Framework on Anti-Racism, Anti-Oppression and Equity: Factoring the Determinants of Health on Services Deliver for Survivors of Violence in Canada: Persisting inequities in the organization of service of survivorsof violence in Canada

Quadro sobre o anti-racismo, a anti-opressão e a equidade: Aspectos dos determinantes da saúde em serviços ofertados para sobreviventes de violência no Canadá: Persistindo desigualdades na organização do serviço de sobreviventes de violência no Canadá.

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Resumo: Apresentamos neste artigo aspectos dos determinantes da saúde em serviços ofertados para sobreviventes de violência no Canadá.

Palavras-chave: Anti-Racismo, Anti-opressão, Equidade, Saúde em serviços ofertados para sobreviventes, violência no Canadá.

Abstract: We present in this article aspects of the determinants of health services offered to survivors of violence in Canada.

Keywords: Anti-Racism, Anti-Oppression and Equity, Services Deliver for Survivors, Violence in Canada

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Introduction

The Peel Institute on Violence Prevention (PIVP) is an interdisciplinary and intersectorial collaborative initiative among agencies in the Region of Peel, in the province of Ontario, Canada working toward the eradication of all formsof violence.

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Objectives of the Institute

- Engage in policy analysis on current responses to violence and conduct academic and participatory action research on best-practices for the treatment and prevention of violence

- Enhance the capacities of community-based agencies by developing program evaluation tools to ensure that survivors of violence have access to seamless, interdisciplinary services and support

- How to Achieve the Objectives

- Mobilizing regional resources and sectors with expertise in the areas policy making, programs and services, development and implementation, community advocacy, and development and evaluation

- Utilizing human resources development, innovative programs and services, participatory community development, policy analysis, and evaluation methodologies with the objectives of minimizing the disparity across population sub-groups, ensuring fairness and accessibility to services and programs, and reducing violence

- Close collaboration between services providers and individualswith the lived experience of violence

- Establishing leadership focused on violence prevention

The institute recognizes that inequities are present in the day to day lives of individuals in the Region of Peel, and that health and social service agencies have not yet been able toeliminate the inequities seen across the diverse populations of this region. Diversity is a prominent characteristic of Region of Peel. According to the most recent census of 2011 provided by Peel Data Centre Peel has a population of 1.3 million, the second highest population in Ontario, where 50% are immigrants and 56.8% visible minorities (CENSUS, 2011). The top countries of birth for immigrants are India, China, Pakistan and the Philippines; for instance, 52.5% of Brampton's recent immigrants were born in India, and Mississauga residents have an average of 3.7 ethnicities (CENSUS, 2011). Additionally, eight different languages, apart from English and French, are spoken in Peel homes; yet interestingly, no city is the same within Peel (CENSUS, 2011). Punjabi is the top language in Brampton, Urdu in Mississauga, and Italian in Caledon (CENSUS, 2011). The diversity seen across Peel requires a multifaceted approach to delivering health and social services, which should recognize the unique experiences and needs of each individual or group. Ultimately, such efforts are aimed to make the Region of Peel a more just and equitable society.

Life conditions greatly influence health of an individual and overall population health. People's life conditions include where they are born, grow, live, work, and age (WHO, 2012). These societal factors are shaped by the distribution of money, resources, and power at the local, national, and global levels, and ultimately, are ***the social determinants of health***. Social determinants of health can be classified as distal, intermediate, and proximal. Distal refers to the historic, social, political, and economic factors that are impacting health outcomes, while intermediate refers to the community infrastructures, systems, resources, and capacities impacting health outcomes. Lastly, proximal factors are the ones most immediate to the individual such as, health behaviours and physical and social environment (READING; WIEN, 2009).

