Framework on Anti-Racism, Anti-Oppression and Equity: Factoring the Determinants of Health and Persisting Inequities in Services Delivered for Survivors of Violence in Canada

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Abstract: It is now understood that the differences between individuals and population groups which are preventable and avoidable are differences which are unfair and unjust; this unjust inequality is defined as inequity. The Institute on Violence Prevention recognizes inequities present in the day to day lives of individuals in the diverse Region of Peel have not been eliminated by the health and social service agencies. The literature review describes the Intersectionality of multiple social determinants of health and wellbeing as integral to delivering equitable health and social services and achieving optimal health and wellbeing according to the Aboriginal Circle of Health. The Equity Framework proposed by the Peel Institute on Violence Prevention contributes to the discussion of racism, oppression, equity, and determinants of health and well-being; it prioritizes gender and race as key determinants, which cannot be ignored at the intersection of other social determinants of health and well-being such as, violence. The Institute expects the client-centered approach of the framework can help to deliver a vision for a more unified community that eliminates inequity among the populations.

Keywords: Equity in Accessibility, Inclusion and Exclusion

Background

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

Objectives of the Institute

The objectives of the institute are to 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. Furthermore, the institute enhances 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

In order to achieve the objectives, PIVP mobilizes regional resources and sectors with expertise in the areas of policy making, programs and services, development and implementation, community advocacy, and development and evaluation. It furthermore utilizes 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 individuals with the lived experience of violence is essential, along with, 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 to eliminate the inequities seen across the diverse populations of this region. Diversity is a prominent characteristic of Region of Peel, which includes the cities of Mississauga, Brampton, and Caledon. 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 (2011 Census). 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 (2011 Census). Additionally, eight different languages, apart from English and French, are spoken in Peel homes; Punjabi is the top language in Brampton, Urdu in Mississauga, and Italian in Caledon (2011 Census). 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.

Figure 1. Social Determinants of Health and Well-being

Introduction to Social Determinants of Health and Wellbeing

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 and wellbeing. Social determinants of health and wellbeing can be classified as distal, intermediate, and proximal. Distal refers to
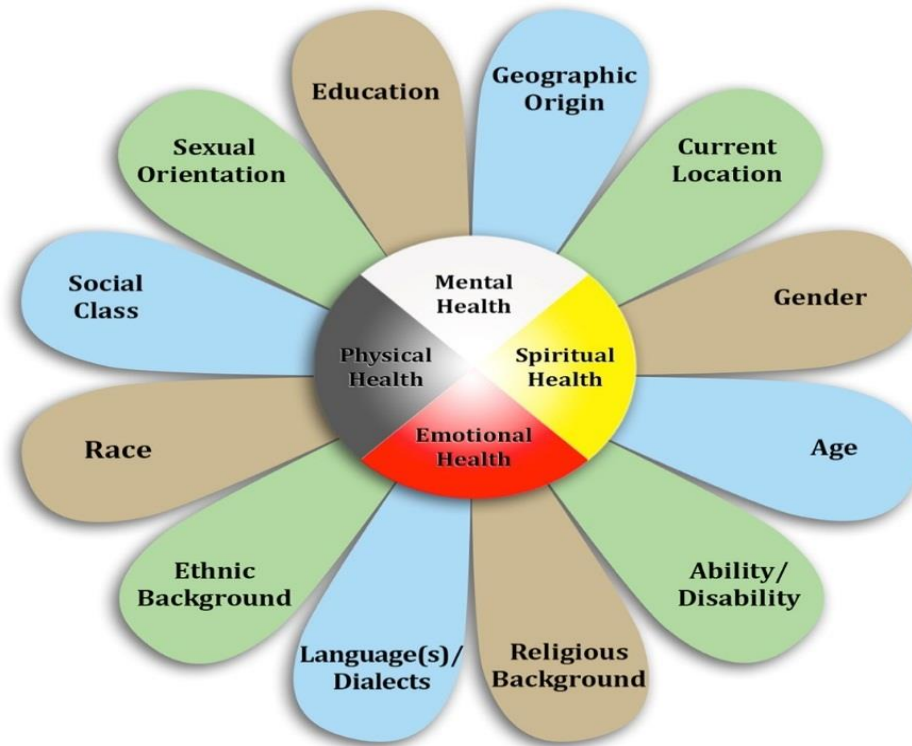
the historic, social, political, and economic factors that are impacting health outcomes, while intermediate refers to the community infrastructures, systems, resources, and capacities impacting health outcomes. Lastly, proximal factors are the ones most immediate to the individual such as, health behaviors and physical and social environment (Reading and Wien 2009).

