Inside the FP Story Podcast

SEASON 5

EPISODE 2: Why Intersectionality is Important: Community Perspectives

[About the *Inside the FP Story* Podcast]

From Knowledge SUCCESS and VSO, this is Season 5 of *Inside the FP Story*—a podcast developed *with* the family planning workforce, *for* the family planning workforce.

Each season, we hear directly from program implementers, decision makers, and others from around the world on issues that matter to family planning programs. Through these honest conversations, we learn how we can improve our family planning programs as we work together to build a better future for all.

I'm Sarah Harlan, Partnerships Team Lead with the Knowledge SUCCESS project. I'm pleased to introduce our narrator, Charlene Mangweni-Furusa.

[Intro to Episode]

Narrator
Welcome to Season 5 of *Inside the FP Story*. This season, we are exploring the reasons why an intersectionality lens is important for sexual and reproductive health programs, and are discussing tools and resources we can use to ensure that policies and programs are more inclusive and accessible to all.

During our previous episode, we spoke with individuals from the Make Way Project about the fundamentals of the intersectionality approach. If you are new to the concept of intersectionality, we recommend going back and listening to that episode before continuing.

This episode, we will highlight the experiences of community members—both those seeking FP services as well as those providing services. Their perspectives will shed light on the importance of using an intersectional lens to plan our programs.

[music break]

[Client stories: Furaha Mariga Leonard]

Narrator
First, we will feature the story of Furaha Mariga Leonard, a 27-year-old woman who works as a stylist at a beauty salon in Kenya. She was born with a hearing impairment, and communicated with our colleagues from Kuhenza for the Children, via a sign language interpreter. We asked her to tell us about her experience obtaining health care, specifically sexual and reproductive health care.

Furaha Mariga Leonard
> I often have communication problems because of a lack of interpreters. I also experience negative attitudes from service providers, and a lack of communication has sometimes even led to the wrong medication being given.

Narrator
When she described her experiences seeking sexual and reproductive health services, Furaha talked about harmful stereotypes that people with disabilities often face.

Furaha Mariga Leonard
> People in the community, when they see a deaf person who is pregnant, they think maybe she's been raped. They don't understand that we can be loved and that we can have a strong family.

Narrator
We asked Furaha to share a story about the challenges faced by those with disabilities who are looking for sexual and reproductive health services. She told us about a friend who is also deaf. After delivering a stillbirth baby, doctors at the hospital gave her a family planning method without her consent. When she wasn't getting pregnant, she was upset and then discovered she had been given contraception. This caused a lot of pain and anguish for her friend.

We also asked Furaha what advice she would give to sexual and reproductive health programs to make them more accessible to people with disabilities.

Furaha Mariga Leonard
> First, the advice I would give to SRH programs is to look for more sign language interpreters for deaf people. Also, the labor beds in the hospital should be adjustable for the people with physical disabilities, and also the toilets should be friendly to all disabilities.

Narrator
Furaha's experience speaks to the importance of prioritizing inclusion and accommodation for people with disabilities. However, it is important to keep in mind—when Furaha seeks care at a health center, she arrives not *only* as a person with a disability, but with other characteristics as well. Factors like gender, age, and socioeconomic status can also impact her quality of care. Therefore, it is important to consider the ways that a range of identities—including

disability—shape an individual's ability to obtain SRH services. We will talk more about intersecting identities throughout the remainder of this episode.

[Client stories: Mary Junwa Karisa]

Next, we will hear from Mary Junwa Karisa, a 36-year-old woman who is visually impaired. She works as a teacher at a secondary school in Malindi, Kenya, and is also the treasurer of the Persons with Disability Initiative in Kenya. Mary spoke about her experience obtaining health care—specifically SRH.

