinion about a group of people.

Power is also used in various ways to maintain the margins. An example is the disciplinary power used by the Center to punish those who deviate from the "norm" with torture, incarceration, or other varying punishments. Hall described this as the property of constraint, when others have control over the body of the marginalized person.[4] The margins are also maintained through the creation of stereotypes, myths, lies, images, and labels that are transmitted to societal members; building concrete or psychological borders; costs that prevent marginalized people from accessing resources; stigma; humiliation and intimidation of marginalized people and corruption.[24,25,28,29]

While the process of marginalization has been primarily described in terms of the hierarchical power structures that exist, another source of power is also discussed in relation to marginalization: horizontal power. This refers to the power exhibited by peripheralized people in response to their marginalization. As opposed to the Center's hierarchical power structure focus on differentiation, horizontal power values commonalities and the creation of human bonds. Hooks describes the space between the margins, where horizontal power resides, as a site of resistance and radical possibility.[30] It is a source of resistance against the Center and other dominant groups.[1,31] Central to this power is the

opposition, resistance in the face of oppressive force.[28,30,32] As marginalized groups insist on having their own identity, the structural invisibility of the Center becomes harder to maintain.[12] Understanding and valuing horizontal power means that we deconstruct the powerful/powerless binary of the Center/Other, and instead find potential in a type of power that often remains hidden.

LAYERS OF MARGINALIZATION

The hierarchical power involved in marginalization manifests itself on both the global and local levels.[33] At each level, marginalization is experienced differently, the margins are constructed and maintained in different ways, and the opportunities and challenges of working with marginalized groups differ.

Global marginalization crosses nations and creates a persistent structural framework upon which global institutions act. An example of marginalization occurring at a global level is reflected in the stigma associated with HIV/AIDS. In this case, stigma in response to fear and illness is created and passed through social fabrics to marginalize groups of people, and in some cases the population of entire countries living with the disease.[29]

Locally, marginalization occurs on a community level and on an interpersonal level. Communities can experience marginalization from a more dominant community.[34] Community marginalization also occurs between communities and individuals, such as when an immigrant finds difficulty adjusting to a new environment and finds comfort in groups such as gangs, which are not approved of by the majority of the community.[35]

At the interpersonal level, individuals interact to exert power over one another and transmit the societal structures of differentiation and oppression.[36] This can be a function of tone of voice, use of language, facial expressions, or emotions conveyed or implied through body language and differential treatment. Marginalization at the interpersonal level is illustrated through quotes taken during an interview with people in Tanzania. They report that before they have a chance to describe their symptoms to health workers, they are "yelled at, told they smell bad," and that they are "lazy" and "good for nothing."[25] The process of marginalization is perpetuated during their interpersonal relations with health workers, and influences how ill Tanzanians experience marginalization in the healthcare system.

Marginalized people often have several characteristics by which they are defined and excluded.[11,19] When these characteristics intersect, the multilayered effect compounds the disadvantage of individuals and groups. For example, many authors discuss the intersections of gender, race, and class.[36,37] In this case, one social construction, such as culture, cannot be isolated from the other structural factors that affect the lives of individuals and communities.[38]

Gloria Anzaldua writes about the psychological/sexual/spiritual "borderlands" that develop when the social and cultural boundaries or borders of 2 or more groups attempt to exist in the same space.[28] This creates an unnatural and unsafe territory, a space between margins. This space is constantly in flux, in response to the changing social powers and flexibility of the boundaries.[18,28] The physicality of these borderlands is described as the place where marginalized people and marginalized activities exist in secrecy.[1] This secrecy and inability to control life in the borderlands results in both physical and psychological consequences including physical, emotional, or mental violence and abuse; poverty; torture; rape; illness; health disparities; dehumanization; starvation; isolation; humiliation and shame; pain; loss of self-esteem; fear; powerlessness; feeling unneeded, shut-out, shut-up, silenced, or devalued; exploitation; hopelessness; malnutrition; starvation; loss of housing; dissolution of families; substance use; economic oppression; fatigue; being feared, confined, or murdered; a shortened life span; depersonalization and cultural collapse; internalized self- or group-hatred; war; and violent death.[1,3,4,17,21,25,27]

DISCUSSION

Nurses interface with the concept of marginalization in 3 important ways: to begin, we must be able to understand the *experiences* of marginalized people. This will allow us to work with marginalized populations in a more meaningful and responsible way, and we will be able to more fully understand the relationship between health disparities and marginalization.[1,4] We also need to understand the physical and psychological *consequences* of social marginalization, as they affect the health and well-being of our patients.[3,21,25] Finally, as this concept development has shown, we must also understand the *process* of social marginalization and increase our awareness to the ways we resist or contribute to the marginalization of our patients within our practice and research.

