Chapter

An Intersectional Innovative Analysis of How Providers' Discourses Interact with Universal Healthcare Access

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Abstract

Intersectionality is an analytical tool for understanding the ways gender intersects with and is constituted by other social factors such as social class, age, and ethnicity, among others. The chapter discusses the theoretical and analytical intersectionality perspective, focusing on its application to an analysis of empirical data obtained from qualitative research. Semi-structured interviews took place with healthcare providers in Cordoba, Argentina. Thematic analysis was conducted. The findings show the existence of multiple domination systems incorporated in providers' discourses. All of them interact and contribute to gender inequalities in health, specifically on women's access to universal healthcare for violence against women and/or health of migrant women increasing their vulnerability. Training and sensitization among providers regarding gender and health from an intersectional approach are highly recommended as the first step toward a better healthcare system response.

Keywords: intersectionality, gender, access to health, qualitative methodology, healthcare providers, migration, migrant's healthcare, violence against women

1. Introduction

Intersectionality has increasingly been applied to health system research, especially works that aim to understand and respond to how multifaceted power structures and process produce and sustain health inequalities [1, 2]. Emerged from black feminist thought and first formulated by American sociologist Kimberlé Crenshaw in 1989 [3], intersectionality moves researchers beyond understanding individuals' unique circumstances and identities toward considering the drivers of inequality and to examining power relations at both individual and macro levels. Intersectionality challenges practices that privilege any specific form of inequality, such as race, ethnicity, class, or gender, and emphasizes the potential of different configurations of social locations and interacting social processes in the production of such inequities.

Intersectionality approach has been applied to healthcare studies and health inequalities to achieve two crucial aims. First, it brings attention to relevant differences within population groups that are often portrayed as relatively homogenous

such as migrants, indigenous people, or healthcare professionals. For example, it sheds light to an understanding that a white poor woman might be discriminated for her gender and class status when accessing healthcare but has the relative advantage of ethnicity or race over an indigenous or migrant woman. Second, it highlights the fact that health outcomes resulted from power structures of social domination and historical discriminations [4].

Thus, intersectionality moves beyond examining individual factors of health inequities such as biology, socioeconomic status, sex, age, gender, and race or the sum of them. On the contrary, it focuses on the relationships and interactions between such factors and across multiple levels of society to determine how gendered inequalities intersect with other aspects of oppressions that include not just gender but multiple social dominations [5]. Gendered inequalities thus intersect with other aspects of oppression, resulting in unique constellations that include not just gender but race, sexuality, ability, age, social class, caste, or position as a citizen, indigenous person, and refugee, among others. For example, an undocumented migrant will have qualitatively different experiences from a migrant who holds citizenship status.

Therefore, intersectionality has the potential to enrich public health research through improved validity and greater attention to both heterogeneity of effects and causal processes producing health inequalities [5]. As an overarching concept, intersectionality has much to offer to population health in providing a more precise identification of inequalities, in developing intervention strategies, and in ensuring that results are relevant within specific communities. Moreover, it was recently identified as an important theoretical framework for public health [6], as well as for gender and health studies [7].

To illustrate the relevance of intersectionality on understanding providers' discourses, we consider two important health issues on women's access to universal healthcare: violence against women and health of migrant women.

It is well-known that violence against women is an extreme manifestation of gender inequity, targeting women and girls because of their subordinate social status in society [8, 9]. In its multiple forms, it is recognized as a global healthcare problem and a serious violation of women's rights [10–13]. Moreover, violence affects women in different ways, particularly their health [14–16]. Therefore, healthcare systems have a crucial role in detecting, referring, and caring for women affected by violence [17]. A recent systematic review has explored primary care providers' opinions and experiences of tackling violence against women. The findings show that providers hold a range of opinions on the causes of violence against women. For example, some primary care providers perceived violence as a private matter mainly caused by relationship problems, drug abuse, or unemployment. Therefore, there is a need to better understand the social gendered roots of violence against women [18]. This is important considering that healthcare providers frequently, and often unknowingly, encounter violence among their users.

On the other hand, the increasing participation of women in migration processes, the growing tendency to incorporate gender approaches in the social sciences, and the conceptual opening to the figure of the migrant woman [19] have shown that migration processes are complex phenomenon shaped considerably by gender relations [20]. Social sciences have highlighted the need to approach the dynamic intersection between the different components present in the historical structures of domination [21, 22]. Social science analyses have demonstrated the value of the intersectionality of gender dimensions, ethnicity, social class, and national origin in migration studies [23] and the outcomes of the interactions of the categories which, in the case of female migrants, are placed in the social periphery. This has led to a growing attention to the relationships between migration;

intra-family dynamic, social contexts of women; impacts of displacement on gender roles; and migration outcomes on the quality of life of women, including their sexual and reproductive health [24].