Social determinants can impact health on multiple levels—physical, mental, spiritual, emotional—and have distinct impacts on distinct populations (READING; WIEN, 2009). The complexity of these social factors is they create health problem, which when left unaddressed, may lead to further social difficulties.
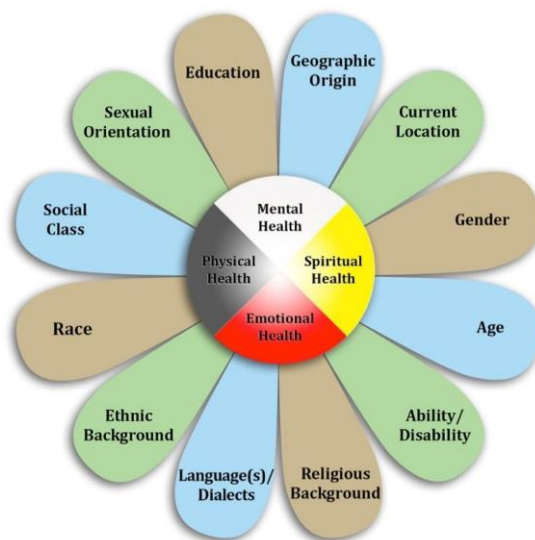

Diagram 1 – Social Determinants of Health and Well-being

Gender

Gender has become an underlying basis for discrimination in many societies (WHO, 2010). Women and girls have unfortunately bornethe

majority of the negative health effects from the socially constructed modes of masculinity, although men and boys too suffer from adverse health consequences (WHO, 2010).

In numerous societies, women and girls have difficult accessing resources, and thus, access to power and prestige (WHO, 2010). There are also too often limitations in attaining education, as well as, respected and well paid types of employment (WHO 2010). Altogether, these limitations underline women's social disadvantage and lower social status, which exposes them to numerous health risks (WHO, 2010). A study using multivariate analyses of Canadian National Population Health Survey data shows gender differences in health, measured by self-rated health, chronic illness, distress, and functional health (DENTON *et al.*, 2004). Psychosocial and social structural health determinants were overall more important for women than men, while behavioural determinants of health were more important for men (DENTON *et al.*, 2004). Gender-based health inequalities result from varying social locations of men and women, their varying lifestyle behaviours, and their varying number and levels of chronic stressors (DENTON *et al.*, 2004). Interestingly, Denton *et al.* (2004) noted significant gender differences persisted even after controlling for structural, behavioural, and psychosocial exposures.

Furthermore, Trans is a terminology used to include a diverse group of people that have gender identity different from the main societal expectations (BAUER *et al.*, 2009). Trans includes people that are gender queer, transsexual, transgender, and transitioned (BAUER *et al.*, 2009). Several research studies and needs assessment reveal day-to-day challenges faced by this sidelined group in society. Some of these challenges include ability to access appropriate health care services, and social services such as, addiction services, homeless shelters, and sexual assault services (BAUER *et al.*, 2009). Additionally, they often face direct discrimination and harassment in institutions and social environments (BAUER *et al.* 2009). The LGBTIQ—lesbian, gay, bisexual, transsexual, intersexed, and questioned queer—youth are an underserved group that has increased healthcare needs as they face greater risks to their health and well-being relative to the heterosexual youth (DYSART-GALE, 2010).

RACE

Race is used to refer to social groups that often share an ancestry and cultural heritage (WHO, 2010). The process of creating races as different, real, and unequal in manner that it impacts social, economic, and political life is called Racialization (LEVY *et al.*, 2013). In the process of constructing race, one group benefits by dominating other groups; this can be done either directly or indirectly through varying types of racism.

Racism is a concern for Canadian society, as racialized differences are evident in employment, education, and housing. For instance, the 2010

nationally representative public opinion poll of 1,707 participants showed that 38 percent of all respondents and 58 percent of respondents between ages 18 to 24 witnessed a racist episode in the past year (LEVY *et al*., 2013). Furthermore, there were 1,332 hate crimes reported to the police in 2011, of which 52 percent were motivated by ethnicity or race, and a little over half happened in Ontario (LEVY *et al*., 2013).

RACISM

Racism, a social determinant of health, is the main cause of racialized health inequities that is expressed through multiple pathways (VISSANDJEE *et al*., 2001; LEVY *et al*., 2013). For instance, racism causes stresses, including stress of discrimination; this psychological impact then initiates detrimental biological and physiological processes in the endocrine, immune, and cardiovascular systems (BOURASSA *et al*., 2004; LEVY *et al*., 2013). More extensive research in United Kingdom and United States has continued to find racialized groups experiencing poorer health outcomes compared to non-racialized groups in terms of higher rates of poor or fair self-rated health, higher infant mortality rate, and higher blood pressure and diabetes (LEVY *et al*., 2013). While Canadian research is more limited, it continues to find chronic diseases such as, high blood pressure and diabetes to be more common in some racialized groups (LEVY *et al*., 2013).

