

10 Best resources on . . . intersectionality with an emphasis on low- and middle-income countries

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Abstract

Intersectionality has emerged as an important framework for understanding and responding to health inequities by making visible the fluid and interconnected structures of power that create them. It promotes an understanding of the dynamic nature of the privileges and disadvantages that permeate health systems and affect health. It considers the interaction of different social stratifiers (e.g. 'race'/ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion) and the power structures that underpin them at multiple levels. In doing so, it is a departure from previous health inequalities research that looked at these forms of social stratification in isolation from one another or in an additive manner. Despite its potential use and long history in other disciplines, intersectionality is uncommonly used in health systems research in low- and middle-income countries (LMICs). To orient readers to intersectionality theory and research, we first define intersectionality and describe its role in public health, and then we review resources on intersectionality. We found that applications in public health mostly increased after 2009, with only 14 out of 86 articles focused on LMICs. To arrive at 10 best resources, we selected articles based on the proportion of the article that was devoted to intersectionality, the strength of the intersectionality analysis, and its relevance to LMICs. The first four resources explain intersectionality as a methodology. The subsequent six articles apply intersectionality to research in LMIC with quantitative and qualitative analysis. We provide examples from India, Swaziland, Uganda and Mexico. Topics for the studies range from HIV, violence and sexual abuse to immunization and the use of health entitlements. Through these 10 resources, we hope to spark interest and open a needed conversation on the importance and use of intersectional analysis in LMICs as part of understanding people-centred health systems.

Key words: Intersectionality, inequalities, race, gender, class, sexual orientation

Key Messages

- Intersectionality can be applied in low- and middle-income country settings to understand and respond to health inequities embedded in dynamic, interlocking systems of power.
- We selected 10 best resources (4 conceptual, 2 quantitative and 4 qualitative articles) that describe intersectionality, provide general methodological guidance and serve as examples.
- Practical applications of intersectionality are provided from India, Swaziland, Uganda and Mexico and across a wide array of health topics spanning HIV, violence, sexual abuse, immunization and health entitlements.

Introduction

People-centred health systems have come to the forefront of health systems thinking, research and practice, building on decades of work emphasizing the social construction of health inequities and the power relations that underpin them (CSDH 2008; Sheikh *et al.* 2014). A key frontier that requires further attention is how we understand and respond to health inequalities, not as static, inevitable disadvantages suffered by marginalized groups, but as constituted by individuals whose perspectives are essential to understanding and changing the dynamic, interlocking social systems and structures of power they are embedded in. We argue that intersectionality theory (defined in Box 1) and research is a critical part of that frontier.

Box 1. Definition of Intersectionality

Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations (e.g., 'race'/ ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected system and structures of power (e.g. laws, policies, state governments and other political and economics unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created. (Hankivsky 2014)

Intersectionality mainly 'seeks to demonstrate the convergence of different types of exclusion and marginalization' (Hankivsky 2014). In doing so, it embraces the complexity of a marginalized population's lived experiences and makes linkages to the dynamic relationships, processes and structures that affirm or disrupt the simultaneous inequalities and/or privileges faced by them. For example, single mothers are typically seen as disadvantaged. However, a well-educated, single mother with significant financial resources and social networks may experience single motherhood as liberating compared to a poor woman, who does not have the resources to provide for her family without additional support, and if she is poor and a sexual minority without legal rights, she may also face legal challenges that she cannot afford to battle or evade.

Intersectionality was originally coined by Kimberle Crenshaw (1989) in the USA as a response to the exclusion of black women from feminist theory and race studies despite their 'intersection' in both these worlds (Mburu *et al.* 2014). Over time, it has come to represent ideas from diverse activists and scholars engaged with understanding and transforming inequalities, including those concerned with low- and middle-income countries (LMICs) (Mohantry 1984). Intersectionality has risen in importance in the social sciences, with increasing applications to public health from the late 2000s onwards. Despite its potential contributions, experience applying the approach is relatively nascent within health systems research in LMIC contexts, and significant variance exists in how it is understood and applied.

