Policy Brief: The Strongest Link: advantages of an intersectional approach

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This is one of an initial five Policy Briefs developed by the Centre for Sexualities, AIDS and Gender at the University of Pretoria, for the Irish Embassy Pretoria, as a follow on to training provided by the Centre to Irish Aid personnel at the University from 18 – 21 April 2016. The aim of these Policy Briefs is to expand briefly on a core topic area relevant to the intersections between HIV and AIDS, gender, gender-based violence and sexualities, providing the reader with a brief background, an examination of key issues and setting out challenges for those working in the field.

Context

One of the key challenges in HIV work which strives to offer nuanced prevention, treatment and care initiatives which are relevant to the diversity of individuals, populations and contexts, is finding the balance between "structure" (the economic, social, cultural, political, legal, policy and other systems which shape behaviour) and "agency" (the amount of control and choice an individual has over their life).

Structural factors can be seen as those which "push" behaviour (drivers, like socio-economic need) and those which "channel" behaviour (enablers or inhibitors, like gender norms). Individual factors describe the many personal characteristics (such as personality, gender, race, age, class, sexual orientation, ethnicity, dis/ability) we all bring to our intra - and inter-personal dynamics. If we also factor in the effect of other variables and factors – the causal pathways which may account for choices; whether influences are close (proximal) or far (distal); and the levels at which our interventions occur (micro, meso and macro) – we can see that there can be no "one size fits all" approach to HIV work.

Here are some examples of push factors, inhibitors and enablers that can act as possible influencers of human choices, action and experience:

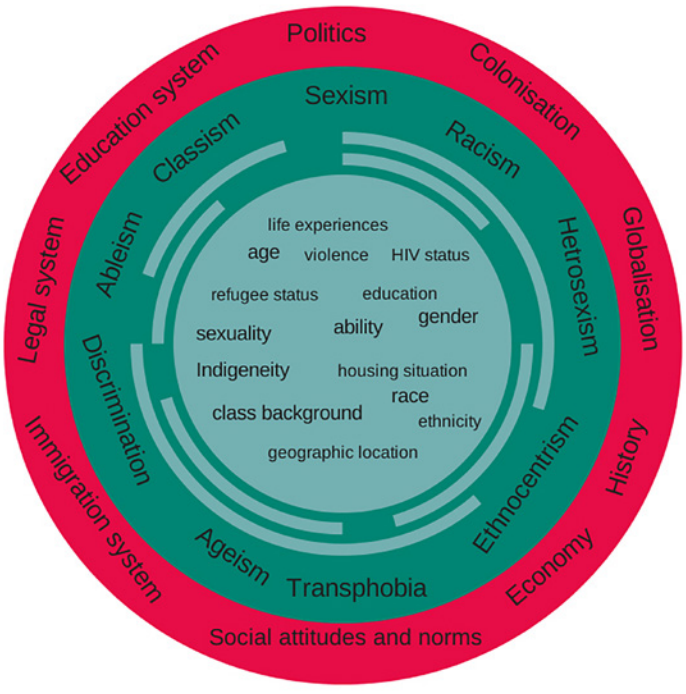
In addition, there has been the rise of the idea of "key populations", seen as those most likely to be living with HIV, or as most vulnerable, or as linked to the possibility of transmitting HIV. Examples include men who have sex with men, sex workers and people who inject drugs, but also, in some contexts, young women. A challenge in this approach is to not treat key populations as one thing, as a homogenous group, but to factor into our work the nuances of structural and individual variations.

One way to do this is to adopt an intersectionalities approach.

Evidence

What is intersectionality?

Intersectionality was born out of the Black feminist movement in the United States and has emerged in feminist theory as an approach that focuses on multiple historically oppressed populations. Coined in 1989 by American critical race scholar Kimberlé Crenshaw, it has its roots within and beyond the United States in the work of Latina, post-colonial, queer and indigenous scholars examining the complex factors and processes that shape human lives. These scholars and activists were asking new questions about how the various aspects of each person's identity position them differently in relation to power and privilege.