Analysis of Canadian Community Health Survey (CCHS) data reveals worst health outcomes for some racialized groups in the following:

- Overweight or obesity (people who identified as Black)

- High blood pressure (people who identified as Black, Latin American, Multiple ethno-racial identities, Other)

- Pain or discomfort (people who identified as Black)

The East or Southeast Asian group had a better health outcome than non-racialized groups on the health indicator of overweight and obesity. The CCHS and Neighbourhood Effects on Health and Well-being (NEHW) data analysis showed no differences among racialized and non- racialized groups in depressive symptoms of self-rated health, and self-rated mental health (LEVY *et al*., 2013).

Furthermore, racism limits socioeconomic opportunities for racialized groups. In every province of Canada, Canadians of colour experience higher unemployment, under-unemployment rates, and lower-incomes (GRAHAM, 2004). Labour force was the most common area in which people reported

experiencing racial discrimination in an analysis of Statistics Canada in 2002, and such stresses as in employment can lead victims of racism to begin to adopt unhealthy behaviours as a coping mechanism (LEVY *et al*., 2013).

Colonialism: The Ongoing Social Exclusion

Colonialism is defined as the governing influence or control of a nation over a dependent people, territory, or country, and it can also be defined as the policy or system that is used by a nation to maintain or advocate such influence or control (CZYZEWSKI, 2011). Colonialism results in social exclusion, which is where certain groups are denied full, equal opportunity to participate in Canadian life. The people who are more likely to experience social exclusion in Canada are Aboriginal Canadians, recent immigrants, Canadians of colour, women, and people with physical and mental disabilities; a number of areas in Canadian society neglect such populations by limiting their access to economic, social, and cultural resources (MIKKONEN; RAPHAEL, 2010). Canadians that are socially excluded have higher unemployment rates or earn lower wages, less access to social and health services, less educational opportunities, and less of an influence in political decision-making (MIKKONEN; RAPHAEL, 2010). Ultimately, social exclusion can develop a sense of hopelessness, powerlessness, and depression, which further decrease chances of inclusion within society (MIKKONEN; RAPHAEL, 2010).

On the other hand, a social safety net can be advantageous to health; it provides numerous types of programs, benefits, and support to protect individuals during life changes which affect health (MIKKONEN; RAPHAEL, 2010).

Although Diagram 1has helped to shed light on some very important social determinants of health, it fails to capture the complexity of life experiences caused by multiple interacting social identities of individuals and power relations. It does not identify a comprehensive list of determinants in a ranking order, nor does it define how each determinant should be interpreted and measured in a policy and research studies (HANKIVSKY; CHRISTOFFERSEN, 2008). As a result, a wholesome understanding of unjust disparities in health and social inequalities is still lacking.

This analysis of relationship between health and social determinants is too general. What is needed is an understanding of the multiple intersecting social identities (e.g. race, gender, socioeconomic status, violence) that contribute to the complexities of health disparities for populations that have especially been historically oppressed, and an understanding of how systems of privilege and oppression resulting in racism, sexism, and other inequalities cross at the macro social-structural level to maintain disparities (BOWLEG 2012; COLE, 2009; VIRUELL-FUENTES *et al*., 2012).

We can say that the overall health and well-being status of an individual cannot be determined by looking at only one determinant of health and well-being, but rather, in order to fully understand the status of an individual, multiple determinants impacting the individual must be recognized.

