FAMILY SERVICES of PEEL
Since 1971

Persisting Inequities at the Intersection of Multiple Identities of Victims of Violence Due to Inequities in Social Determinants of Health and Well-being: Literature Review

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Peel Institute on Violence Prevention

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BACKGROUND

Peel Institute on Violence Prevention

The Peel Institute on Violence Prevention is an interdisciplinary and intersectorial collaborative initiative among agencies in the Region of Peel. In 2013, the Institute was secured in a grant from the Ontario Trillium Foundation, which is administered by Family Services of Peel.

The Institute was established to be a central, region-wide initiative focusing on the prevention of all forms of violence in Peel. Operating under an anti-oppression, anti-racism framework, the Institute will be a central point for data-driven, evidence-informed practice, which will improve the organization of community services, combining the perspectives of the diverse population served, academia, and community service providers.

The research and violence prevention work of the Institute will focus on survivors of sexual assault, domestic violence, elder abuse, youth violence, and human trafficking for the following at risk groups: youth, seniors, women, aboriginal population, people with disabilities, and male victims of sexual assault/abuse. The data collected by the Institute will enable the reorganization of services and programs to be more focused on survivors' needs.

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 individuals with the lived experience of violence
- Establishing leadership focused on violence prevention

Why is the Institute Interested in Work on Inequities in Social Determinants of Health and Well-being?

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. 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; yet interestingly, no city is the same within Peel (2011 Census). 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.

PART 1: SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

What are Social Determinants of Health and Well-being?

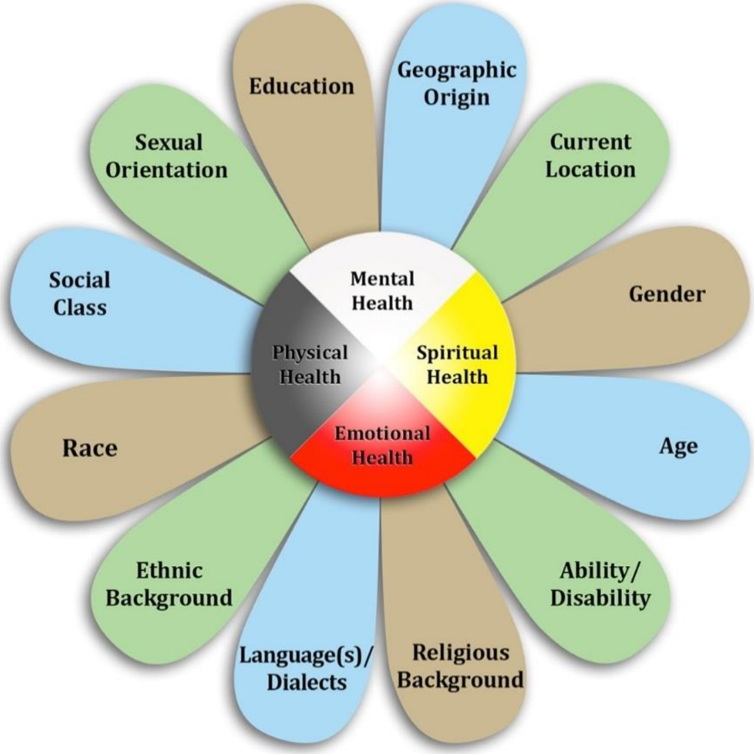
An individual's good health and well-being do not merely result from the absence of disease; it needs to be understood from a holistic perspective that incorporates the physical, mental, spiritual, and emotional dimensions in an interrelated way (Reading & Wien, 2009). It is recognized overall in health literature that the complexities of health issues require a more holistic approach rather than just concentrating on prevention and treatment of illnesses (Reading & Wien, 2009).

Diagram 1. Aboriginal Circle of Health

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. For example, it is a known fact that living in low-income conditions, a social determinant, is linked to increased illness and disability; consequently, these health conditions decrease opportunity to attain employment, which ultimately aggravates poverty (Reading &Wien, 2009). The following is a brief overview at certain determinants and their potential impact on the quality of health and well-being.

Diagram 2. Social Determinants of Health and Well-being



Proximal Determinants of Health and Well-being

Behavioural and Biological Factors

Health behaviours work to either impact health positively or negatively. While positive health behaviours such as, regular exercise and balanced diet can protect and improve health, negative health behaviours like smoking, drinking, poor diet, lack of exercise, and violence can be damaging to health. According to World Health Organization (2015), violence is "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." Thus, violence inherently has negative health impacts upon the victim. In 2009, Peel Regional Police countered 13,319 domestic disturbances, which was a 40 percent increase compared to 2005 (Portraits of Peel, 2011). The witness of violence against their mother causes children's health to suffer emotionally, cognitively, and physically; furthermore, children who are exposed to abuse have a greater chance of being abused or being abusive as adults. In 2008-2009 Peel Children's Aid investigated

1,499 cases of physical abuse, 601 cases of neglect, 196 cases of sexual abuse, and 99 cases of emotional abuse (Portraits of Peel, 2011).

Biological factors also come into play; this includes genetic factors and age and sex distribution from social determinants of health perspective (WHO, 2010). Social differences in lifestyle behaviours can be seen in physical activity, nutrition, and alcohol and tobacco consumptions. Lifestyle differences in themselves only partially explain social inequalities in health as researchers are not always in agreement on their significance; lifestyle choices are perhaps more closely related to education, income, status of employment, and other material circumstances (WHO, 2010).

For instance, a link is noted between experiencing racial discrimination and partaking in unhealthy behaviours (Levy et al., 2013). One reason is that perhaps by engaging in unhealthy practices, it helps to cope with and manage the stress of a racial discrimination experience; another explanation is the experience and response to racism depletes psychological resources required to avouch unhealthy behaviours (Levy et al., 2013).