What are the key take-home messages on intersectionality?

- Human experiences cannot be reduced to singular characteristics, such as being female or Black, as these characteristics interact with others to produce health outcomes. For example, to be black and female and poor might mean a very specific health outcome.

- Using singular social categories, such as class, race, gender or sexual orientation in HIV work risks masking the lived experiences of people with multiple social identities that intersect and affect their health and wellbeing, in ways which are dynamic and ever changing. We need to explore the meanings of these social categories as a starting point for our work, recognising that people do not live "single-issue" lives.
- Intersectionality theory suggests that multiple social identities and categories are not additive: that is, an HIV positive woman who injects drugs does not face the same challenges and have the same needs as the sum of the needs of an HIV positive individual, a woman and a person who injects drugs. Rather, that woman's lived experience is a unique and ongoing intersection of these identities, and we should be wary about generalising.
- Because intersectionality is rooted in understanding how social structures oppress people, based on the unique meeting points of their identity, it also acknowledges the role of power, stigma, discrimination and exclusion in health access, noting that even those who are oppressed may have some power. This approach addresses the micro-level (the personal and interpersonal), the meso-level (society and community) and the macro-level (national and other systems and structures) in looking at health inequalities.
- An intersectional approach to health tries to find the balance between ways in which people are the same and different, the ways in which different identities and contexts shape lives in an ongoing, interactive and ever changing way; and asks about power and systems and their role in shaping health and life opportunities.

Strategies

There is no one single way to adopt an intersectional approach to HIV work. Parkhurst, while not explicitly calling his approach "intersectional", might be said to adopt elements of an intersectional approach.

He calls for a "package" of interventions for a local target population, and the intervention strategy and the choice of actual activities should be the result of a process of identifying relevant structural drivers or barriers/enablers which respond to the needs of a specific target population in a way that is feasible to implement. This approach also recognises (or should) that a specific target population is itself a combination of many differences.

He calls this a "decision tree", where a series of questions are answered, or a series of steps are taken, to arrive at an intervention and evaluation strategy. Included in this decision tree process should be a critical examination of our assumptions about identity categories (such as race, class and gender), which is a core aspect of intersectionality.

One famous paper by McCall suggests three approaches to thinking about identity categories:

- The inter-categorical approach: here we are critical of categories but recognise that unequal relations within social groups are associated with worse health outcomes, so we use the idea of a category (e.g. woman) as a starting point. And rather than just looking at the category "young woman" in relation to health outcomes, an intersectional approach here would look at the health outcomes of different kinds of young women.
- The anti-categorical approach: here categories are rejected and unpacked, and our starting point to this intersectional approach is to ask people lots of open-ended questions about themselves so that we learn about their intersecting identities and experiences. Here we would ask young woman to tell us their health stories.
- The intra-categorical approach: here categories are also seen as limited in being able to capture the complexities of identity, especially for those people whose identities are neglected or cross over the boundaries of existing categories. Here we might problematize the term "woman" and explore the health outcomes of trans women, or people who identify as intersex or agender.

Measuring the impact of an intersectionalities approach

Hankivsky *et al* draw on intersectionality theory to describe an "Intersectionality-Based Policy Analysis (IBPA) Framework" which captures and responds to the multi-level interacting social locations, forces, factors and power structures that shape and influence human life and health.

The IBPA Framework has two core components: a set of 8 guiding principles and a list of 12 over-arching questions to help shape the analysis:

Guiding principles:

- Equity
- Social justice
- Diverse knowledges
- Time and space
- Reflexivity
- Power
- Multi-level analysis
- Intersecting categories

Descriptive questions:

- What knowledge, values and experiences do you bring to this area of policy analysis?
- What is the policy "problem" under consideration?
- How have representations of the "problem" come about?
- How are groups differentially affected by this representation of the "problem"?
- What are the current policy responses to the "problem"?