As reflexivity represents a central tenant of intersectionality, we explain our positionality to understand the influence our backgrounds have on our interpretations of the included articles. We are female public health researchers based in the USA, with different types and levels of graduate training and varied sexual orientation, ethnic and national backgrounds. While most of our work is based in LMICs with an emergent interest in intersectionality, one of us has extensive experience applying an intersectionality lens to health

and social justice concerns in the USA. Our aim in this article is to introduce intersectionality to a broader health systems audience, outline its contributions and provide a list of key conceptual and empirical articles to further encourage intersectional analysis in LMIC health systems research and practice. In the sections below we explain in greater detail what intersectionality is, followed by an overview of ten articles that we felt effectively discussed what intersectionality is and/or how intersectionality analysis was incorporated into health systems research.

What is intersectionality?

Intersectionality is useful for health systems research as it allows us to improve our understanding of inequality through better reflecting the complexity of the real world. It moves beyond understanding social hierarchies either in isolation from one another (e.g. gender as separate from race) or in an additive manner (e.g. gender plus race equals greater disadvantage). Instead, it highlights social categories (such as gender, age, class and race) as mutually constituted and intersecting in dynamic and interactive ways (Bowleg, 2012; Hankivsky 2012b). Rather than seeing a particular social category as uniformly negative, intersectionality considers how individuals can simultaneously experience and embody privileges and disadvantage as different social hierarchies combine in varied ways across time and diverse locations. For example, black males in the USA may experience both social privilege (as a result of their gender) and disadvantage (as a result of their race), which differs from white males who experience social privilege in relation to the intersection of their gender and race. This becomes even more complex when you consider class, (dis)ability and/or sexual orientation. Furthermore, by focusing on social inequalities that are context specific, intersectionality does not make a priori assumptions regarding the importance of any one or multiple social categories, as a person's relative social privilege or disadvantage will be dependent upon the context in which they live (Hankivsky 2014; Ravindran 2014).

In addition to better understanding social inequalities, intersectionality pushes health systems researchers and activists to understand the drivers of such inequality. It seeks to understand how social identities and individual agency interacts with social processes and structural factors to reify and/or subvert inequalities in dynamic ways. It examines power relations as multi-level processes and therefore links the social circumstances in which marginalized groups are located to forms of discrimination and the structural factors underpinning them. For example, Figure 1 depicts how each individual is located not only in a unique nexus of overlapping forms of individual identity that co-constitute one another, but are also shaped by and interact with diverse categories of social and structural discrimination (Hankivsky 2014; Simpson 2009). Kennedy *et al.* (2013) describe how within the Swazi health system (third ring), social homophobic and discriminatory forces (second ring) compound a male's identify as HIV-positive and as a man who has sex with men (first ring). This produces a specific circumstance of power, privilege and identity that contrasts with the experiences of HIV-negative men who have sex with men, HIV-positive men who do not have sex with men, or HIV-positive women who may or may not have sex with men (inner circle).

More than just an analytical method for understanding how different social inequalities combine, intersectionality is understood as a broader philosophy underlying researcher and activist engagement (Nygren and Olofsson 2014; Ravindran 2014). Even when examining the experience of elite or middle groups, it does so to better understand how power relations structure social benefits and harms

with implications for the lived experience of those most socially vulnerable or disadvantaged (Sen *et al.* 2009). Intersectionality ideally has transformational aims, seeking to give voice to those most marginalized, linking directly with community-based initiatives where possible (Hankivsky 2012a). In doing so, reflection on the positional and power of all actors involved in its use is vital.

Intersectionality is an important approach for health systems research because it better reflects the dynamic nature of human experience, its inequalities and interaction with social context. It also highlights principles for orienting research and activist engagement for building relationships that challenge and transform power relations to sustain more responsive and equitable health systems. We summarize some of these key elements in Table 1.

Profile of intersectionality analysis in public health

Before reviewing the 10 best resources we recommend, we discuss here our process for identifying and selecting these resources. We started with a preliminary review of articles using intersectionality in public health. After experimenting with a range of terms in Pubmed ('Intersectionality', 'Intersectionality LMIC', 'Intersect* LMIC', 'Intersectionality Health' and 'Intersections Health'), the

term 'Intersectionality Health' was selected as it generated the highest number of articles and those that were the most relevant. Pooling together articles known by team members and those from Pubmed from any time period, we generated a database of 104 potential articles. We reviewed the abstracts and rejected any that were not in English, did not relate to health or did not have an abstract.