Mary Junwa Karisa

> I am visually impaired in the first place. So because of the visual impairment, there are challenges like, we do incur expenses. For me to visit a facility where I am to get the services, reproductive health services and the sexual health services, I have to use a guide to take me to that specific facility of the ward. It is somewhat expensive to me because I have to incur both my cost and the guide's cost. And then the other challenge is that on the receipt of these services, there is no confidentiality or privacy for that matter. Because I know when I report to the hospital, because of pregnancy, I have to undergo some tests. For example, the urine test, the hemoglobin test, HIV tests. So now that I'm visually impaired, I cannot read the test results for myself. So, I have to use my guide, for instance, to read the HIV results for me, of which I feel there is no privacy, no confidentiality.
>
> So my situation of living with a disability has really affected me in very many ways. Like the way I've seen that sometimes I do hesitate going to access [SRH] services. When first of all, I think of the cost that I will incur. I have to incur incredible cost so as to access these facilities. And then secondly, there is no availability of a guide yet that we can use for privacy. For instance, in the phones that we do use, there is a software that can be able to read for you, whichever, messages, video or sub messages, Facebook messages, but in hospitals we don't have the softwares that can read us the test results. So it is very challenging when I have the visual impairment, I cannot read these results. It's quite challenging. And then some buildings are not also very friendly for persons with disability. You may end up getting places with stairs and all that. So accessibility becomes a problem. Again, when we talk of, for example, specific facilities, you know, with a person with disabilities, it is very impossible to share the other regular facilities like the others. Therefore, we don't have specific facilities to be used for persons with disability.

Narrator

Mary's experience is common among people with disabilities, as they often pay more for accommodations and specialty care. These additional costs can prevent access to SRH services among many groups, especially those with additional vulnerabilities—for example, young people, and those living in poverty.

Beyond the lack of privacy and accessible facilities, Mary also described the stigma and bias she faces when obtaining SRH care. Similar to Furaha, she mentioned that health care providers are often surprised when they learn that women with disabilities are engaging in consensual sex.

Mary Junwa Karisa

> There is a lot of stigma because when the other clients and other health care providers see a person with visual impairment who is pregnant, they are normally shocked and think that someone has raped you and that's why you are pregnant. They can't believe that you can be loved, and conceive as the way the ordinary citizens do.

Narrator

In addition to sharing her own personal experience, Mary also spoke about issues faced by the disability community overall.

Mary Junwa Karisa

> Okay. The persons with disability really face a lot of challenges in terms of access of the reproductive health services and family planning services. For instance, for the persons with disabilities with hearing impairment, we find that there are no sign language interpreters in hospitals. At least nowadays, the National Council for Persons with Disabilities has really tried, but still we have some deficits. We don't have enough sign language interpreters. Therefore, persons with hearing impairment really suffer when they reach these facilities seeking services because of lack of people who can interpret sign language for them. So, hardly can the healthcare providers understand them. Again, we have talked about the infrastructure, which is still poor. In many public hospitals, we don't have the adjustable beds. So it becomes very difficult for a person with the physical impairment to use this building because if they could be having some adjustable beds, they could be lowered for them to go to the bath very easily, but they don't have such facilities which are friendly for persons with disabilities.
>
> Again, on the subject of persons with visual impairment, sometimes, they are not allowed to stay in hospitals with guides. So, there is normally a challenge between the service provider in including the subordinate staff. When they find a guide staying with a person with visual impairment, they start [saying], “Why are you staying two in the same ward?” and all that. So, the understanding is very minimal. For the service, the health care service providers, and also the persons with disability. So, I think the sensitization and creation of awareness has not yet been fully done. So persons with disabilities are not understood.

Narrator

We asked Mary what advice or recommendations she would give to SRH programs looking to include people living with disabilities.

Mary Junwa Karisa

I have several pieces of advice. And the first one, I would advise that as they come up with the programs, as they formulate their policies, I think it is better if [policy makers] can include some persons with disability in their programs who will be able to articulate issues that will be affecting persons with disability in these policies. So persons with disabilities should be included at the policy-making level, so that they are able to represent matters of persons with disabilities. So that is the first advice. Second advice is that sensitization should be done, not just creation of awareness that the health care providers need to be capacity-built on matters of disability.