The key question in intersectionality is *Who has power and control over whom?* In Canadian society, the power to influence social norms has rested with white, able-bodied, heterosexual, middle-class men; therefore, Euro-centric values or white culture has been the norm again to which all other groups have been compared (HANKIVSKY; CHRISTOFFERSEN, 2008). Intersectionality requires looking at historically oppressed and marginalized groups—racial minorities, women, people of low-income and disabilities—within their own contexts rather than how far they have deviated from the norms of white-middle class people (BOWLEG, 2012).
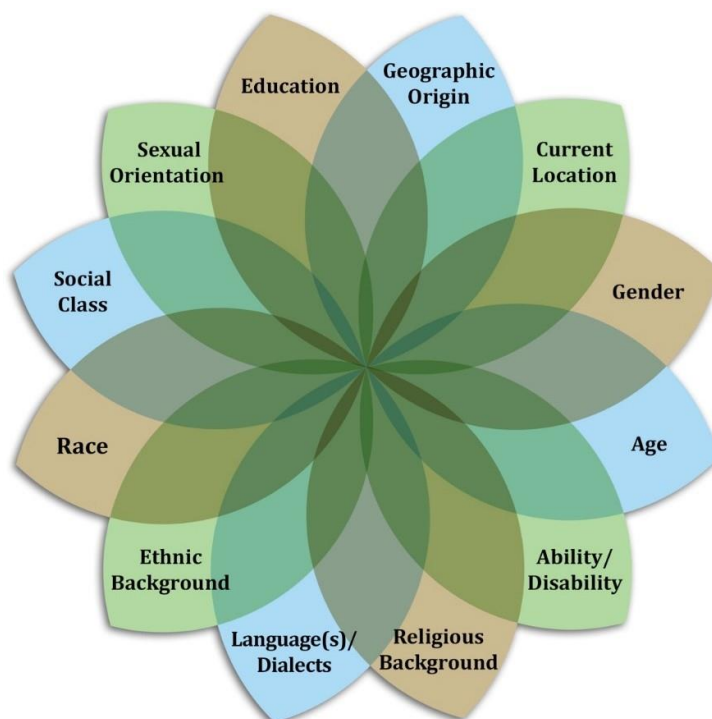
Diagram 2. Intersectionality of Social Determinants of Health and Well-being

Intersectionality and Violence

Although it is overall accepted that abuse against women occurs across social classes, races, geographic regions, and diverse societies (GILL; THERIAULT, 2005; JEWKES, 2002; MICHALSKI, 2004), a closer look at the complex relationship between violence and other social factors shows that some women are at a greater risk than others due to systemic oppressions such as, sexism and classism. In an effort to attain a healthy community for all, violence prevention, especially against women, needs to be addressed. A closer understanding between violence and social determinants of health and well-being is essential in order to deliver more equitable services that are appropriate for the needs of each individual in our community.

Gender and Race Intersectionality

Race and gender are intersected in such a way that one identity alone cannot explain the unequal outcomes without understanding the relative intersection of the other.

In another study, being an ethnic minority posed a greater health risk than the other social constructs of gender and income, and being a female was a greater risk factor than low-income (WAMALA *et al*., 2009). Being a minority and a female had greater impact on health than income-level.

Sexism and racism are also influential factors in employment opportunities. For instance, compared to Canadian men, Canadian women are less likely to be employed, and, in the pre-retirement age of 55-64, their income is barely over half that of men (STATISTICS CANADA, 2005). When race intersects with gender, it creates even higher rates of unemployment among women who are Indigenous, African Canadian and immigrant. Women's relative higher poverty rates are a result of inadequate structural systems of Canadian society. The chronic stresses of poverty, combined with everyday stresses of racism, sexism, and impacts of colonialism have a grave negative impact on physical and mental health.

Gender, Race, and Violence Intersectionality

The unfortunate experience of domestic violence is primarily rooted in gender and rooted in racialization of other determinants of health and well-being such as, socioeconomic status. For countries all over the world, violence is a major public health problem (DAHLBERG *et al*., 2002). According to World Health Organization's *World Report on Violence and Health* (2002) violence by an intimate male partner or husband is the most common form of violence against women, whereas, violence by stranger or acquaintance is the more common

form of violence for men. Violence against women includes behaviours such as, stalking, sexual harassment, forced marriages, domestic violence, rape, trafficking, and female genital mutilation. Although men may also be impacted by such forms of violence, women continue to be the primary victims of these abuses,thus, making gender a key health determinant of violence.

While there is no debate about the negative consequences of violence on women's overall health, there is controversy over the role social inequities playin making women more susceptible to violence.

Throughout Canada members of racialized groups appear to have worse circumstances than members of non-racialized groups (LEVY *et al*., 2013). While data shows that the two groups have comparable levels of education, the historic income analysis shows increasing income inequalities between racialized and non-racialized groups (LEVY *et al*., 2013). Therefore, victimization is associatedmore so with populations which are socially and economically isolated, as is the case for blacks who are disproportionately represented in socially disadvantaged communities (RENNISON; PLANTY, 2003).