As seen in the figure below social determinants can impact health on multiple levels—physical, mental, spiritual, emotional (Reading and Wien 2009). The complexity of these social determinants is they can create health problems, which when left unaddressed, may lead to further social difficulties.

Gender
Gender has become an underlying basis for discrimination in many societies (WHO 2010). Women and girls have unfortunately borne the 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 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 (Statistics Canada, 2013) data reveals worst health outcomes for some racialized groups such as overweight or obesity for people who identified as Black, high blood pressure for those who identified as Black, Latin American, and multiple ethno-racial identities. 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 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 and 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 and Raphael 2010). Ultimately, social exclusion can develop a sense of hopelessness, powerlessness, and depression, which further decrease chances of inclusion within society (Mikkonen and 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 and Raphael 2010).

Intersectionality of Social Determinants of Health and Wellbeing

Although Figure 1 has 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 and 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)

Figure 2. Intersectionality of Social Determinants of Health and Well-being

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, as reflected in Figure Two. 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 and 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).
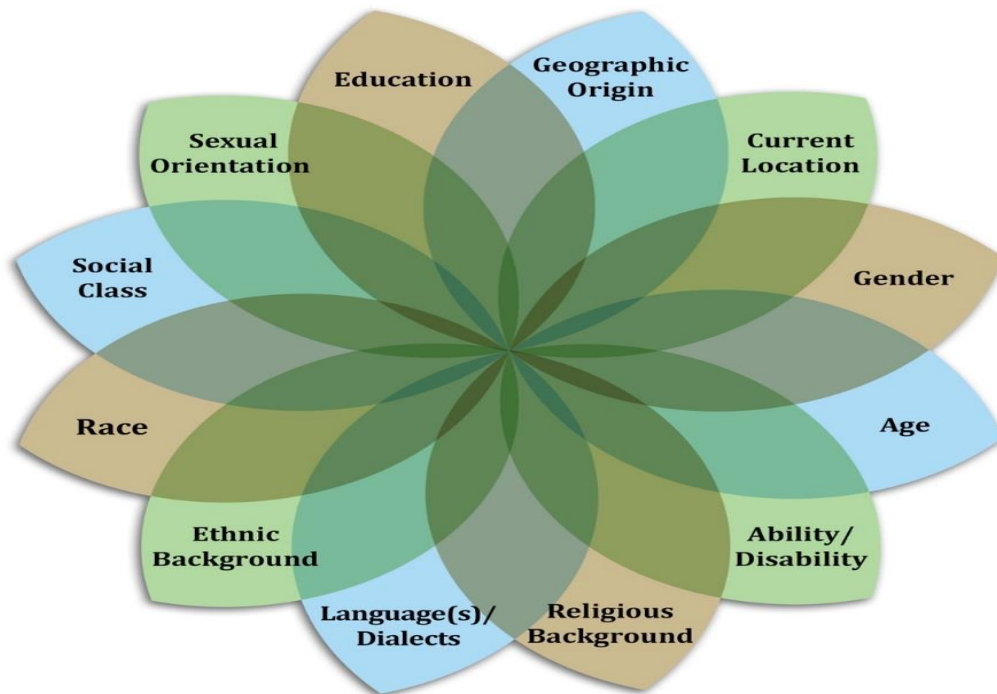
Intersectionality and Violence

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 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 play in 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 associated more so with populations which are socially and economically isolated, as is the case for blacks who are disproportionately represented in socially disadvantaged communities (Rennison and Planty 2003).

Current literature also 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 and 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 and 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).

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 re-victimization.

Applying Intersectionality to a New Framework: Equity Framework of Determinants of Health and Wellbeing

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 figures one and two. F 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.

The following Equity Framework of Determinants of Health and Wellbeing 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.