Narrator
Both Furaha and Mary pinpointed ways that living with a disability has helped shape their experience with SRH care. Using an intersectional lens, we also recognize that a range of *other* identities impact their experience accessing SRH services. As we learned in our previous episode, some identities can offer opportunities for greater access to care—for example, higher education. On the other hand, the impact of disability may be particularly pronounced among those with characteristics that further increase their vulnerability to stigma and discrimination—for example, young people or those living in poverty.

Research has widely shown that, around the world, people with disabilities are more likely to be economically insecure. Poverty can increase the risk of disability—for example, due to malnutrition or unsafe working conditions. At the same time, living with a disability may perpetuate the cycle of poverty. Those living with disabilities may be less likely to have steady employment or educational opportunities, and they may spend more of their income on disability-related needs—like communication devices, caregivers, or medications. For these reasons and more, it is important that decision makers resist looking at any community as a homogenous group—and instead recognize the interactions among social identities and how they relate to the context around them.

[Client stories: Uwase Divine]

Narrator
Our next story highlights how another underserved community—female sex workers—could benefit from a more intersectional approach that recognizes the many factors that shape one's sexual and reproductive health needs and experiences.

Uwase Divine, a 19-year old female sex worker in Rwanda, spoke to our partner from VSO Rwanda, who provided interpretation during this interview.

She started out by describing her experience, specifically the judgment and stigma she faces when accessing sexual and reproductive health care..

Uwase
She said it's so difficult for her to search [for] these services because she's a sex worker and it is so hard for her, because they're doing this work, it is so hard when they go to

search [for] the services. Sometimes they choose to give them the services. Sometimes they deny [services] for them.

Narrator
We asked Uwase what recommendations she has to improve services for her and others in her situation.

Uwase
She said what could help them, if they go to look for services, they should value their work and not judge them because of their work and give them their value for what they they're doing.

Narrator
Uwase described an experience of going to a health center to ask for condoms and to receive HIV testing. Unfortunately, she was not able to receive the services she needed.

Uwase
When you go to the hospital or to the health center, it is not easy to to be helped as as soon as we need the service because you cannot just go there seeking for their condom and you will be served. Because they already have [too] many people. So they just consider that as a not a very emergency case, so they cannot easily get these services, because they just have to wait for a very long period so that other people can be treated. It is not easy for them to access these services whenever they go looking maybe for a condom or any other thing. Because of what they do, [the service providers] overlook them and just help others and they come to them later, or they don't even want to go and help them.

Narrator
The clinic staff gave Uwase different reasons why they could not help her—they did not consider her case an emergency, and the clinic was full. But beyond this, because of her profession as a sex worker, Uwase felt judgment from the clinic staff, who overlooked her and did not meet her healthcare needs.

Uwase shared her hopes and dreams for the future, and talked about how sexual and reproductive health would make her life better.

Uwase
She's saying their life would be really great if they're just provided with those services without difficulties. Just going there where they are seeking for their services and they're given the condoms there is a little chance of being infected by those sexual transmitted diseases. There will be no chance of getting pregnant when you are really not into it. So she thinks that their life will be very great if they can be provided with those services because some of the challenges they are likely to face that makes their life worse is because they are not able to access these services as they really need them.

> Maybe if there is a person who is there for them to speak for them, to provide all services for them without taking a role or without taking a long period of time, or maybe a person who will be able to to understand them, to understand their life. Who can provide all of their tools that it that are needed for them to do their work freely. So what they really need is just to to be free and do what they do freely and without getting any consequences from it that is getting access to all of these services easily, getting access to the condoms because they are really essential for their work and any other thing that can help for them. So that one will be will make their lives very OK. And she is not just speaking not for herself, but also for the general community of the sex workers.

Narrator
The three stories we just heard—from Furaha, Mary, and Uwase—highlight the ways in which a variety of factors—age, disability, poverty, stigma, and more—combine to affect an individual's ability to receive sexual and reproductive health care.

