Using Intersectionality to better understand health system resilience

Since 2010, RESYST researchers have been working to better understand complex health systems, focusing on the daily routines and challenges faced by health managers and how they continue to deliver services in the face of constant strain – a new concept termed everyday health system resilience. The research has involved engaging with health managers and other front-line health workers over a long period of time, and collaborating with them to identify and implement interventions that support everyday resilience.

In dealing with complex systems and multiple actors, operating at different levels of the health system and influenced by power relations, the research lends itself to intersectionality analysis – an approach that focuses attention on studying the interaction of different factors or social categories (rather than each in isolation or as simply additive), and the power structures that underpin them. This brief outlines the main tenets of intersectionality analysis and its value to health systems research. It then shows how an intersectionality lens is starting to be applied to RESYST research on everyday resilience and the potential of this approach going forward.

The value of intersectionality in health systems research

Intersectionality has increasingly been applied to health systems research, especially work that aims to understand and respond to health inequalities. There are several benefits to this approach.

Supports equity analysis
Intersectionality helps researchers to deepen their understanding of inequity through better reflecting on the complexity of the real world. It doesn’t make assumptions regarding the importance of any one social category, such as gender or race, as a person’s relative social privilege or disadvantage will be dependent upon the context in which they live (Hankivsky, 2014). For health systems, intersectionality analysis can be woven into examining distributive justice (fairness in inputs and outcomes), procedural justice (who is involved in decision-making processes and in what way), and interactional justice (the quality of relationships among people, including aspects of status and dignity).

Draws attention to the drivers of inequality
Intersectionality moves researchers beyond understanding individuals’ unique circumstances and identities towards considering the drivers of inequality and to examining power relations at both individual and macro levels. It contributes to generalisable knowledge, linking social circumstances of marginalised groups to forms of discrimination and the structural factors underpinning them (Larson, 2016).

Leads to more targeted interventions and policies
An intersectionality approach is supportive of rights and justice based approaches to health and health care. It can lead to precise insights about who is involved in and affected by policies or interventions in different settings, thus allowing for more targeted and effective policies (Hankivsky and Cormier, 2011).

What is intersectionality?

Intersectionality is a research approach that explores the interaction of different social categories such as race, ethnicity, gender, class, religion and sexuality. These categories might be fixed (e.g. race, ethnicity) or fluid (e.g. geography, occupation, migration status). They intersect in dynamic and interactive ways to privilege or disadvantage (oppress) different people depending on their characteristics and contexts.

Definition of intersectionality from Hankivsky, 2014

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. law, policies, state governments, religious institutions, media. Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created.

The approach goes beyond describing or documenting intersecting categories; rather it brings a set of principles to the research that place power as central to the analysis and that seek to redress imbalances by giving voice to those most marginalised.
In Kenya and South Africa, researchers have been exploring the routine challenges experienced by health managers and front-line workers and how they continue to deliver services in the face of constant strain. The research approach – termed a learning site - has involved engaging and collaborating with health managers and other front-line health workers over a long period of time to better understand the system from within. It also involves working alongside health managers and front-line workers to strengthen the system. Learning site work has contributed to current discourse on health system resilience, emphasising that attention needs to be paid to: a) everyday resilience and not simply responses to sudden shocks; b) health system software as well as hardware; and c) creative adaptation, and transformation, rather than simply bouncing back. An emerging framework (figure 1) outlines the different types of strategies used to overcome challenges faced by health managers, as well as the organisational capacities that drive what strategies are used, and whether or not they nurture everyday resilience. Within this framework, leadership practices are identified as being central to building the organisational capacities and strategies that underpin everyday resilience.

Research in Gender and Ethics (RinGs): Building Stronger Health Systems

RinGs is a partnership that brings together four research networks encompassing 23 institutions across 26 countries to galvanise priority for gender analysis in health systems research. Since its inception in 2015, RinGs has increasingly emphasized the need for an intersectional approach to gender analysis within health systems research, and has supported researchers in incorporating an intersectional lens within their work.

More information about RinGs:
http://resyst.lshtm.ac.uk/rings

Figure 1: RESYST framework for analysing everyday health system resilience
Incorporating an intersectional lens into the emerging everyday resilience framework

An intersectionality lens can be woven into the everyday resilience framework by asking questions such as who are the actors in the health system, and how do intersecting aspects of their identity (such as gender, class, professional cadre and location) influence their involvement in organizational processes and health system functioning? Does identity influence who takes up leadership roles and leadership experience at different levels of the health system, including whose capacities are drawn upon and built up through routine organizational processes?

Questions may also be about who gains and loses (both within and outside the health system) from the kinds of strategies that are revealed in routine organizational processes? And whether these gains and losses suggest a move towards greater equity in relation to intersecting social categories over time (an indicator of resilience) or greater inequity (an indicator of maladaptation)? Importantly, an intersectional lens requires us to examine the mechanisms behind and drivers of differences between actors (whether distributive, procedural or interactional) based on their identities.

These questions are complementary to the transformational interest embodied in RESYST’s concept of everyday resilience. Everyday resilience is not about maintaining the status quo, or promoting inaction, but about identifying and building agency, adaptation and transformation. Intersectionality analysis ensures we take seriously who has voice and agency in action, and if and how system adaptation and transformation differentially impacts on staff and public.