Migration is, therefore, recognized as a key determinant of health [4]. For example, compared to their native counterparts, migrant women experience a higher number of unwanted pregnancies and report lower use of contraceptives and a lower propensity to attend reproductive health services in Latin America [25]. In this sense, migration has been identified as a risk factor, showing that the confluence of gender, ethnicity, and nationality and the lack of official citizenship documents can lead to the most extreme human rights violations, including sexual abuse, deterioration of reproductive health, and threats to physical integrity [26].

In the specific case of women, migrants are even more exposed to encountering obstacles to healthcare services. In addition to the difficulties they have as migrants, women face obstacles due to factors associated with their social class, gender, and ethnic-cultural background [27]. Despite these factors, studies have overemphasized cultural differences between migrant populations and the health system as relationships based on distrust among professionals and users due to cultural gaps [28]. This is why intersectional lens are crucial to understand multilevel factors shaping healthcare provision, practices, and use among migrant groups [4].

This article aims to include intersectionality theory to better understand the multiple axes of inequalities that cross healthcare providers' discourses on violence against women and health problems of migrant women. Intersectional lens becomes a promising approach to highlight the limits to health research and healthcare responses to migration and violence against women that overemphasize a single causal element of health outcomes—such as cultural differences or class—while highlighting multiple factors that shape healthcare views and healthcare practices in Argentinian healthcare system.

2. Method

This qualitative study was conducted in two phases in Cordoba, Argentina.

In phase one, healthcare providers from primary care centers or a regional hospital from urban and semi-urban regions of Cordoba were recruited using purposive sampling. Data were collected in different periods from June 2013 to November 2016.

In phase two, we used purposive sampling to recruit healthcare providers who worked in primary care centers or in a regional hospital from a semi-urban northern region of Cordoba. Professionals with least than a year of experience working in the setting were excluded. Data were collected over a period of 15 months from November 2016 to February 2018.

In both phases semi-structured interviews were conducted. All interviews were conducted by the authors. The interview guides used in each phase were pilot tested. It included basic sociodemographic information. In phase one the guide included questions that gathered their perceptions regarding migrant populations in general and the Bolivian flow in particular, as well as the existing barriers and facilitators in the access and use of health services by migrant women. In phase two the questions focused on four main topic areas: violence against women's opinions, experiences, barriers to provide care, and ways to overcome these obstacles. The interviews were conducted during regular working hours in a private place located in the health center or in the hospital. Each interview lasted ~60 minutes. They were audio recorded and transcribed verbatim for analysis. Full signed and informed consent was gained from all participants. Ethical approval was obtained through the College of Psychologists of Cordoba.

Inductive thematic analysis was conducted following Braun and Clarke's method [29] for identifying, analyzing, and reporting patterns (themes) within data. Transcripts of each phase have been reviewed independently by the researchers in an iterative process with the following stages: familiarization with the data, production of initial codes from the data, identifying themes, reviewing themes, and defining and naming themes. Saturation was achieved within the themes and categories. When all of the transcripts from each phase were coded and analyzed, the investigators met to reorganize them all into meaningful themes focusing on intersectionality and taking into account sociodemographic information. As Anuj Kapilashrami and Olena Hankivsky [4] mentioned, there is no single way to approach intersectionality and no preferred method. However, the authors recognized the importance of interpreting the commonalities and differences within and across population groups without being reductionists and linking individual levels of experience to social structures of power. This last stage resulted in an organized and comprehensive summary of multiple domination systems incorporated in providers' discourses. ATLAS.ti version 7.5.4 was used to help with management of the data.

A total of 50 providers (39 female and 11 male) participated in the research aged 30–59 years. They were from five communities (three from northern Cordoba, one from the center of Cordoba, and one from the periphery of Cordoba City). Regarding their professions, 20 of them were physicians, 13 nurses, 8 psychologists, 6 social workers, 2 dentists, and 1 radiologist.

3. Violence against women

The opinions of the healthcare providers regarding violence against women were varied and show how multiple factors shape healthcare opinions and practices contributing, some of them, to gender inequalities.