The relationship between social determinants of health and victimization of women is a complex one; there is not one determinant of health that is most linked with violence against women but rather multiple determinants of health are interwoven together to create circumstances resulting in domestic violence. For instance, the direct and indirect health impacts of intimate partner violence are mediated by factors like stress, social support, and self-care agencies (PLICHTA, 2004). However, gender is a key factor that cannot be ignored in understanding the link between violence and health outcomes

To begin with, service providers' interventions should address victimization from either a causal or a consequential direction. When a woman accesses economic support, a referral system to a social service agency may also need to be implemented as her decline in economic status may have been due to the victimization; on the other hand, agencies serving women of low socioeconomic status should be aware of victimization as a causal possibility of their status and should be prepared to provide referrals to a social service agency (BYRNE, *et al*., 1999). Thus, it may be most beneficial for a woman to receive both social and economic support simultaneously with the hope of preventing revictimization.

Current literature shows intimate partner violence or domestic violence as a serious concern among the Aboriginal community and especially for Aboriginal women (CAMPBELL, 2007; PALETA, 2008; WOOD; MAGEN, 2009). In Canada, Aboriginals are three times more likely to be victims of spousal violence, which does not suggest that it is more inherent to their culture but rather indicates the oppressed and underprivileged status they endure in Canada (GILL; THERIAULT, 2005). The male-domination of societies and the historic

context of colonialism have contributed to the oppression of Aboriginal women (MOFFITT *et al*., 2013).

Colonization introduced the patriarchal nature of North American society among the Aboriginal communities, which removed the Aboriginals from their established egalitarian culture that offered men and women equal power in the economy; in the post-colonial society, however, Aboriginal men had difficulty enforcing patriarchy in the midst of socio-economic downturn as women became the primary wage earners (MOFFITT *et al*., 2013).

EQUITY FRAMEWORK OF DETERMINANTS OF HEALTH AND WELL-BEING

The following Equity Framework of Determinants of Health and Well-being prioritizes gender and race as key determinants of health that together play a central role in the experiences of everyday life of an individual. Gender and race often cannot be ignored at the intersection of other social determinants of health and well-being. Additionally, the intersection of any proximal, intermediate, and distal determinants should result in optimal health in all of its aspects—physically, emotionally, spiritually, and mentally. The intersection of social determinants in this model goes to further indicate an array of experiences that can result from various life experiences. Thus, all life experiences are equally valuable and must be equally addressed in the community.
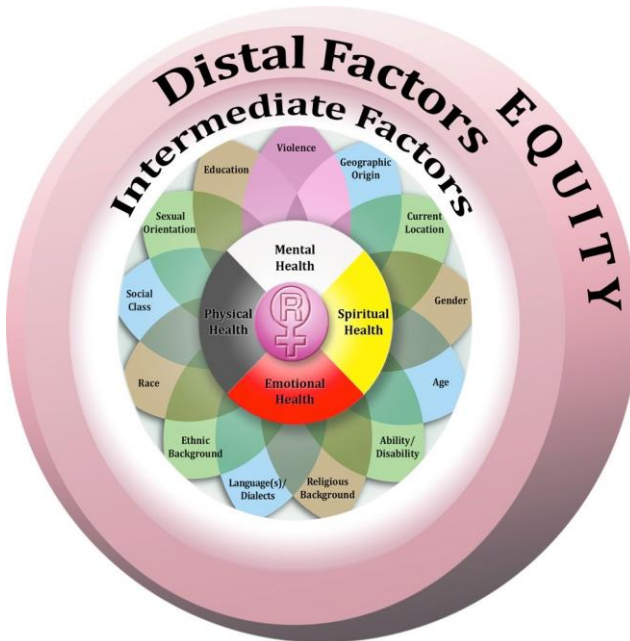
Diagram 3 – Equity Framework

EQUITY IN SERVICE DELIVERY

INEQUALITY VS. INEQUITY

Inequality is merely the difference between individuals or population groups, and may not necessarily be unjust. However, when these differences between individuals and population groups are preventable and avoidable, it makes those differences unfair and unjust. This unjust inequality is defined as inequity. For instance, women generally live longer than men, which is likely due to biological sex differences; therefore this is not inequitable. However, in cases where women have the same or lower life expectancy as men, inequity persists due to the social conditions reducing the seeming natural longevity advantage of women (WHO 2007). Inequities are seen across social determinants of health and well-being and are maintained by an unequal distribution of economic and social resources, along with power and prestige across social hierarchies. A distinction has to be made between the social factors influencing health and well-being and the distribution of the social determinants through the social processes (BRYANT *et al*., 2011). This distinction is essential because even after improvements in health and health determinants have been made, social disparities continue (GRAHAM, 2004).