While each of these women has unique experiences and faces different sets of challenges, there were some common themes among their stories. They *all* spoke about wanting health providers to take the time to understand their needs and respect them as individuals—not to make assumptions about their SRH needs. They also spoke of the bias and stigma they face, and how this often prevents them from realizing their full potential and obtaining the SRH care they truly want. To counteract this, it is very important for health providers to be able to support each individual and to understand the different identities that intersect to impact their access to health care.

Using an intersectional lens allows us to understand an individual's layered identities, examine how these overlapping identities facilitate or impede one's ability to access services, and then respond accordingly to improve access to high-quality SRH programs and services for all.

While we have heard about a number of experiences where services have fallen short in providing respectful care, we will now hear from some health providers who are deeply committed to providing the full spectrum of sexual and reproductive health care, including family planning, to under served communities.

[Provider stories: Belyse Mponi]

Narrator
Belyse Mponi works as a health care worker at a district-level health care center in Rwanda, where she is in charge of adolescent sexual and reproductive health.

We asked her to talk about some of the challenges she experiences in her work. Our partner from VSO Rwanda provided interpretation during this interview.

Belyse

She’s been working with adolescents for three years while delivering all these SRH services. And one of the challenges they are likely to face is that the youth or the adolescents, they are not really approached them for knowing more about this services. They're still shy to approach them so that they can learn more about their sexual and reproductive health. Which means that if they really don't affect them to learn all of that, they are not likely to know their rights or all the services around SRH.

The other thing is, the adolescents, it’s not easy to teach them or to provide some necessary information about these services, because they already have some information from people—maybe some rumors around SRH, which means whenever they approach them to know more about these services, it really takes time for them to teach those young people about these services. So you can just understand it is not easy to change what they have been learning before approaching [the service providers].

One of the other challenges they face is that many young people who are in different churches or different religions, they have been told that these services—their sexual and reproductive health services—are just taboo. Like you don't have to to look for them. It's taboo. You are not supposed to be looking for it if you are a Christian. So whenever they try to approach them, it is not easy to convince a young lady or a young boy that these services are necessary for you, or maybe this is your rights, because they have already learned from their religious leaders that it is a sin. You don't even have to to try it. So generally the challenges they are facing is trying to change the mindsets of young adolescents about these services.

Narrator
This example points to another important identity—religion. A person’s identity can interact with other factors—such as age—to either prevent or facilitate their ability to receive quality SRH care. This is also highly dependent on the setting, as well as social norms.

Keeping all these factors in mind, we asked Belyse what health centers need in order to better provide services for adolescents and young people.

Belyse
What is most needed this time is the right number of people to provide [SRH] services but also the constant capacity building about the services so people can know more about this and change their mindset about it. So what is really needed to be done to overcome all of these challenges is increasing the number of the people that are delivering these services because, you can find that maybe there is a one person or two people to the health centers that are in charge of providing these services, while there are still many young people that approaches the health centers to get these services.

Narrator
According to Belyse, the health providers she works with are supportive of this.

We asked her what support she thinks she would need to better meet the needs of the individuals that they serve.

Belyse

> One of the supports that is needed is one of a key person who is in charge of delivering these services. Because you can go to a health center and you find that a person in charge of it has other responsibilities, and whenever a young person approaches the health center, it is not easy to to be helped as soon as possible.

Narrator

Belyse works with the Make Way program, which was described in the first episode of this season. Through this program, she and the other health workers on her team are working to improve service delivery among underserved communities, including young people. She spoke about how they implement intersectionality in her community—specifically, this starts with a recognition of other identities that compound to affect a person's access to sexual and reproductive health services. Specifically, she mentioned issues faced by low-income youth as well as young people with disabilities.

Belyse

> Some services should be paid. And sometimes those young people are not able to pay for those services. For instance, if a person is just wanting to see if she's pregnant, just pay for the pregnancy test, sometimes those people do not have such money to pay for those services.
>
> Another issue is about disability. We find that maybe where the health center is located is far a bit where they are living so sometimes it is not easy to get money to pay for transport so that they can go to look for those services. Or maybe if they manage to go there, some people they are not easy to access them due to their disability.