A mutual couple conflict, being in an unhealthy couple relationship, no respect, or lack of values were the root causes of violence against women according to the majority of healthcare providers. From this point of view, violence was as a private/domestic matter, making either men or women responsible for violence. For some providers interviewed, both members of the couple were considered "sick." From their point of view, these "unhealthy links" would cause a vicious circle between both members. Moreover, due to the naturalization of the violence, it was difficult to identify certain acts as violence and, therefore, to break circle of violence, according to providers' points of view.

> *"From my medical point of view, I believe that it is a disease of both. I think probably he has previously gone through other situations and came to this one...." (Woman physician, hospital)*

> *"The violence starts with the values, the limits, the culture that they receive, first from the family, the school, the social environment... We always see the last part of the film, when we have to act ... with someone already physically or psychologically injured. But we see the end, almost the end, because that story started many years ago. Why a person becomes an aggressor, becomes violent with another, and why that other one did not respond to stop that violence and accepts and justifies it...We works with two sick people...." (Men physician, primary care)*

This psychologization of the problem is a way of reducing a complex social problem to an individual or couple's disorder or conflict, which would reveal that the health sector does not correctly address the problem of violence against

women by not understanding it as a multifaceted phenomenon that is produced by the complex interaction of individual, relational, community, and social factors [30, 31]. Also, they defined violence against women as a pathology or a defect. Understanding violence as a sign of disease reveals biomedical conception of health and places the health sector in an active and expert role. From this place, healthcare providers would have the knowledge/power on how the relationships between men and women "should be." Healthcare providers have been trained to investigate and diagnose a disease, to solve a problem, and to help their patients. However, in the case of violence against women, this role must be left aside to focus on the needs of patients, giving them a leading role in the decision-making process [32].

On the other hand, several people interviewed consider that women, mainly from vulnerable sectors, were partly responsible for their situation of violence since, from their perspective, they are also "sick" and justified the mistreatment they receive. These ideas not only release men from their responsibility but also contribute to normalizing violence against women by blaming vulnerable women for remaining in situations of violence [33]. It has been pointed out that not knowing about violence against women not only could hinder professionals to not inquire about this problem [18, 34] but also could influence women's trust in professionals [35], which contributes to perpetuate this serious problem.

This is important because it is related to how providers understand women as victims of violence and the barriers that prevent women from reporting their situation. For instance, some providers highlighted women's tendencies to hide abuse, low self-esteem, lack of family support, economic dependency, and social isolation, as well as their feelings of shame, guilt, or insecurity, their own acceptance of traditional gender roles, or their fear of social stigmatization.

Moreover, violence against women was understood as a patron of behavior transmitted from generation to generation. From providers' opinions, lacking values and limits, especially in childhood, childhood abuse, and/or violence experienced in childhood within the family context would explain why men perform violence in their adult life and also why women choose violent couples and justify their violence.

> *"...it is always repeating, things that have happened as a child they will do it again and so...afterwards it will happen later with the creatures raised in that family. It will continue, it seems to me. There is a lack of education, of emotional contention." (Woman radiologist, hospital)*

> *"Mainly that women become aware and take conscience of the situation... I think it will take a long-term work, I would tell you from the time they are girls, from elementary school, to do a raising awareness work focusing on women to show them that this situation is not normal, even though they see it at their homes: my dad hit my mom or spit on her, or insulted her, and those situations goes unnoticed. It is important that girls become aware that violence is not good... so they are clear about what is right and what is wrong." (Men physician, hospital)*

These opinions stated families not only as a power structure but also as the main agent of socialization that produce and sustain violence and gender disparities. This belief could be an important barrier to understand violence against women as a multifactorial phenomenon that is part of the patriarchal social structure where all social agents are responsible for its maintenance and reproduction, including the health sector [36].

Moreover, social class bias underlined providers' ideas about family models, violence, and education illustrating how various factors are affecting providers' opinions

and practices simultaneously. Belonging to the working class was a risk factor for violence against women, according to some providers.

> *"It is very difficult for the victim of violence to get out of that situation and when she does sometimes, she not has a supportive family network... she not has the resources...it is very complicated... I have people who have decided, have been gone two, three years and after she returned to the violent relationship...." (Woman social worker, primary care)*

Finally, it is important to note that no differences were noted within healthcare level of care, professions, gender, or years of experience regarding opinions of understanding violence against women.

4. Healthcare of Bolivian migrant women

The intersectional approach also highlighted the limits of providers' responses to migration that mainly stress cultural differences between them and migrants or that focus primarily on developing intercultural programs to address cultural barriers.

