

What is intersectionality and what promise does it hold for advancing a rights-based sexual and reproductive health agenda?

Anuj Kapilashrami 

Global Public Health Unit,
Centre for Primary Care & Public
Health, Queen Mary University of
London, London E1 4NS, UK

Correspondence to

Dr Anuj Kapilashrami, Global
Public Health Unit, Centre for
Primary Care & Public Health,
Queen Mary University of
London, London E1 4NS, UK; A.
Kapilashrami@qmul.ac.uk

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INTRODUCTION

Significant progress has been achieved in the field of sexual and reproductive health (SRH) in the last three decades as evident in global commitments and national legislative, policy and programme level reforms. However, such progress is truncated by decades of low prioritisation, weak political commitment and funding,¹ political backlash, and systematic assault on the broader set of socioeconomic and civil-political rights necessary for SRH. Amid these challenges, adoption of the Sustainable Development Goals (SDGs) is promising for its explicit recognition of the importance of SRH rights for development, and for offering an integrated framework of goals that address both entitlements (ie, positive right to services, medicines and information) and freedoms (from violence and discrimination) necessary for full realisation of the broad spectrum of sexual and reproductive health and rights (SRHR) (see [box 1](#)). Their ‘universal’ premise, however, calls for a more nuanced assessment of how systems and provisions can be made more responsive to the SRH needs of those who are left behind and remain excluded from mainstream policy and planning. Such assessment will benefit from an explicit adoption of the ‘lens’ of intersectionality in examining and tackling SRH challenges.

WHAT IS INTERSECTIONALITY?

Intersectionality is both a theoretical and methodological ‘lens’ that brings attention to the distribution of power in society and in analysing how these power structures and wider social, political and economic processes shape our everyday interactions, experiences and

outcomes.^{2–4} When applied to health, this approach challenges the view that our health is shaped by individual factors (such as biology, income levels, education) or singular identities (Black or Asian, refugee or internal migrant, women or men). Instead, it argues that these factors do not work in isolation but interact with each other to co-determine inequalities and shape health across contexts and populations groups.⁴

Intersectionality contributes to our understanding of inequalities in three distinct ways.

First, it challenges assumed similarities within population groups, revealing important differences that are often made invisible when calling attention to universal experiences and vulnerabilities of specific identity groups such as ‘women’, ‘men’, ‘migrant’, ‘adolescent’, and so on. In the context of SRHR, this calls for unpacking harmful biases and differences related to class, ethnicity, race, disability and other social inequalities among these groups to inform more targeted policy and programme responses. Such a view is critical for SRH, which in both clinical and community settings poses important challenges and dilemmas related to differential experiences of common problems based on individuals’ social position and reality. Here, I impress on the importance of examining the unique disadvantages as well as privileges afforded by different aspects of these social locations. This is because people may experience privilege and oppression simultaneously. For instance, a young white heterosexual woman may be disadvantaged in seeking sexual health services due to her age and gender but will have the relative advantage of race and sexuality over a young



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Box 1 Synergies between SRHR and SDGs**Goal 3: Ensure healthy lives and promote well-being for all at all ages.****Target 3.1**

By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 births.

Target 3.7

By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Target 3.8

Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.**Target 4.7**

By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence and appreciation of cultural diversity and of culture's contribution to sustainable development.

Goal 5: Achieve gender equality and empower all women and girls.**Target 5.2**

Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

Target 5.3

Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

Target 5.6

Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD [International Conference on Population and Development] and the Beijing Platform for Action and the outcome documents of their review conferences.

lesbian Asian woman living in the UK. The latter may be constrained by conservative cultural and familial norms, as well as in having to navigate a health system that may be ignorant, alienating or even hostile to her needs.

Second, it suggests that social identities and structures of disadvantage do not simply add together but are interdependent, mutually constituting and reinforcing. For example, the 'intersectional' experience

of a migrant woman seeking healthcare in transit will be greater than the sum of sexism experienced due to her gender and racism experienced due to her race and migrant status. Rather, her experience of migration itself is both gendered and racialised and impacted by immigration policies of the countries of origin, transit and destination.

Third, it enables an examination of the multiple sites and structures of power that interact to produce multiple levels of social disadvantage (or privilege). In doing so, it allows us to link individual lived experiences to institutional forces such as the role of religious institutions, State and market, legislation and policies, with the broader political-economic environment. The latter may include processes of displacement, conflict, climate change and growing conservatism within which SRH policies are being implemented.