Everyday resilience sees strategies for change as being both bottom up from within the system and as highlighting wider or higher-level action needed to challenge the political economy that contributes to system shocks and stressors. Intersectional analysis promotes understanding of the drivers of inequalities and differences in health systems and the people they serve. In revealing (and challenging where appropriate) processes of privilege, marginalisation and discrimination, an intersectional lens is key to understanding the software of the health system.

Intersectional analysis of challenges faced by health managers and front-line health workers

RESYST will start applying an intersectional lens to the analysis of the shocks and stressors experienced by health managers and frontline providers in order to deepen their learning and impact. For example, in Kenya, one of the shocks identified soon after health system devolution in 2013, was salary delays and job insecurity. This created tensions between managers and facility workers, contributing to a series of health worker strikes and staffing shortages.

Using an intersectional analysis to further investigate these shocks could help identify differing levels of job insecurity faced by health workers based on their ethnicity, gender, type of education and migration status. For example, whether nurses that were not local to a county feared discrimination from new county managers causing them to move locations. A sense of feeling othered and an outsider may have, for example, been strong among some groups and contributed to greater likelihood to move jobs. If this was the case, the drivers of these inequalities in job security would need to be explored, and the implications for everyday health system

Intersectional analysis and health system leadership

Recognising that health system leaders and managers are far from homogenous, a RESYST study examined the role of gender in career progression and leadership at sub-national level in Kenya, Nigeria and South Africa. In all three countries professional categories and hierarchies played a dominant role in career progression, with a tendency for medical doctors to be preferentially selected for leadership roles. There were, however, unique country-specific aspects in each setting. For example, in South Africa, although medical doctors were more likely to be selected for leadership positions, the intersection of professional category with race and gender had an important influence on leadership appointment and experience.

“I had my first challenges at [X] hospital. Because I was asked to act [as medical superintendent] it was a huge issue, it caused a lot of conflict. The white male establishment gave me a hard time… They wrote long letters wanting me to be removed, [saying] I’m causing havoc”

(Mixed-race female health manager, South Africa)

In Kenya, the intersection of professional hierarchies and gendered socio-cultural norms and expectations had an important influence. In particular, the role of women as child bearers and nurturers influenced their appointment to leadership positions and career progression. Across all three countries, the study highlighted that a range of contextual factors intersect with gender to influence experience, including professional hierarchies, social and political networks, and the nature of appointment to health leadership positions.
resilience considered. Widening inequities in shocks and stressors faced by health system staff, and in the quality and range of health services offered across counties, would potentially be an indicator of health system maladaptation as opposed to resilience in the longer term, and suggest the need for specific policies and interventions to strengthen equity and build resilience.

**Leadership and management support to nurture resilience**

There is potential value in applying an intersectionality lens in other ways, such as in thinking about interventions or policies to strengthen health management.

Current research is investigating how everyday resilience is influenced by mid-level managers and their leadership practices, including tracking interventions aimed at building their soft skills (such as communication, motivation and responsibility). Examples of two interventions being tracked are coaching initiatives (South Africa) and participatory training in communication with colleagues and emotional management (Kenya). To enrich their learning and impact, researchers will be considering whether the types of support needed for mid-level managers differ based on intersections between ethnicity, gender, type of education and training.

**Taking intersectionality forward**

This brief has highlighted the potential of introducing an intersectionality lens to qualitative health systems research. Even small steps to incorporate it can help deepen our understanding of health workers and the power relations and intersecting factors that affect how health systems function.

For RESYST, intersectionality work to date has been a process of experimentation and of sharing new learning with the wider group of researchers to take forward in their work. Moving forwards, we will adopt a more structured approach with clear research methods, drawing on new guidance about how to apply intersectionality in practice in health systems research.

**Questions for researchers**

For researchers hoping to adopt an intersectionality lens for their work in future, here are some key questions and resources that might be helpful.

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<thead>
<tr>
<th>Inception phase</th>
<th>How might your own, or your research teams’ social position play a role at each stage of the research process?</th>
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<tbody>
<tr>
<td>Research question</td>
<td>What social identities are relevant to the study and most dominant in the context?</td>
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<tr>
<td>Research design</td>
<td>What data needs to be collected and disaggregated e.g. gender, sex, type of health worker, to enable an intersectional analysis?</td>
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<td>Research analysis</td>
<td>How might interview questions be formulated to explore intersecting social identities?</td>
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<td>Research analysis</td>
<td>How can the findings be interpreted within the wider context?</td>
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<td>Research analysis</td>
<td>Are there any unexpected findings, e.g. identities that only emerge as important during the data?</td>
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<tr>
<td>Research analysis</td>
<td>What do the findings mean for policy and practice, especially in relation to addressing inequalities and vulnerabilities</td>
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</tbody>
</table>

**References and resources**

- Hankivsky O. Intersectionality 101. Institute for Intersectionality Research & Policy, SFU; 2014
- Larson E, George A, Morgan R, Poteat T. 2016. 10 Best resources on... intersectionality with an emphasis on low- and middle-income countries. Health Policy and Planning.

**About the brief**

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