Transformative questions:

- What inequities actually exist in relation to the "problem"?
- Where and how can interventions be made to improve the "problem"?
- What are feasible short, medium and long-term solutions?
- How will proposed policy responses reduce inequities?
- How will implementation and uptake be assured?
- How will you know if inequities have been reduced?
- How has the process of engaging in an IBPA transformed:
  - your thinking about relations and structures of power and inequity?
  - the ways in which you and others engage in the work of policy development, implementation and evaluation?
  - broader conceptualisations, relations and effects of power asymmetry in the everyday world?

Applying the IBPA Framework to HIV work could be one way of subjecting an HIV intervention, whether it is a prevention, treatment or care programme, to a form of analysis which acknowledges the complexities of social and identity categories, allowing for the design of a policy or programme which is nuanced, sensitive and dynamic.

Examples of using intersectionality in HIV work:

- A community-based study looked at HIV positive, lesbian, bisexual, queer women and transgender women – they felt excluded from HIV research and faced inter-locking barriers (e.g. stigma and heteronormative assumptions) that reduced their access to HIV care and support
  A study which looked at the role of racism, unemployment, incarceration and police surveillance on black heterosexual men in the US and the effects of these factors on their HIV risk
- A study which examined the multiple identities affecting the sexuality and HIV risk of Latina women with severe mental illness in New York
- A study which found aboriginal Canadian men and women with mental health concerns and on methadone maintenance treatments had experiences of racism, abuse and violence which made them wary of state health systems
- Multiple studies in the African context have shown that vulnerability to HIV in men who have sex with men is exacerbated by the combination (or intersection) of political, social, religious and cultural marginalisation – interventions must take this complexity into account. [1]

Critiques and challenges

One of the main ideas of intersectionality theory is that social identities, locations and categories are fluid and constantly changing based on time, place, social structures and power.

Thus, intersectionality-focused work in one community is unlikely to be relevant for another community, despite some similarities between populations. It is therefore important that intersectionality-based work be conducted according to specific historical, social, political, economic and cultural contexts.

Issues to flag

- Using intersectionality theory to highlight differences within a group, for example men who have sex with men, can run the risk of limiting the possibilities of that group to mobilise around the thing that makes them the same (that is, they have sex with other men) – practitioners of intersectionality informed work must find that balance between sameness and difference.
- Scholars, researchers and implementers need to consider their own social position, role and power in their work – this "reflexivity" is a key aspect of working in an intersectional way.
- Based on its origins, it is critical that we see intersectionality as being a social justice approach to health, which is explicitly aimed at transforming systems, not just individuals, and asking questions about the power (and who has it or not), and inclusion (who is in and who is out) and who has access to resources to change their lives.

1 Nicholas Muraguri , Marleen Temmerman & Scott Geibel (2012): A decade of research involving men who have sex with men in sub-Saharan Africa: Current knowledge and future directions, SAHARA-J: Journal of Social Aspects of HIV/AIDS: An Open Access Journal, 9:3, 137-147

- Intersectional work can be time consuming – it can be useful to link up with other practitioners thinking in this way to learn from each other.

References and Resources

(i) Intersectionality 101. Olena Hankivsky. Institute for Intersectionality Research and Policy (see https://www.sfu.ca/iirp/documents/resources/101_Final.pdf)

(ii) Intersectionality in HIV and Other Health-Related Research. Ontario HIV Treatment Network. Rapid Review #68: June 2013 (see http://www.ohtn.on.ca/Pages/Knowledge-Exchange/Rapid-Responses/Documents/RR68-2013-Intersectionality.pdf)

(iii) Intersectionality: A Tool for Gender and Economic Justice. Women's Rights and Economic Change. No 9, August 2004 (see https://lgbtq.unc.edu/sites/lgbtq.unc.edu/files/documents/intersectionality_en.pdf)

(iv) An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. Hankivsky et al. International Journal for Equity in Health 2014 13:119 (see https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-014-0119-x)

(v) Parkhurst, Justin O. 2013. Structural drivers, interventions and approaches for prevention of sexually transmitted HIV in general populations. Definitions and an operational approach. STRIVE research consortium.

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