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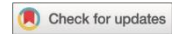


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Intersectionality as a lens to the COVID-19 pandemic: implications for sexual and reproductive health in development and humanitarian contexts

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Introduction

Millions of people have now been infected with COVID-19, with numbers increasing daily. As countries have implemented social distancing, quarantine and other community containment measures to limit the spread of the virus, data show higher infection rates and deaths among particular minorities. In the United States, African Americans have been disproportionately affected by the virus, exposing decades of health and social inequalities, including lower health insurance access, overrepresentation in essential work, greater health risk factors, poor health service coverage in certain geographical areas, and even unconscious bias among health providers. Such findings, similar to data emerging from the United Kingdom, challenge the notion that COVID-19 is “the great equalizer”. [1] Instead, COVID-19 lays bare stark disparities in power. Among the world’s poorest and conflict-affected populations, these power hierarchies persist, albeit in different forms. In refugee camps, social distancing is a luxury made impossible by living in close quarters. In many low-income communities around the world, the poorest lack access to basic water, sanitation and hygiene to protect themselves from the virus. [2]

Alongside these entrenched inequalities, as health services shift towards the COVID-19 response, other vital health services may be disrupted. In Sierra Leone, as the focus was diverted to responding to Ebola, health service provision of critical sexual and reproductive health (SRH) services decreased, including antenatal care and family planning services. Consequently, an increase was documented in maternal, neonatal and stillbirth deaths from 2014-15. [3] Importantly, these “indirect” consequences of disease outbreaks may be overlooked in the immediate need to provide “life-saving” health services as part of the response to COVID-19.

In development and humanitarian contexts, which already face significant challenges including poverty, forced displacement, conflict and economic instability, low access to SRH may indeed have life and death consequences. In these settings, health services may already be stretched, struggling to provide basic services and information to communities. Without regular health checks, antenatal care and attendance of a skilled birthing attendant, complications during pregnancy and childbirth can lead to morbidity and mortality for mother and child, particularly for adolescent mothers.

Access to information about family planning is critical for young women and men in particular. However, social norms about sex and limited resources may prevent this vital information from reaching these groups, increasing the risk of unintended pregnancies, sexually transmitted infections and HIV transmission. The consequences of an unmet need for contraception can be disastrous for women, leading to high maternal mortality and unsafe abortions. SRH outcomes may worsen due to gender-based violence (GBV) which can increase the risk of chronic health conditions, disability, HIV transmission, pregnancy complications and even death. These impacts of low SRH access clearly demonstrate the critical importance of SRH services, particularly in development and humanitarian settings. [4]

SRH access is further complicated by power hierarchies. In many contexts, gender norms around sex, chastity, marriage, caregiving, and decision-making power on birth spacing and contraception make SRH a taboo topic. For example, adolescent girls who are expected to embody societal expectations around chastity and virginity may not feel comfortable asking for information about contraception within settings where their sex, age and marital status is seen as making them ineligible for such SRH services. Although girls may be sexually active, or may be survivors of sexual violence, they may lack vital information about sexually transmitted infections including HIV/AIDS, avoiding unintended pregnancies and the risks of health complications during adolescent pregnancies. Issues of stigma and social norms may result in unmarried pregnant adolescent girls being sanctioned by health providers and their families when they try to seek SRH services. In a refugee camp setting, it may be even more difficult for adolescent girls to access contraception without their families knowing. The decreased mobility they experience in camps due to their sex and age, as well as gender norms about their expected behaviour, thus results in low access to SRH.

The perception that SRH services are not needed may be a particular issue faced by women with disabilities. Despite the fact that an estimated 15% of the world's population have some form of disability, women with disabilities are often infantilised and perceived as asexual. [5] Their needs for SRH services, including family planning and antenatal care, may be neglected amidst perceptions that they are not capable of reproduction or caring for children. A woman with a disability is likely to face greater barriers to SRH access than a woman who does not have a disability – both during the coronavirus outbreak as well as in normal circumstances.

Despite the fact that power hierarchies may heighten the risk of more negative SRH outcomes in development and humanitarian settings, these inequalities persist. A recent systematic review on SRH interventions in humanitarian crises did not find any studies focusing on people with disabilities, adolescents or LGBTQ populations. [6] While “women and girls” are acknowledged as facing limited SRH access, analysis tends to take a one-dimensional, horizontal lens.

Moving beyond gender: intersectionality in practice

In development and humanitarian contexts, agencies have sought to learn from previous disease outbreaks to recognise the differing impacts of disease, particularly the gendered dimensions. The most striking example of this relates to the Ebola outbreak, where women were more exposed to the virus due to their role in caregiving for family members, and due to their traditional involvement in funeral rites which exposed them to bodies which had been infected with Ebola. [7] Since the Ebola outbreak, agencies have been focusing on understanding the gendered dimensions of outbreaks, including for the coronavirus. This has resulted in a number of resources, gender analyses and guidelines, designed to ensure gender considerations are embedded in COVID-19 responses within development and humanitarian settings. [8-10]

Disease outbreaks like the novel coronavirus expose the magnitude of existing inequalities. Social distancing and isolation - the very measures taken to flatten the curve and protect populations from the virus - can create an environment that intensifies the experience of GBV in the home. Existing power hierarchies and ongoing violence in the home may worsen due to the virus, as prolonged quarantine and economic stressors increase tension in the household. In many development and humanitarian settings, services for GBV survivors can only be accessed where SRH services are available. GBV survivors thus face challenges accessing support as funding is diverted to COVID-19, or as social distancing and quarantine procedures make it difficult to access assistance. In development and humanitarian settings, service providers do not always have appropriate training to be able to respond confidentially and sensitively to GBV disclosures. Referral pathways may be disrupted, making it difficult for service providers to ensure continuity of care for survivors. SRH services are a critical entry-point for GBV survivors; routine health centre visits and antenatal care sessions are important opportunities for GBV screening. COVID-19 may affect the ability of SRH workers to appropriately screen, leading to gaps in care for GBV survivors.

