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HSR2016: Fourth Global Symposium on Health Systems Research

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Plenary 3: Intersectionality as a research approach to understanding and promoting resilience and responsiveness in health systems

Thursday 9:00 – 10:30 AM

Chair's (Daniel D Reidpath) opening remarks

Good morning. I'd like to start by thanking you all for coming to the plenary on "Intersectionality as a research approach to understanding and promoting resilience and responsiveness in health systems." In yesterday's plenary, the idea was developed that systems and people can have multiple vulnerabilities. This notion of multiple vulnerabilities at an individual, population, and systems level leads naturally into a discussion of intersectionality. We would argue that the ideas you will hear today are necessarily a part of developing research for resilient and responsive health systems. More significantly, we think the ideas to be presented today need to be aired widely, discussed and debated thoughtfully… [and ultimately used]. And we appreciate the fact that you chose to be here and did not sneak an extra hours sleep, a leisurely breakfast, or a side meeting.

The Sustainable Developments Goals, which replaced the Millennium Development Goals, have a clear equity agenda of "leaving no one behind". In the context of health systems this ideal is probably best encapsulated by the idea of *Universal Health Coverage*. The question that necessarily arises from these two ideas, however, is what do we mean by "no one" – as in "leave no one behind"; and what do we mean by "universal" – as in universal health coverage?

A little over a decade ago some colleagues and I were interested in how one created the limits on community – how one defined "no one" to mean that you could leave some people behind but not others; and how you could define "universal", so it didn't quite include everyone.

We started with an idea proposed by the political theorist Michael Walzer in his 1981 article "The distribution of membership".[1] He wrote …

"The primary good we distribute to one another is membership in some human community. And what we do with regard to membership structures all our other distributive choices. It determines with whom we make those choices…and to whom we allocate goods and services"

And the goods and services we are interested in here, today, are those that relate to health systems. Who can access health services, what services can they access, what rules govern that access, and what are the structural factors that delineate community and impede or enhance utilisation?

In our work we identified some very clear strategies for legitimizing the marginalization of groups based on a range of attributes from gender, sexual orientation and poverty, through to health status,

1 Walzer, M. (1981) The distribution of membership. In Brown, P.G. and Shue, H. (eds) Boundaries, National Autonomy and its Limits. Totowa, NJ: Rowman and Littlefield.

geography, and religion … in fact just about any characteristic you care to name could be a source for "legitimate" marginalization. And the characteristics can layer, or intersect. The obverse of marginalisation, of course, is that the rules of inclusion and access are also there.

Our article appeared over a decade ago in *Sociology of Health and Illness*.[2] It has more recently found a new audience among a class of rising stars in the firmament of Applied Political Science. Among the most famous readers whom we think we can claim are Vladimir Putin, Rodrigo Duterte, Narendra Modi, and most recently and most famously Donald J. Trump. These are people who have used identity politics to squeeze, mould, and shift the envelope of "community" redefining politically who is in, who is out; and how broad and inclusive is the umbrella of community.

The applied political scientists' use of these ideas provide highly visible examples of the way power, resources and access are distributed or withheld according to social rules of inclusion and exclusion. They can be applied to a wide range of social goods and services including health services. Attributes of entitlement or restriction are not simple binaries, but interplay and intersect.

In this plenary we will have three speakers and two discussants. They are followed, I hope, with some lively discussion with questions from the floor. We had anticipated that we could use twitter as one way of taking questions from the floor, and while it is not 3am, and we do trust you with your accounts, the technology has just not been set up for it.

Each of the speakers will present for 10 minutes, and each discussant will respond to the ideas raised for 5 minutes.

The first speaker is Olena Hankivsky. Olena is the Director of the Institute for Intersectionality Research and Policy at Simon Fraser University and is a Canadian Institutes of Health Research Gender and Health Research Chair and a Michael Smith Foundation for Health Research Senior Scholar. She is one of the leading thinkers in the area of intersectionality and will provide the background to our discussions.

The second speaker is Sundari Ravindran. Sundri has a Ph.D in Applied Economics from the Centre for Development Studies, Trivandrum, Kerala, India; and is currently a Professor at the Achutha Menon Centre for Health Science Studies in Trivandrum. Her work has concentrated on gender and marginalisation and she will give some examples from her research using intersectionality as an approach.

The third and final speaker is Saira Shameem. Saira is the UNFPA country office Head in Malaysia. Saira has been working in the field of human rights, women's rights and the right to health for the last 27 years in various capacities, spanning community mobilization, public education, organisational development, advocacy as well as national and international policy development. Saira's talk uses a marginalised community in East Malaysia to consider the application of intersectionality from an institutional and structural standpoint.

The first discussant is Asha George. Asha is the South African Research Chair in Health Systems, Complexity and Social Change at the University of the Western Cape. She is a qualitative

2 Reidpath, D.D., Chan, K.Y., Gifford, S.M, Allotey, P. (2005). 'He hath the French pox': stigma, social value and social exclusion. Sociology of Health & Illness;27(4): 468–489. https://www.ncbi.nlm.nih.gov/pubmed/15998347

researcher engaged with health systems to advance health and social justice in low- and middle-income countries. Using a gender and rights lens, she focuses on the frontline interface and governance of services, taking into consideration community engagement and health worker perspectives.

The second discussant is Jean-Frederic Levesque. Jean Frederic is the Chief Executive of the New South Wales Bureau of Health Information in Australia. And a member of the Strategic Analytic Advisory Committee of the Canadian Institute of Health Information. He has acted in healthcare system performance measurement roles in Australia and Canada and conducted research on access to healthcare and various models of primary healthcare services in Australia, Canada, USA and India.

And now, please join me in welcoming our first speaker to the podium, Olena Hankivsky