Narrator

At the end of our conversation with Belyse, she emphasized the great importance of SRH services for young people—particularly acknowledging that many young people are unaware of the services available to them.

Belyse highlighted the intersecting factors—age, income, disability, education, religion, and more—that come together to influence the individuals she serves. Belyse is working with Make Way to use an intersectional lens to serve the adolescents at her health center. Together, they are actively counteracting harmful social norms, to ensure that everyone has the knowledge and access to the services they need the most.

[Provider stories: Mary Adong]

Narrator

Similar to Belyse, the final story we are featuring in this episode is a health care provider dedicated to using an intersectional approach to understand and better serve clients.

Mary Adong, a midwife from Uganda, has been practicing midwifery for 20 years. Over the course of her career, she has worked delivering babies, providing pre- and post-natal care, and meeting couples' needs for family planning. She currently works in the Mulago specialty women and neonatal hospital in Kampala, Uganda—and she also works part-time as a health tutor, training other nurses and midwives.

She started out telling us what she enjoys about providing family planning services at her center.

Mary Adong

> What I mostly enjoyed, when I was working in the family planning department because there I would see so many people coming in—from the young to the middle age to the old age. All of them were coming to access the services. And I really wanted so, so much to offer such services to all the age groups. Though there were some challenges that were attached to that,, but I really enjoyed working there.

Narrator

Mary's particular interest is ensuring that young people are able to access a range of family planning methods. She expanded on the challenges that she has faced in this work. She started out describing the bias she sees in her clinic—not only provider bias, but harmful social norms upheld by older people seeking family planning services.

Mary Adong

> Now the most challenge that I got there was the negativity of the health workers. You know, in nursing or in midwifery, there are these types of health workers who are negative, who are biased to the young age group that comes in for family planning. For them, the idea behind what they heard was that family planning is only meant for the old people. So they had a very negative attitude seeing a young girl below 18 coming into access family planning services. So these young people were chased, and they were denied access to having family planning services. Why? They believed that it's only meant for people who have ever given birth. So it only happens when I'm on duty that they would see, I would give all the services.
>
> Even if it wasn't the negative attitude of the health worker, even the patients themselves, they found at the family clinic unit would also feel so biased about the young generation, about the young youth who were coming in to access family planning. And you find then that even if they came earlier, they would fear to line up with these grownups.
>
> And remember in our setting, people line up for all the services that they have to get in the government hospital. They have to make queues. So the queues are long. So you

find that this young person came in the morning and ends up getting the service like at 1:00 PM after the older age groups have already left.

Because the moment they try to come in early, they would be, they would shy away. And second, these older people would chase them away, would say that “You've not yet reached the age of delivery. What has brought you here? This service is meant for us people who are married. It's meant for us people who have given birth.” But if they happen to talk like such, when I'm listening, I come in, I intervene and tell them, no, they have a right and they have a choice to get this service.

Also you'd get a problem of when they come, they don't have a private area where they wait from. They're all put in the same gathering. That's why you find that the older age groups had time to tease the young people who would come in. They would be intimidated. They would be sometimes abused by these older people claiming to be knowing more and they would tag them with the sorts of namesSo when they're tagged with all such names, they fear, they shy away. They couldn't really come to access the service.

Narrator
This bias, teasing, and intimidation is even more pronounced when young people are also unmarried. This is an example of how different identities—in this case, age and marital status—intersect to impact access to quality SRH services. Gender can also impact quality of care—Mary discussed that women’s male partners often try to prevent them from using the contraception of their choice. Part of her role as a health provider is to counsel couples while also making sure women are able to receive their choice of contraceptive. This is sometimes further complicated by challenges related to stockouts and the cost of contraceptives.