For example, the last thirty years have seen great improvements in health determinants such as, declining smoking rates and rising living standards, and improvements in people's health such as, life expectancy. Nevertheless, these improvements have not broken the association between social disadvantage and premature death, nor the greater link between socioeconomic position and health (GRAHAM, 2004). A more in-depth analysis is needed to understand the health inequities seen across the populations, which are not reflected in the health determinant model portrayed in diagrams one and two. These diagrams do not identify any social processes that play a role in maintaining inequities. By using these models to define both health and health inequity, it obscures the difference between the social factors that impact health and the social processes that define their unequal distribution.

ROLE OF HEALTH AND SOCIAL SERVICE ORGANIZATIONS

Health and social service organizations are well-intended to eliminate social injustices in their communities. Although the organizations' intent is to be impartial and provide just service to all individuals who seek their assistance, it is important to be cognizant of the fact that such organizations do not exist in a vacuum and are vulnerable to indirectly adopting systems of oppression that are present in the larger society to which they belong and serve (COLLINS; BARNES, 2014). If organizations are internally structured according to systems of domination like racism, classism, and sexism and adopt the norms and values

of the dominant culture in their organizational policies and practices, then they cannot successfully promote services that reflect empowerment, diversity, and sustainable social justice (PERKINS *et al*., 2007; COLLINS; BARNES, 2014). As a consequence of not looking at their internal inequities, Collins; Barnes (2014) state that the health and human service may "alienate, silence, and create continual need for services in marginalized communities (p.74)." In order to prevent this, organizations need to carefully look at how they allow access to services, coordinate care, and provide continuous care in line with the principles of equity across determinants of health and well-being.

ACCESS

According to Ontario's Local Health Integration Network (2014), accessibility is "the ability, opportunity and means to approach, consult, and utilize an organization's services and organizational structure." Equity in access then implies that every individual in the community has the ability to, the means to and the opportunity to attain the needed health and human services, regardless of their gender, race, ethnicity, socioeconomic status, religion, or other socially created constructs or circumstances. Unfortunately, barriers in accessing health care are filled with oppressive practices that are embedded in systemic oppressions such as, racism, sexism, and classism; altogether these function "within complex public service systems, with their inherent densely connected networks" (MCGIBBON; MCPHERSON, 2011, p. 76).

By limiting equal access to resources across a population, health will inevitably suffer in some populations more than others (WHO 2007). Across social groups there are differences in levels of stress, frustration, deprivation, and access to resources to deal with negative life circumstances. It is argued that while people with higher socioeconomic positions have access to more resources to better cope with life stressors, those of lower socioeconomic status lack such resources, causing them to be more strongly affected by negative life events (WINNERSJO *et al*., 2012). Such differences in access to resources may also help to explain why victims of violence of low socioeconomic status report higher odds of poor health than those of high socioeconomic status and are non-violence victims (WINNERSO *et al*., 2012). Furthermore, racism also restricts access to care. For instance, African Canadians and Aboriginal Canadians face continuous barriers in access to care that includes discrimination and racism at point of care (MCGIBBON; BASSETT, 2008, FISH, 2007, KARLSEN; NAZROO, 2002).

Interventions aimed at increasing access to material resources to historically marginalized groups is a required effort to address historical oppression and promote community well-being; despite this effort, inequities have persisted due to the fact that dominant groups and institutions control how, when, and whether marginalized groups access resources through the programs and

policies reflective of their values and experiences (COLLINS; BARNES, 2014). Essentially a close look is needed at the processes of these oppressive systems and how determinants of health and well-being operate within them rather than just looking at the consequences of oppressive systems such as, discrimination, health disparity rates and so forth. The former will help us to better understand the persisting inequities between different groups of a population.