This analysis has differed from previous analyses of the concept because it focused specifically on the process involved in marginalization. By exploring the process rather than just the experience, several ideas emerged that are relevant to nursing. The first is the way the process of marginalization creates invisible populations, and also an invisible Center. Utilizing the concept of marginalization provides an opportunity for nursing to bring those who have been silenced and depreciated to the attention of those with the power to change things. Allowing marginalized voices to be heard means that we can learn from them and further understand how marginalization affects health.

Giving voice to marginalized groups necessitates nursing becoming a forum in which marginalized voices can be uncovered and given respect.[3] Nurses working with marginalized groups must acknowledge the secrecy involved in protecting marginalized knowledge, and find ways to ensure the safety of those sharing testimonies and other personal narratives that elaborate on exteriorizing life experiences.[4] This is more than just confidentiality, but involves creating safe spaces in which marginalized voices can be heard and feel that they are valued.

Creating safe spaces requires attention to the methods we employ in our research. Methods that involve individuals and groups who experience marginalization actively in the research process may yield voice. Examples include qualitative work with marginalized populations, and community participatory action. Giving voice to individual's needs, expectations, and strengths will help nurses understand the context in which people live, extrapolate multiple layers of oppression and authority, create awareness of relevant identity and power differentials, and acknowledge issues related to disclosure and empowerment.[39] Through this process, marginalized people are humanized, a process that some suggest will significantly transform Western epistemology.[40]

In giving voice to marginalized groups, a philosophical and ethical pitfall arises. As educated, academic nurse researchers, there is inherent risk of speaking from the Center, to the Center, about those in the margins.[41] Spivak warns academics against reducing the voices and the consciousness of the subaltern when their experiences are brought to the Center.[42] Similarly, hooks discusses the way researchers explore and retell the experiences of marginalized people. She writes,

> No need to hear your voice when I can talk about you better than you can speak about yourself . . . . Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you I write myself anew. I am still author, authority. I am still colonizer, the speaking subject and you are now at the center of my talk.[30(p343)]

Her words are a powerful reminder of the need to reflect the lives of marginalized people as accurately and sensitively as possible, with awareness given to the power of our writing.

The second important feature this analysis has uncovered is that the process of marginalization can be viewed as a function of hierarchical power structures. Viewing marginalization through this lens provided nurses with

the opportunity to question the way power is structured and may provide interesting alternatives to the power structures currently existing in Western culture. For example, a current trend in public health is to emphasize the human rights perspective. This perspective justifies change in social systems on the basis of the human rights of health and freedom from poverty. By starting with health as a human right, resources are allocated to the areas with the greatest health disparities. A human rights perspective humanizes the most marginalized individuals and makes their health and well-being a focus for those in power, the ones who allocate resources. In this way, the Center would be defined in terms of the marginalized, and marginalized people would thus determine how resources are allocated.

There is also a continued emphasis on horizontal power within the process of marginalization, and there is great potential in horizontal power. Writing about the colonization of feminist knowledge across the borders of class and race, Mohanty notes that the differences are valued over commonalities.[18] Furthermore, the "differences" spoken of in the literature separating marginalized from nonmarginalized groups are presented as decidedly negative. Each binary is composed of a good and a not-as-good alternative; the process of marginalization is discussed as negative sets of oppressions and the experience of the marginalized is described in terms of their vulnerability and disadvantage. Alternatively, nursing practice and research could seek to examine and strengthen horizontal power, focusing on commonalities rather than differences. This might lead to innovative and insightful methods for addressing marginalization. What if the strengths of marginalized groups were the focus of nursing research? We could then look at marginalization and marginalized groups in terms of their commonalities across or within margins. Through research and writing that focuses on the strengths of marginalized groups, nurses can potentially give voice and body to "invisible" marginalized people.

A third finding of this analysis is that there may be multiple sources of marginalization occurring to individuals at one time. This helps us understand the compounded effects and consequences of laboring under various oppressions and raises awareness of this possibility. When there are multiple layers of oppression and marginalization, the binaries associated with marginalization may be inhibiting our ability to see the more complex process of marginalization, or value the space "between" margins.