Figure 3. Equity Framework
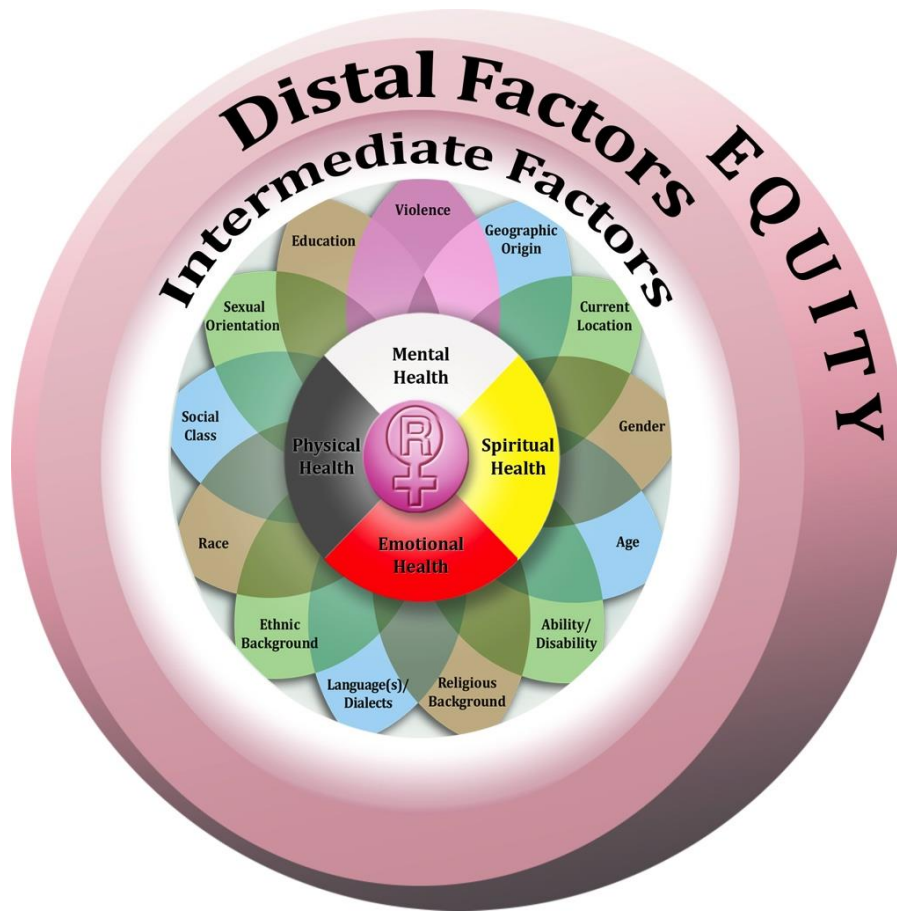
Areas to Apply the Framework

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 and 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 and Barnes 2014). As a consequence of not looking at their internal inequities, Collins and 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 and McPherson 2011, 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 (Winersjo 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 (Winersjo 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 and Bassett 2008; Fish 2007; Karlsen and 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 and 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 regarded in cases such as client centeredness, quality of care/service in chronic or long-term cases and conditions, and fragmentation in delivery of care and services (Gulliford et al. 2006).

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 is where the primary service provider focuses on the needs of a client whom he/she may know well and the focus is on interpersonal care. It focuses on the quality of client-professional relationship. To what extent are the client's consultations concentrated in the hands of one or a small number of professionals? 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 the patient's life?

Seamless Service aspect of continuity of care focuses on quality of teamwork, the degree of communication, consistency, and coordination among varying service providers or specialists; here 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
A Goal with an Approach
The goal is 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.

In order to achieve the goal, the Peel health and social organizations are encouraged to do four things. First, collectively standardized systems for collecting data and sharing the data should be established; this will require collecting information on the same key demographics and determinants of health and well-being, identifying best methods for data collection, and developing a procedure and location to share data and maintaining most updated information.

Second, design of the services need to reflect the diversity of experiences in Peel and 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. Figure 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 with methods such as, one-on-one interviews, focus groups, and surveys.

The communication methods ultimately should help to yield the following information: patterns of experiences and identifying who is having similar experiences, ability to identify subpopulations according to these experiences, determine which or how many determinants of health and well-being have intersected to create that experience, and identify the determinants having a direct impact on each other or having a cyclic relationship. Communication with those seeking services needs to be an on-going process in order to identify new experiences, for which the most-appropriate set of services can be provided, along with implement the most appropriate continuity of care and coordination of care to gain the client's confidence.

Third, staff training must entail how 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.

Fourth, Evaluation an organization's programs and services are needed in order to determine whether the needs of the diverse populations are being met and to ensure that the Region of Peel is working towards a more equitable society.

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