Mary Adong
So another challenge that I experienced there is the stockouts. Most of the time, the contraceptives would get out of stock and you find when these young people come in, they don't get, we just prescribe for them. We write for them in a little piece of paper and we ask them to go and buy. But the majority of them would tell you how they cannot afford, they don't have money. First of all, they've run away from class or from some other place that they attended to, to come to the hospital to access the service. So when they reach the service area, the place doesn't have the contraceptives that they want. It is lacking the method that they want, and preferably, most of these youth, when they were coming in, they wanted mostly the injectables and most of the injectables were the first thing that would get finished. Because the majority of them wanted that injectable. And we would ask them to go and buy such that they bring it back to the clinic and we inject them. But when you follow up, you find that majority would not turn up, would not turn back again with the injection to be injected at the clinic.

Then the other challenge that I would say is also the, the high costs that I can tag, like there's some family planning methods, like the implants. The implants. First of all, the

nurses would ask money from these people, whoever who wanted to get it. And they would go at an extent of asking like, for 20,000, I don't know how much dollars it is. They would ask for money from those youth before they go ahead and put in that method. And majority of them, they're not employed, they're not working. They couldn't have access to such methods. So you find it was really a major challenge.

Narrator
Infrastructure can also cause particular issues among young people—particularly among poor young people and those in remote areas—another example of how intersecting identities can impact access to SRH care.

Mary discussed the effects of traffic jams and the unwillingness of some family planning providers to offer services in a flexible way to young people.

Mary Adong

In Uganda, we have a lot of [traffic] jams. By the time they try to come in to reach to the hospital, it's already late. And when you get her midwife who is not friendly, she'll ask you when you reach her, the hospital, like at late hours, coming to late hours, they'll ask you where you have been and they tell you, “Go back. Come back tomorrow.” Now, I would imagine when you send back a youth who has come to access the service to be sent back home and come back tomorrow, majority wouldn't turn back again. So it was really a major challenge.

Narrator
Another challenge is that many times, individuals with disabilities cannot physically access services.

Mary Adong

Most of the time the lifts are not functioning, and those people cannot really climb steps to go maybe to level four or to level three where they are placed. So you find it's really a big and just challenge. They would not access the services just because they cannot reach there easily.

And you find most of the services that were put on the ground floor where things like emergency areas. So they were not valuing family planning units also to be one of the critical things that would be put down. So they would be put higher at higher places.

Narrator
Mary also discussed myths and misconceptions surrounding family planning, and how some of these are particularly prevalent among certain women—for example, women from certain regions or who have low literacy. She talked about how she does health education and family planning counseling with this in mind.

Mary Adong

You'd look all the local ways of how you can educate them and then you do creating other materials that can make them understand better. Now, for example, like when you are going to counsel a client for family planning, you use the suitable names that can be used in the local language. So what you need to do, you must soften your words and you lower it down. So that this person who is an illiterate is able to understand you. And we have found it a bit easier to involve men also other clients, other patients who come in for a method. Like you can get some clients who do not totally know even the local language that you are speaking, but you make use of other patients who come in at that place, at that vicinity or maybe like a family planning. You make use of the third party now to come in and explain to this person, to the language that they know.

Narrator
She explained that she also uses visuals and diagrams in her counseling—for example, uterine models to demonstrate IUD insertion.

Mary also mentioned specific ways that provider bias shows up in clinics where she has worked. For example, when the lines or queues were very long, many providers would prioritize older clients, claiming they had more responsibilities to get to, while making the assumption that young people had more free time. In addition to prioritizing older clients, providers also overlooked many individuals with disabilities.

Mary Adong
There was one mother, one specific mother who wanted the [family planning] service, but she was in a wheelchair. And that day I remember there was no power, no electricity, and the lifts were not working. So what happened? She happened to come with her husband, but the husband could not really access the place very well. So what the man did, the man walked alone and left the woman down[stairs]. He walked and came up where we were and said, “There's a mother, there's a woman who wanted family planning, but she cannot access it because the lifts are not working.Is there any possibility that maybe one of you could go and try to explain to her?” I remember that day I was on duty. We walked towards that place and then we encouraged other people to support this man, to help him wheel the chair up to the family planning unit. And when she came there, we offered the service and we encouraged her after counseling. She had chosen oral contraceptives, but we helped her choose a method and we put in the implant. And we told her the implant was more comfortable for her than the oral contraceptives. And afterwards she went home happy and they were both happy. And at the time when I left, I'd never had not yet seen them come back with either major challenge on the method that we helped them choose. And I believed it was really a suitable method that would work for them.