This exposes one of the challenges of utilizing marginalization as an independent concept in nursing: Although the concept is becoming clearer, the tools to measure the phenomenon do not exist.[21] For example, how do we know someone is "marginalized"? Simply because they experience economic oppression? Because they feel "left out" of their community, family, or society? Because we, as researchers, feel that they are marginalized? And for people who consider themselves "marginalized," can we then assume that they are at risk for health consequences? Do different types of marginalization result in differential risks? More discourse is needed within the discipline to determine whether such tools would be appropriate and useful, and how they would be structured.

The future of nursing depends on the ability of the discipline to address the health needs of diverse populations and marginalized groups.[43] The concept of marginalization provides an innovative perspective on health disparities, focusing on the social inequalities from which disparities result, rather than reducing them to functions of race, culture, gender, or other variables taken out of their social context. Farmer approaches this idea when he describes the way "... social forces, ranging from political violence to racism, come to be embodied as individual pathology."[44(p13)] For example, understanding culture has historically been very important to the discipline of nursing and helped us become more understanding practitioners who acknowledge and value the cultural diversity of our clients.[21] However helpful valuing culture is to the

profession, it does not, by itself, determine how diverse populations respond to the healthcare system. Rather, as Meleis and Im write, "it is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized and ordered around."[21(p96)] In other words, it is the extent to which people experience marginalization that determines their response to the healthcare environment, and it is the process of marginalization that contributes to their experience. Furthermore, solely focusing on culture as a guiding concept for nursing research can potentially create and perpetuate stereotypes, casting certain groups as "outsiders."[15]

Finally, viewing marginalization as a *process* brings added value because it implies that marginalization is an active concept; and therefore a concept that is potentially amenable to change. This involves changing the way we think about the power structures involved in the process. It also involves changing our practice and research environments so they reflect a process that does not perpetuate health disparities. Acknowledging the presence of marginalization in our populations, how it affects their lives and how we can uncover the process and their experiences will give voice to marginalized groups and advance knowledge about reducing health disparities.

REFERENCES

1. Hall J, Stevens P, Meleis A. Marginalization: a guiding concept for valuing diversity in nursing knowledge development. *Adv Nurs Sci*. 1994;16:23–41.
2. St Hill P, Lipson J, Meleis A. *Caring for Women Cross-culturally*. Philadelphia: FA Davis; 2003.
3. Hall J. Marginalization and symbolic violence in a world of differences: war and parallels to nursing practice. *Nurs Philos*. 2004;5:41–53.
4. Hall J. Marginalization revisited: critical, postmodern, and liberation perspectives. *Adv Nurs Sci*. 1999;22:88–102.
5. Alexander GL, Kinman EL, Miller LC, Patrick TB. Marginalization and health geomatics. *J Biomed Inform*. 2003;36:400–407.
6. Flaskerud J, Winslow B. Conceptualizing vulnerable populations in health-related research. *Nurs Res*. 1998;47:69–78.
7. Flaskerud J, Lesser J, Dixon E, et al. An emerging discourse. Toward epistemic diversity in nursing. *Adv Nur Sci*. 2003;26:44–52.
8. Gift A. *Clarifying Concepts in Nursing Research.* New York, NY: Springer Publishing Company; 1997.
9. Narayan D, Patel R, Schafft K, Rademacher A, Koch-Schulte S. *Voices of the Poor: Can Anyone Hear Us?* New York, NY: World Bank, Oxford University Press; 2000:chap 6.
10. Bryant L. Marginalized curriculums: transforming one's place in the margins. *Transformations.* 1993: 58–72.
11. Tangenberg K. Marginalized epistemologies: a feminist approach to understanding the experiences of mothers with HIV. *AFFILIA*. 2000;15:31–48.
12. Ferguson R. Introduction: invisible center. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Culture*. Cambridge, Mass: MIT Press; 1990:9.
13. Tucker M. Director's foreword. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:7.
14. Canales M. Othering: toward an understanding of difference. *Adv Nurs Sci*. 2000;22(4):16–31.
15. Johnson J, Bottoroff J, Browne A. Othering and being othered in context of health care services. *Health Commun*. 2004;16:253–271.
16. Lorde A. Age, race, class, and sex: women re-defining the difference. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:281–287.
17. Narayan D, Chambers R, Shah M, Petesch P. *Voices of the Poor: Crying Out for Change*. New York, NY: World Bank, Oxford University Press; 2000:chaps 4, 7, and 11.
18. Mohanty C. "Under western eyes" revisited: feminist solidarity through anticapitalist struggles. *Signs J Women Culture Soc*. 2002;28:499–535.
19. Cheng C. Marginalized masculinities and hegemonic masculinity: an introduction. *J Men's Stud*. 1999; 7(3):295–315.
20. DiNapoli P, Murphy D. The marginalization of chronically ill adolescents. *Nurs Clin North Am*. 2002;37:565–572.
21. Meleis A, Im E. Transcending marginalization in knowledge development. *Nurs Inq*. 1999;6:94–102.
22. Said E. Reflections on exile. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization*