CONTINUITY AND COORDINATION OF CARE AND SERVICES

Continuity of care and services is how an individual experiences a series of care/services over a period of time as linked and coherent; this occurs when separate and distinct elements of care/service are connected and are maintained and supported over time (HAGGERTY *et al.*, 2013). However, segmenting the delivery of care and segmenting the delivery of services has increased rapidly due to changes in treatments and specializations, causing individuals to seek care from various types of providers from various types of settings. As a result, an increased interest in continuity of care/service stems from concerns regardedin cases such as the following (GULLIFORD *et al.*, 2006):

- Client-centredness

- Quality of care/service in chronic or long-term cases and conditions

- Fragmentation in delivery of care and services

Different organizations have defined continuity of care/service in various perspectives; while some definitions concentrate on the relationship between patients and physicians and clients and service providers over time, others define it in terms of the coordination and consistency between different settings and different staff members (GULLIFORD *et al.*, 2006). Continuity of care and service is essentially concerned with quality of care, which is rooted in client-centeredness. In order to ensure satisfactory continuity of care and services for all groups of people, equity is an important value that cannot be overlooked when providing the best quality of care possible. Numerous continuity of care definitions reveal two core concepts— continuity of care as 'continuous caring relationship' and continuity of care as a 'seamless service' (GULLIFORD *et al.*, 2006).

***Continuous Caring Relationship*:** the primary service provider focuses on the needs of a client whom he/she may know well; the focus is on interpersonal care

- To what extent are the client's consultations concentrated in the hands of one or a small number of professionals?

- Quality of client-professional relationship

- How personal is the care?

- Is it tailored to individual needs?

- Is there a concern for the 'whole person'? Is the illness being managed in the context of thepatient's life?

Seamless Service: this aspect of continuity of care focuses on quality of teamwork, the degree of communication, consistency, and coordination among varying service providers or specialists; interpersonal continuity is not the primary focus (GULLIFORD *et al.*, 2006)

Ultimately, continuity and coordination in the delivery of care and services are valuable if they lead to increased client satisfaction and more equitable outcomes in determinants of health and well-being.

CONCLUSION

What is the Goal?

- To incorporate anti-oppressive and equitable practices in health and social service agencies of Peel in order to eliminate inequities experienced by Peel's diverse populations

The goal can be met by reorganizing the services in Peel so that they are all-inclusive and reflective of the diverse population of this region. The current system of delivering health and social services focuses primarily on the average, white Canadian and does not account for the diversity of experiences of the people of this region.

THE APPROACH

In order to achieve the goal, the Peel health and social organizations are encouraged to do the following:

1. Collectively standardize systems for collecting data and sharing the data

- This will require the following:

- Collecting information on the same key demographics and determinants of health and well-being

- Identifying best methods for data collection

- Developing a procedure and location to share data and maintaining most updated information

2. Redesign the services to reflect the diversity of experiences in Peel and according to the demographic diversity revealed in the data

A full understanding of the unique experiences of the diverse populations coming to seek services is essential to developing the most efficient services. Diagram 4 is a useful tool to begin to understand the diversity of experiences in Peel. This begins by developing communication with the populations served and identifying how many determinants of health and well-being simultaneously play a role in the status of their health and well-being. The communication should begin with the current population being served and can be developed by the following means:

- One-on-One interviews
- Focus Groups
- Surveys

The communication methods ultimately should help to yield the following information:

- Note patterns of experiences and identifywho is having these similar experiences?
- Create subpopulations according to these experiences
- Identify which or how many determinants of health and well-being have intersected to create that experience for them?
- How many of these determinants of health and well-being are having a direct impact on each other or have a cyclic relationship?
- What services can be provided for this unique experience?
- How to implement continuity of care and coordination of care to gain the client's confidence?

Communication with those seeking services needs to be an on-going process in order toidentify new experiences, for which the most-appropriate set of services can be provided.

3. Train the staff to recognize and manage the diversity of experiences

The staff should be trained to understand the diverse set of experiences that the clients may bring forth at their organization, and how to provide the appropriate and matched set of services for each.

4. Evaluate the organization's programs and services

Evaluation of the programs and services in essential in order to determine whether the needs of the diverse populations are being met andto ensure thatthe Region of Peel is working towards a more equitable society

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