The final number of articles totaled 86, most being published since 2009, with 33 being conceptual in nature and 53 being empirical in nature, i.e. presenting results based on primary or secondary data. Among those articles that were empirical in nature, only 14 were from LMICs (one of which addressed issues in both high- and low-income country contexts) (25%). The majority of the empirical LMIC articles were qualitative ($N = 11$), with only three using a quantitative analysis, and none implementing a mixed methods approach. This contrasts with the empirical articles focused on high-income countries (HICs), where although 17 of the articles were qualitative, 21 articles were quantitative and two applied mixed methods.

While intersectionality argues against a priori assumptions about any one social stratifier, it does come from critical feminist analysis. We therefore present the gender focus across all empirical articles. In HICs, the majority of articles center on women's lived experiences ($N = 22$), followed by articles that examine both men and women ($N = 18$), with only three articles using an intersectional analysis to understand how power relations affect men. Among LMIC empirical articles, an almost equal distribution exists between papers focusing on men and those focusing on women ($N = 3$ and 4 , respectively), with more articles considering both men and women ($N = 7$).

When examining intersections across different stratifiers, empirical papers set in HICs primarily analyse how gender intersects with race/ethnicity/caste ($N = 20$), gender and economic status ($N = 15$), and race/ethnicity/caste and economic status ($N = 13$). In LMICs the main intersectional analysis occurs between economic status and gender ($N = 3$) or economic status and race/ethnicity/caste ($N = 3$) (Table 2). In terms of health topics, intersectionality has been applied to a broader range of topics in HICs, starting with mental health and access to healthcare, while in LMICs many of those who have used intersectionality work on HIV (Figure 2). While almost all the LMIC articles focused on the unique vulnerabilities of certain populations and how this affected their health outcomes, intersectionality was also applied to the experience of Caribbean, female, migrant nurses and to Lebanese female managers (Jones *et al.* 2009; Tlais 2013). Both articles highlight how female health personnel shape their careers in negotiated manners with broader social determinants at micro-, meso- and macro-levels that intertwined gender

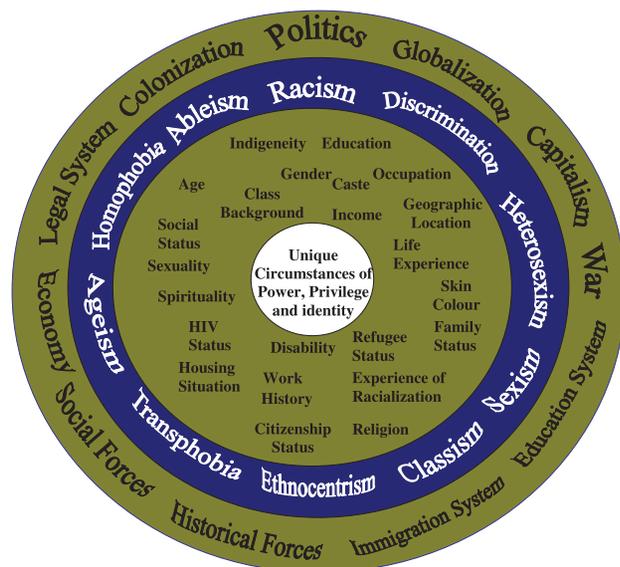


Figure 1 Intersectionality wheel (Simpson, 2009).

Table 1. Intersectionality: What it is and isn't

Focus of intersectionality	What it is...	What it isn't...
Social inequality	Based on mutually constituted and intersecting social categories	Based on adding up advantages and subtracting disadvantages assuming equivalence between them
Dynamic nature of inequality	A way of understanding inequalities as dynamic relationships	A static examination of inequalities which omit relational aspect
Contextual dependency	Based on the understanding that power configurations are time and location dependent	A group of a priori assumptions regarding the importance of any one or multiple social categories
Structural and political context	Focus on structural and political factors which shape inequalities	Focus on individual behaviour without consideration of structural and political constraints
Power relations	Explores how social inequalities are shaped by power relations	Ignores the impact of power relations on social inequalities
Implications for most disadvantaged	Focus on implications for vulnerable and marginalized within a group	Focus on implications for those whose status are protected or elevated with a group
Researcher reflexivity	Researchers reflect upon how their own background identity shapes research process and interpretation of results	Researchers attempt to completely remove themselves from the research and analysis process