While gender is most often invoked as a lens through which to understand inequalities affecting women's and girls' access to SRH, this sole lens may obscure how a number of intersecting oppressions further disadvantage certain people. "Intersectionality" is a means of understanding the interconnectedness of multiple and overlapping systems of discrimination. It refers to a term developed by Kimberlé Crenshaw to recognise the intersections between different power differentials, including class, nationality, race and gender. Crenshaw posits that a singular level of analysis that fails to capture the complex combinations of intersecting power differentials has detrimental effects. [11] Intersectional analysis means that "women" are not seen as a homogenous group, rather it recognises that intersecting oppressions shape their experiences.

It is important to note that the consideration of power hierarchies more broadly is a significant gap in development and humanitarian agency programming. While it has become relatively commonplace to emphasise the needs of "women and girls", such analysis does not always focus on the power dynamics and the systemic nature of discrimination and inequality surrounding the lives of women and girls, but rather positions this category as perpetually vulnerable. [12] There is a distinct difference between addressing women and girls as a "vulnerable" group, versus understanding how power shapes their life experiences, that is, how gender may interact with other social categories including age, disability, race and economic status, among others. The use of the "women and girls" category has inadvertently lacked nuance in recognising multiple and intersecting forms of discrimination and inequality, leaving power side-lined while stereotypes about who is vulnerable dominate policy discussions. For example, within humanitarian emergencies, the elderly remain "virtually invisible" despite facing unique challenges including poor access to health services and chronic untreated illnesses. [13] During the coronavirus outbreak, the elderly face particular health risks due to age, but also play an important role in decision-making and caregiving within family structures; even in humanitarian settings they may reside with their children. The historical neglect of the elderly within development and humanitarian settings means engaging them may be particularly difficult.

Analysis of these intersecting oppressions offers the potential of understanding the impacts of COVID-19 differently. It may mean that instead of assuming that "women and girls" as a homogenous collective lack access to SRH, asking the question of "which women and girls?" to understand how gender inequality overlaps with other forms of systemic discrimination, such as racism, ableism and homophobia, to increase barriers to SRH. This may be worsened as SRH services are diverted in the COVID-19 response – a particular challenge in development and humanitarian settings where resources are already limited and where the consequences of COVID-19 may be more dire. Analysing these unique challenges for those who sit at the intersections of these overlapping

systems of oppression, such as adolescent refugee girls, disabled women of lower caste, homeless transgender youth, or migrant workers from minority ethnicities, enables stronger consideration of power hierarchies and systems of discrimination.

Intersectionality thus is different to “vulnerability”. In contrast to development and humanitarian narratives about the importance of reaching “the most vulnerable”, intersectional analysis places power at the centre, analysing not what makes people vulnerable but taking a broader approach to conceptualising how power hierarchies and systemic inequalities shape their life experiences. This means not only collecting data that disaggregates (both quantitatively and qualitatively) for sex, age, race, economic status, geographical location, migrant/refugee status, disability, sexual orientation, gender identity and expression, and HIV status, but also recognising the social and geopolitical forces shaping people’s lives, such as poverty, displacement and conflict. It means challenging narratives about communities being homogenous and seeking to critically situate people’s experiences in a systemic analysis of power. It is vital that this analysis informs the work of agencies seeking to understand how COVID-19 affects the lives of people in development and humanitarian settings.

Conclusion

Intersectional analysis offers the development and humanitarian sector a more critical lens through which to understand multiple and intersecting forms of oppression and inequality. It goes beyond gender – which at times has been reduced to being solely about “women and girls” – to grasp the intersections between different power hierarchies and forms of oppressions as a way of understanding differences in lived experiences. While aggregated data or even data only disaggregated by sex may give the impression that COVID-19 has relatively neutral impacts, data that draws attention to how power hierarchies and systemic inequalities affect people’s lives demonstrates the complexity of factors that define access to SRH.

There are three things development and humanitarian agencies can do to ensure an intersectional lens to SRH during this virus outbreak:

- Conduct intersectional analysis using both quantitative and qualitative data to show how multiple forms of oppression, inequality and the historical and socio-political context shape SRH access in different contexts.
- Engage people who live at the intersections of these oppressions and inequalities in meaningful decision-making within COVID-19 preparedness and response at the community and national levels, ensuring their voices and lived experiences inform planning processes on SRH access.
- Ensure that, as the virus outbreak escalates, decision-making on SRH resource allocation (including decisions on how to adapt SRH service delivery), seek to address the increased barriers faced by those who experience intersecting oppressions and inequalities.

Even without the virus outbreak of COVID-19, access to SRH in development and humanitarian settings is uneven. As focus shifts towards recognising the impact of COVID-19 on communities, it is important to recognise that barriers to SRH are not “new” but represent existing, highly entrenched inequalities. Solely fixating on the impacts of COVID-19 may neglect the structural, systemic inequalities affecting SRH access. When it comes to COVID-19, understanding the multiple dimensions of power, historical structural inequalities, and the role of the underlying social context and complexity of lived experiences are critical in informing policy and action, and equalising access to SRH.

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