Having described the key tenets of intersectionality, I now illustrate its relevance to SRHR in relation to the critical challenge of access to comprehensive SRH services, information and rights.

INTERSECTIONAL VIEW OF INEQUITIES IN SRH CARE

Despite wider momentum around integrating SRHR goals within the framework of Universal Health Coverage (UHC) and in national strategic plans (SDGs 3.7 and 3.8), critical gaps remain in equal access to SRH services. Some studies point to a narrowing of social inequalities in the use of family planning and maternal health services such as modern contraceptives, antenatal care and skilled attendance at birth, suggesting improvements in reproductive health equity.^{5 6} However, these studies tend to focus largely on socioeconomic position, measured by differences across wealth quintiles. In-depth countrywide assessments reveal more complex patterns: significant variations within and across countries and SRH services, and across social disadvantages related to place of residence (rural-urban), education and wealth.⁷ For example, an assessment of six countries revealed that the barriers to access and use of specific reproductive health services are most pronounced for women residing in rural areas, remote and island regions, indigenous and ethnic minorities, and for large populations of international migrants.⁶

A further disadvantage is reflected in poor SRH service coverage and use by young people and adolescents that lags behind national averages. It is well established that young people's distinct emotional, physical and psychological needs in their transition to adulthood, and their economic vulnerability undermines their access to services and information on sex, contraception and reproduction.⁸ While these factors affect all young people, wherever they live, their unique experiences of care and information seeking are mediated by a number of interacting factors and processes. Among these, gender is prominent. Forced into early

marriage and motherhood (and repeated pregnancies), young girls in large parts of Asia carry heightened risk of maternal morbidities and SRH infections.⁹ Yet, marital status and pregnancy create opportunities for them to use healthcare systems, receive information and needed healthcare. For unmarried girls, accessing sexual health and contraceptive services carries even greater stigma, discrimination and isolation from the community and family, increasing their risk of infections and unsafe abortions.¹⁰

Healthcare systems are a vital component to improving young people's SRH needs. Yet, the need for parental consent, social attitudes of providers, and legal frameworks that criminalise certain sexual practices and behaviours impede young people's access. These challenges are compounded because systems mirror prevailing gender-power relations and inequalities in society.¹¹ Experiences of racism, casteism, sexism and ableism abound in healthcare settings and create significant SRH burden and fragmented care and information pathways for young migrants and those from historically marginalised caste or indigenous groups. Furthermore, SRH services and interventions presume cis-gender and heterosexual identities and relationships as norm, in the process, stigmatising sexual and gender minorities and rendering their diverse needs invisible.¹² For instance, transgender people are disempowered in their experiences of services related to fertility, menstruation and pregnancy that presume female bodies as the norm and ignore the specific reproductive and psychosocial needs of transgender men arising from their gender identity, body dysphoria, or others' perceptions of their pregnant body.¹³ Adopting a homogenous view of young people and their diverse circumstances can thus counter the promotion of inclusive systems that are responsive to different needs.

Policymakers and practitioners need to be cognisant of differences arising from multiple social realities, and mindful of their own assumptions and prevalent social biases. At the same time, they need to scrutinise policies and interventions for their exclusions and oppressive effects. While youth-friendly open times and distance to sexual health clinics may indeed address coverage, their use will remain a challenge in conservative social and political contexts where health workers fail to deliver appropriate, non-judgemental and supportive services to diverse young people.¹⁴ Here, scholars stress on the importance of improving cultural sensitivities and competence among providers to respond to the health needs of culturally and linguistically diverse populations.^{15 16} This can reduce the gap between interventions and minority communities' expectations that impede their access to SRHR. However, tackling exclusion demands confronting structures and processes that engender stigma and discrimination as well as ensuring that SRH interventions do not inadvertently reinforce negative norms that disadvantage populations.

As countries define their national policies and priorities towards achievement of UHC in alignment with the SDGs, there is a unique opportunity to ensure that policies and interventions prioritise a progressive SRHR agenda that has equality, solidarity and social justice as its core premise. This requires a fuller understanding and appreciation of the ways in which multifaceted power structures and social inequalities perpetuate inequities in SRHR. It also calls for careful consideration of how policies and programmes affect diverse populations (i.e. who benefits, who is excluded from goals, priorities and resource allocation)¹⁷ to create enabling environments that support well-being, social inclusion and equality. This progressive call to action demands mainstreaming of intersectionality in SRH policy, research and practice.

Twitter Anuj Kapilashrami @AKapilashrami

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ORCID iD

Anuj Kapilashrami <http://orcid.org/0000-0002-6719-9216>

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