Table 2. Axis of inequalities examined in empirical intersectionality articles published between 1997 and 2015 ($n=53$) by region. Represents one way of counting the number of intersecting analysis, not the total number of articles reviewed. Each box represents the number of times that particular intersection was addressed within the articles reviewed

	Race/ Ethnicity/ Caste	Gender	Economic status	Immigration status	Sexual orientation	HIV status
Race/ Ethnicity/Caste	X	20	13	0	8	0
Gender	2	X	15	7	6	3
Economic status	3	3	X	5	0	4
Immigration status	0	0	0	X	3	2
Sexual orientation	0	0	1	0	X	2
HIV status	0	2	1	0	2	X
	HIC					
	LMIC					

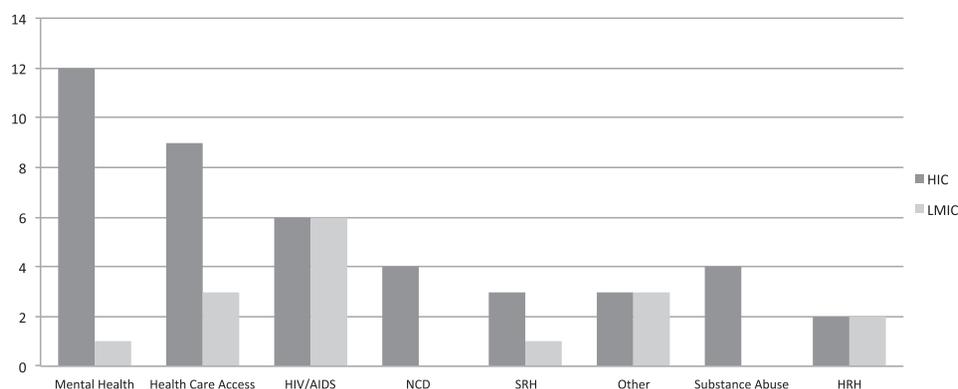


Figure 2 Health topics examined by empirical intersectionality articles published between 1997 and 2015 by region ($n=53$).

with religion, ethnicity, class, migrant status and family structures. We did not find any articles that further examined how this dynamic and varied social profile of providers intersected or interacted with that of patients to influence the care provided.

After a full reading of each LMIC article, we selected best examples of intersectionality, based on the proportion of the article that was devoted to intersectionality, and the strength of the intersectionality analysis using Table 1 as a guide. Out of the 14 empirical articles that did include intersectionality in some way in a LMIC context, we highlight six as best examples. Additionally, four conceptual articles were included as key resources on intersectionality.

Resources that explain intersectionality conceptually and as a methodology

Hankivsky's *Intersectionality 101* (2014) is an easy to understand, succinct primer that provides useful definitions, summarizes key tenants and clarifies the aspects that make intersectionality appealing to public health. She also outlines interdependent principles 'that can guide the "doing" of intersectionality-informed work', including how social categories are seen; the importance of multi-level analysis; how power drives inequality; the role of reflexivity; how change occurs over time and across contexts; the need to respect diverse forms of knowledge; focusing on social justice and equity aims; and the importance of resistance and resilience. Hankivsky reviews how intersectionality differs from unitary or multiple approaches to understanding inequality, and

also how it is distinct from different forms of sex and gender-based analysis and health impact assessments.

In addition to the above conceptual article, we recommend Sen and Iyers's (2009) quantitatively focused *A Methodology to Analyse the Intersections of Social Inequalities in Health* and Christiansen and Jensen's (2012) qualitatively focused *Doing Intersectional Analysis: Methodological Implication for Qualitative Research*. Apart from their explanations of how to apply intersectionality methodologically through quantitative and qualitative analyses, respectively, they also highlight important principles of an intersectionality approach. Sen and Iyer (2009) argue that the layering of social hierarchies at the extremes of inequality (non-poor men vs poorest women) is largely predictable. Focusing on middle groups (e.g. non-poor women, poor men, poor women and poorest men) can instead reveal more about how power relations combine privilege and disadvantage across social hierarchies. With a focus on qualitative approaches, Christiansen and Jensen (2012) demonstrate how life-story narratives and explanations of everyday life can provide unique insight into people's lives. They provide the example of two female Somali immigrants residing in Denmark, who without a focus on their life-stories, could be assumed to have lived the same trajectories. Rather, one's life-story describes a woman with a well-established family and access to numerous resources, while the other chronicles a woman who is far from family and struggling to get by. These stories show how seemingly similar people's lives contrast based upon how power and privilege impact their lived experiences.