Among migrants that arrive to health services in Argentina, the Bolivian one appears as "the other" more differentiated, with its own characteristics (language, dress, customs) and phenotypic features, according to providers. Women have a particular weight in the stories of professionals about the Bolivian flow that is largely explained by the type of services analyzed, mainly linked to health. Relationships between migrants and the health system are conflicting as a result of the cultural differences perceived by providers. Cultural differences are mainly related with Bolivian women's traditional figure, associated with submission and docility [37].

> *"In general, the perception of the health team [about Bolivians] is hygiene. It is a main rejection. The other thing is the language. The rhythms are different. They are calmer, more leisurely; they do not ask many questions, or they stay waiting; They do not dare to ask if they need anything. One is very helpless talking but not knowing what happens on the other side." (Woman gynecologist-obstetrician, third level of care)*

> *"The feeling that I have is that they do not have an expression. You do not know if the message was really understood. With an Argentinian woman, it does not happen that much; Argentinian are more questioning, but according to them [Bolivians] everything is always very good." (Women gynecologist-obstetrician, third level of care)*

> *"Those who arrive from there (from Bolivia) have a language that is sometimes difficult to communicate, and they have a deeply rooted culture, the culture they have is very strong. For example, the culture they have is that the husband is the one who transmits everything to his wife." (Women nurse, third level of care)*

> *"The difference (between the Bolivians) with the Argentine ones is the level of education; the Bolivian is submissive, mainly elementary; that is their cultural characteristic; she talks very little and we cannot understand her." (Women psychologist, third level of care)*

Intersectionality analysis contributes to the knowledge offered by existing studies that have sought to understand the relationship of migrant women to health services and have tended to look at the relationship between migrant patients and providers

on issues related to communications or cultural interpersonal relations, rather than the simultaneous disadvantages behind the exclusion of certain population groups such as migrant women. In this case, the power of intersectionality approach allows opening the cultural "umbrella" behind opinions and experiences of providers toward Bolivian migrants by enhancing a deeper understanding on how and why this group is looked. It not only shows gender stereotypes (women subject of male domination) but also other social inequalities based on structural roots (such as poverty, xenophobic and discrimination attitudes, ethnic-/race-based discrimination) that shape opinions and experiences of providers toward Bolivian migrants.

Moreover, the lens highlights the importance of taking the migration process as an opportunity to redefine the health-disease-care process in places of migration, placing migrants within the broader contexts where they experience their health. This implies not only focusing on the cultural interpersonal relationships between migrants and providers but recovering the explanations of the multiple causes (cultural, economic, political, social) behind healthcare in migration processes.

5. Conclusions

The findings show the existence of multiple domination systems incorporated in providers' discourses. All of them interact and contribute to gender inequalities in health, specifically on women's access to universal healthcare for violence against women and/or health problems in migrant women increasing their vulnerability. For instance, understanding women as responsible for violence, thinking that violence is a prevalent problem among vulnerable sectors, and conceiving migrants from a solely cultural lens were identified barriers to provide universal healthcare. Working toward universal health coverage is a powerful mechanism for achieving better health and well-being and for promoting human development by ensuring that everyone has access to the health services they need without suffering financial hardship as a result [38].

Intersectionality approach contributed to understand providers' opinions and how in their practices they tended to focus on some factors reproducing inequalities, such as the naturalization of violence against women. In that sense, training and sensitization among providers regarding gender, health, and migration are highly recommended as the first step toward a better healthcare system response and goals defined as improving health and health equity, in ways that are responsive, are financially fair, and make the best, or most efficient, use of available resources [39].

However, it has been pointed that those steps are necessary but not enough to address the multilevel factors shaping healthcare provision [4]. As Thurston and Eisener [40] noted, gender, organizational healthcare culture and structure, and other contextual related variables may play an important role in maintaining barriers and should be studied in depth, avoiding a focus on individual (healthcare provider) level variables.

Therefore, and tacking into account our findings, we propose to question the culture, policies, and practices of the broader structures in which healthcare systems are situated. Opening opportunities to discuss gendered assumptions is essential to promoting gender equity access to health in our context. For instance, this should highlight the importance of taking migrant women's voices to understand how they redefine their understanding of healthcare in their migration process as well as their assets as a way of coping with the multiple obstacles encountered in the health-disease-healthcare at their places of destination. This is why the intersectional approach enhances understanding of inequalities in health and should be strengthened in healthcare policies.

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Conflict of interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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