and Contemporary Cultures. Cambridge, Mass: MIT Press; 1990:357–366.
23. Strauss R, Pollack H. Social marginalization of overweight children. *Arch Paediatr Adolesc Med*. 2003;157:746–752.
24. Taylor J. Colonizing images and diagnostic labels: oppressive mechanisms of African American women's health. *Adv Nurs Sci*. 1999;21:32.
25. Dying for Change: World Health Organization and World Bank. 2002. Available at: http://siteresources.worldbank.org/INTPAH/Resources/Publications/Dying-for-Change/dyifull2.pdf. Accessed July 6, 2005.
26. Dear M, Moos A. In: Wilson D, Huff J, eds. *Marginalized Places and Populations. A Structuralist Agenda*. Westport, Conn: Praeger; 1994: chap 1.
27. Meleis A, Im E. Grandmothers and women's health: from fragmentation to coherence. *Health Care Women Int.* 2001;23:207–224.
28. Anzaldua G. *Borderlands/La Frontera. The New Mestiza.* San Francisco: Aunt Lute Books; 1999.
29. International Council of Nurses. *Nurses: Fighting AIDS Stigma, Caring for All. Information and Action Tool Kit*. Geneva, Switzerland: International Council of Nurses; 2003.
30. hooks b. *Outlaw Culture: Resisting Representations.* New York: Routledge; 1994.
31. Minh-ha T. Cotton and iron. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press, 1990:357–366.
32. Jagger A. Globalizing feminist ethics. In: Narayan U, Harding S, eds. *Decentering the Center. Philosophy for a Multicultural, Postcolonial, and Feminist World*. Bloomington and Indianapolis, Ind: Indiana University Press; 2000:1–25.
33. Alexander M, Mohanty C. In: Alexander M, Mohanty C, eds. *Feminist Genealogies, Colonial Legacies, Democratic Futures*. New York: Routledge; 1997:xii–xlii.
34. Menchaca M. *The Mexican Outsiders. A Community History of Marginalization and Discrimination in California*. Austin, Tex: University of Texas Press; 1995.
35. Sheridan M. In N. VA. Gang, a brutal sense of belonging: machete attack suspect lured by group's culture. *The Washington Post*. 2004:A12.
36. Collins P. It's all in the family: intersections of gender, race, and nation. In: Narayan U, Harding S, eds. *Decentering the Center. Philosophy for a Multicultural, Postcolonial, and Feminist World.* Bloomington and Indianapolis, Ind: Indiana University Press; 2000:156–176.
37. West C, Fenstermaker S. Doing difference. *Gender Soc*. 1995;9:8–37.
38. Racine L. Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nurs Inq*. 2003;10:91–102.
39. Meleis A. Culturally competent scholarship: substance and rigor. *Adv Nurs Sci*. 1996;19:1–16.
40. Narayan U, Harding S. *Decentering the Center. Philosophy for a Multicultural, Postcolonial, and Feminist World.* Bloomington and Indianapolis, Ind: Indiana University Press; 2000.
41. Patai D. In: Gluck S, Patai D, eds. *Women's Words: The Feminist Practice of Oral History*. New York: Routledge; 1991:137:158.
42. Spivak G. *In Other Worlds. Essays in Cultural Politics*. New York and London: Methuen; 1987.
43. Stevens P, Hall J, Meleis A. Examining vulnerability of women clerical workers from five ethnic/racial groups. *West J Nurs Res*. 1992;14:754–774.
44. Farmer P. *Infections and Inequalities: The Modern Plagues.* Berkeley: University of California Press; 1999.