Since intersectionality remains a developing field, many methodological questions surround it, both in deciding whether to use quantitative or qualitative methods and in identifying the best analytical approach (Bauer 2014). Many of the reviewed articles, including Bowleg's (2008) *When Black + Lesbian + Woman ≠ Black Lesbian Woman: The Methodological Challenges of Qualitative and Quantitative Intersectionality Research* reflect this challenge. Bowleg employs two previous studies, one quantitative and one qualitative, to respond to the following three queries: (1) How to develop questions to measure intersectionality; (2) How to analyse intersectionality data; and (3) How to interpret intersectionality data. In this way, the article allows readers to reflect upon these questions, and provides insights into overcoming barriers to the successful implementation of intersectionality in research.

Quantitative applications of intersectionality in LMIC

Although less prevalent in LMIC than in HIC contexts, strong examples of the use of a quantitative approach to perform an intersectionality analysis in LMICs exist. Both of the articles we discuss demonstrate how leveraging gender can overcome disadvantages presented by economic status in ways that allow individuals to overcome, or be further entrenched in, social inequalities that are context specific. Sen and Iyer (2012) use dummy variables to represent intersecting categories of gender and class in initiating and continuing treatment based on household survey data. They reveal that poor men in India can leverage their gender to overcome low economic status, thereby matching the same levels of non-treatment as men of higher economic standing. Non-poor women in contrast had higher rates of non-treatment than men of similar economic standing because of gender discrimination. More traditional forms of analysis that singularly look at gender or economic status may overlook this convergence, leading to policies and programs targeting poor populations as a whole, rather than poor women who possess a greater need due to their inability to leverage gender.

Joe (2014) expands upon Sen and Iyer's (2012) quantitative approach and employs a group analogue of the Gini coefficient to determine the magnitude of inequalities in immunization in India. Unitary analysis showed that urban, male and non-scheduled caste and scheduled tribe (SCST) children were better off. However, with an intersectional analysis, immunization coverage gaps between rural, female, SCST children and urban, male, other caste children were even wider, confirming that social hierarchies consolidate disadvantage at the extremes. Joe concludes that greater intersectional inequalities exist in regions with poor immunization coverage, and similar to Sen and Iyer (2012), that understanding intersectionality not only confirms the extremes across social hierarchies, but also at times leads to findings that defy conventional wisdom. When adjusting for wealth and mother's education, rural males had the highest chance of immunization in contrast to urban, female, SC/ST children. Policy and programme implications include the need to focus on female and SC/ST children and inequalities in urban contexts, rather than focus on class alone.

Qualitative applications of intersectionality in LMIC

Both Kennedy *et al.* (2013) and Mburu *et al.* (2014) utilize an intersectional analysis to understand the lived experiences of HIV-positive men in Swaziland and Uganda, respectively. Kennedy *et al.* (2013) identify the juncture of laws, institutionalized discrimination, a man's identity as HIV-positive and a man who has sex with men (MSM), which provides insight into how macro- and micro-level factors interact to affect healthcare access and personal health.

They discuss how the 'dual stigma' of being an HIV-positive MSM in Swaziland shapes experiences within both the healthcare system and in social settings, requiring policy responses specific to their social context. This article embodies a strong intersectional analysis because it explains how the multiple social inequalities of a disadvantaged population intersect. It is only through this understanding that we are able to comprehend that population's particular experience in accessing and receiving adequate healthcare, ultimately improving their health status.

Mburu *et al.* (2014) also examines HIV stigma, but does so in the context of how it interacts with masculinity to inhibit male participation in peer support groups and access to healthcare services in Uganda. Therefore, the article was included because it uses intersectionality to discuss how, although perceived as socially stigmatizing, participation in the peer support groups that support economic opportunities can help HIV-positive men because of how the groups provide opportunities to reshape HIV-positive male identities. As most peer support groups went against what was perceived as masculine and marked men as HIV positive, not only did they tend not to participate, but also when they did so, men tended to assume the more physically demanding roles and chairmanship, even in predominantly female groups. Furthermore, income-generating activities in peer support groups enabled men to resume their breadwinner roles and cushioned them from HIV stigma. Without the use of an intersectional analysis, the dynamic relationship between masculinity and HIV stigma, and the importance of economic activities in peer-support groups may not have been recognized. Rather, Mburu *et al.* may have reached the conclusion that stigma alone keeps HIV-positive men from accessing services and not sought out gender transformative interventions that enable prevailing notions of masculinity and their intersections with HIV stigma to be revised.