Narrator
We asked Mary what changes she would like to see to better address the needs of underserved communities—including young people, those with disabilities, and others.

Mary Adong

> Most of the health workers have a bias. They have these negative attitudes towards some clients who come to access the SRHR services. So my number one priority is, if possible, these midwives would be given sort of a training on attitude change. So if such people are incorporated, are trained on particularly attitude change towards other methods of family planning, I believe it would work a lot in at least creating change towards patients who come to accept such services.

Narrator

In addition to the need for training on sensitivity, Mary discussed the need to improve pay among healthcare workers—when they are fairly compensated and do not have to work multiple jobs, they are more available to attend training and to work flexible hours (for example, evening clinics, which are sometimes more suitable for young people)—which allows them to provide more equitable and high-quality services.

Belyse and Mary both take the time to listen to clients about the issues and challenges they face. They both work to challenge harmful social norms, and to find innovative solutions to provide more equitable care. Their stories offer examples of programming in an intersectional way. They highlight the importance of using an intersectional lens to sexual and reproductive health programs—from understanding their clients' unique needs to training and setting an example for other providers.

As we have mentioned throughout this episode, Individuals seeking SRH services present with a range of different identities. Through these two provider stories, we heard about ways that characteristics like age, religion, disability, employment, social status, gender, and marital status can intersect. But it is also important to note that people may experience different levels of stigma or discrimination depending on social norms and biases. This can vary by context, and changes over time. And as we noted in the last episode, it is often these norms—*not* the identities *themselves*—that influence an individual's ability to access and receive quality SRH care. This complexity makes an intersectional approach even more essential.

[Conclusion]

Narrator

This episode, we heard from community members about a diverse set of challenges, opportunities, and potential entry points for using an intersectional approach to family planning and sexual and reproductive health programs and services.

All individuals are entitled to the full spectrum of sexual and reproductive health care, including respectful and accessible family planning services. However, it is not uncommon for decision makers, health providers, and others with power in communities to make assumptions about people based on their identities. This prevents people from accessing high-quality, affordable care and exercising their full rights to make sexual and reproductive health decisions.

All the stories we heard on this episode speak to the need for inclusion and consideration of the various intersecting identities in FP and SRH programs and services. Join us next episode where we will discuss practical tools, approaches, and models that program implementers can use to design, implement, monitor, and evaluate FP and SRH programs with an intersectional lens.

[Credits]

Season 5 of *Inside the FP Story* is produced by Knowledge SUCCESS and VSO, and for this episode, we also partnered with Kupenda for the Children and Kuhenza for the Children in Kenya.

This episode was written by Sarah Harlan and edited and mixed by Elizabeth Tully. It was supported by an additional team, including Brittany Goetsch, Cariene Joosten, Polly Walker, Marjorie Mbule, Tienke Vermeiden, Caroline Wambui, Loretta Owino-Okeny, Umwali Angelique, Loice Maluki, Martha Karo, and Jessica Charles.

Special thanks to our guests: Furaha Mariga Leonard, Mary Junwa Karisa, Uwase Divine, Belyse Mponi, and Mary Adong.

To download episodes, please subscribe to *Inside the FP Story* on Apple Podcasts, Spotify, or Stitcher; and visit knowledgesuccess.org for additional links and materials.

The opinions in this podcast do not necessarily reflect the views of USAID or the United States Government.

If you have any questions or suggestions for future episodes, feel free to reach out to us at info@knowledgesuccess.org.

Thank you for listening.

Resources

- Make Way Website
- Kupenda for the Children Website
- VSO