Through the use of a qualitative intersectional analysis, Parikh (2012) addresses the unintended consequences of the implementation of a Defilement Law in Uganda, which increased the age of sexual consent from 14 to 18 years. The article concludes that the exact power relations it aimed to address, protecting young women from 'sugar daddies', undermine this law. To reach this conclusion, the article describes how the intersections of gender, age and economic standing impact sexual access to schoolgirls and their health (HIV status), and demonstrates that in fact, young, poor males more frequently face prosecution under this law rather than older, richer sugar daddy-types. Had this article not employed an intersectional analysis, Parikh may not have uncovered why this phenomenon occurs, with its roots in economic inequality and the historical context of the region. This article was included because it utilizes intersectionality to show how historical factors combine with structural interventions such as the law to and exacerbate social inequalities and power dynamics.

The final article that we recommend (Grineski *et al.* 2013) highlights how the macro-level context of employment and violence interacts to reorder and at other times reaffirm the gendered positions of poor parents in Juárez, Mexico. Men's role as the primary provider pressures them to exit their houses more often than females do, putting males at increased risk of violence. As women cannot travel outside alone, men became more involved in accompanying women when seeking child health care, albeit by emphasizing their protective roles. Women were interned in their homes, but despite corresponding stresses, had more time to chat and build family intimacies that supported resilience. This article highlights how intersectionality helps to go beyond studies that only measure incidence of violence, to reveal intersecting gender and class nuances in the narratives of those living with violence. In addition, it is also a good example of

reflexivity and the engagement of researchers with community-based organizations working with marginalized communities.

We hope this overview and selection of articles encourages further use of intersectional analysis within health systems research. By increasing understanding of how disadvantage is experienced through the fluid and situational interaction of multiple social determinants and their structural drivers, intersectionality guides more appropriate policy and programme responses and highlights opportunities for research partnerships that not only reveal, but build the basis for, changing inequalities that mar health systems. In doing so, it strengthens the foundations of justice within people-centered health systems in LMICs.

10 best resources

Conceptual

Hankivsky O. *Intersectionality 101*. Institute for Intersectionality Research & Policy, SFU; 2014 April

Bowleg 2008. When Black + lesbian + Woman ≠ Black lesbian woman: the methodological challenges of qualitative and quantitative intersectionality research.

Sen G, Iyer A, Mukherjee C. 2009. A methodology to analyse the intersections of social inequalities in health. *Journal of Human Development and Capabilities* 10:397–415.

Christiansen and Jensen's *Doing Intersectional Analysis: Methodological Implication for Qualitative Research* (2012).

Quantitative

Sen G, Iyer A. 2012. Who gains, who loses and how: leveraging gender and class intersections to secure health entitlements. *Social Science & Medicine* 74:1802–11.

Joe W. 2014. Intersectional inequalities in immunization in India, 1992-93 to 2005-06: a progress assessment. *Health Policy and Planning*.

Qualitative

Kennedy CE, Baral SD, Fielding-Miller R *et al.* 2013. 'They are human beings, they are Swazi': intersecting stigmas and the positive health, dignity and prevention needs of HIV-positive men who have sex with men in Swaziland. *Journal of International AIDS Society* 16(Suppl 3): 18749.

Mburu G, Ram M, Siu G *et al.* 2014. Intersectionality of HIV stigma and masculinity in eastern Uganda: implications for involving men in HIV programmes. *BMC Public Health* 14: 1061.

Parikh SA. 2012. 'They arrested me for loving a schoolgirl': ethnography, HIV and a feminist assessment of the age of consent law as a gender-based structural intervention in Uganda. *Social Science & Medicine* 1774–82.

Grineski SE, Hernández AA, Ramos V. Raising Children in a Violent Context: An intersectionality approach to understanding parents' experiences in Ciudad Juárez.

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