Physical Environment

The physical environment, or the built environment, refers to the housing, community infrastructure, and the transportation systems of a community (WHO, 2010). More importantly, it is the conditions of these in a community that greatly impact the physical and psychological well-being of an individual (Public Health Agency of Canada, 2009). Excessive exposure to contaminants in food, water, air, and soil can lead to a number of adverse health effects such as, respiratory illnesses, gastrointestinal conditions, birth defects, or cancer (PHAC, 2009). The two primary places where the conditions have a great effect on people's lives are workplaces and homes.

Adverse working conditions are experienced often by people who are already most susceptible to poor health outcomes because of their lower education and income (Mikkonen & Raphael, 2010). The factors that determine workplace conditions are physical conditions at work, employment security, working hours, work pace and stress, and opportunities for progress and self-development at work; negative exposure to these factors over a long period of time can result in health issues such as, cardiovascular disease, high blood pressure, anxiety, and depression (Mikkonen & Raphael, 2010).

A number of studies indicate homelessness and poor quality housing are a matter of great concern for Canadians' health. To decrease the risk of health problems, housing must not only be available but also be safe and affordable (Mikkonen & Raphael, 2010). The scarcity of economic resources is the main reason many Canadians have difficulty with housing issues. A large contributor to income inequality and poverty in developed nations is related to housing affordability (Bryant et al., 2011). When large amounts of income are spent on housing, there is little income left to attain resources like quality food and healthcare (Bryant et al., 2011).

Social Environment

A supportive social environment entails social stability, safety, good working relationships, cohesive communities and recognition of diversity (PHAC, 2009). Social support includes the social networks of family, friends, organizations, and other groups, as well as, the material support, emotional support, and sense of belonging provided through them (Region of Peel, 2011). A supportive social environment acts as a buffer against health problems by deterring possible risks to good health (Region of Peel, 2011). For instance, it has been noted that premature death rates decrease as social contacts increase (Region of Peel, 2011).

Long-term social inequalities in health also stem from the fact that different social groups are exposed in varying degrees to difficult and worrying life situations in everyday life (WHO, 2010). Living in high risk conditions subjects people to less social support, fewer social networks, and greater unhappiness, altogether which first trigger self-blame and low sense of power, and then decreased physiological functioning (Labonte, 1993). In turn, these physiological risk factors and relevant illnesses may prevent an individual's ability to maintain social networks of support (Labonte, 1993).

As in the case of victims of spousal abuse, despite the development of a number of institutionalized services, they first turn to informal sources of support prior to formal sources; they confide most frequently to family members, friends, or neighbours (Canadian Centre for Justice Statistics, 2005). As a result, isolated women lacking solid social support, such as those who are divorced, retired, and new immigrants have a significantly greater likelihood of Intimate Partner Violence (Vives-Cases et al., 2011; Michalski, 2004).

Gender

Gender indicates a set of characteristics of men and women that are socially constructed, while "sex" refers only to the biologically determined characteristics (WHO, 2010). This set of characteristics includes various society-determined behaviours, roles, attitudes, personality traits, values attributed to the two sexes differentially, which essentially models the relations between boys and girls and men and women (PHAC, 2009). 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, similar to gender, is also not a biological category; it is socially constructed. Ontario Human Rights Commission defines race as a "socially constructed way of judging, classifying, and creating differences among people" based on physical features such as, skin colour (Ontario Human Rights commission, 2005). Race is also 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).

Intermediate Determinants of Health and Well-being

Health Systems and Services

A health system provides a set of health services that aim to maintain and promote health, prevent disease, restore health and functioning, and support population health (PHAC, 2009). The goal of a universal health care system is to protect the health of citizens and share the health care costs across society (Mikkonen & Raphael, 2010). A universal health care system is relatively effective in protecting its citizens with lower income, who otherwise would not be able to afford private health insurance; however, issues in regards to access to care persist (Mikkonen & Raphael, 2010). For example, the bottom 33 percent of Canadian income earners are 50 percent less likely to see a specialist when needed, relative to the 33 percent of top earners; furthermore, they are 50 percent more likely to have difficulty getting care on evenings and weekends, and 40 percent more likely to wait at least five days for an appointment with a physician (Mikkonen & Raphael, 2010).

Canadians studies have noted racialized inequities in health care access, screening tests, specialist and hospital care, and preventative health care (Levy et al., 2013). Racialized group members also have lower levels of patient satisfaction than non-racialized group members, which can potentially be due to racism and discrimination in health care settings (Levy et al., 2013). The ultimate goals of the health system is to resolve the differential consequences of illness in people's lives, preventing health problems from deteriorating people's social status, and enabling social integration of people with illness (WHO, 2010).

Social Capital

Social capital is overall the connections between and within social networks (Region of Peel, 2011). The importance of social capital in understanding social determinants of health is under debate; while influential researchers do claim it to be a key factor in affecting population health, there is controversy around its definition (WHO, 2010). Analysis of social capital can be approached in the following three ways:

- Communitarian: social capital as a psychosocial mechanism; health is impacted by the social support mechanisms of social relationships
- Network: an ecological and systemic relational perspective looking at resources that flow and rise through social networks; it looks beyond the individual's resources to analyze the impact of power hierarchies, social structure, and access to resources on population health. This emphasizes that people's lifestyle choices and behavioral habits must be accounted for within their social context
- Resource Distribution: this materialistic viewpoint raises caution to promoting social capital as a substitute for structural change when addressing health equity (WHO, 2010).

On the one hand, social capital is expected to develop through strengthening the relationship between citizens of a community and the institutions of the community. This requires the community to have a high-level of influence in developing flexible systems that allow citizen participation and a high influence in decision-making and development of policies impacting their health and quality of life; on the other hand, social capital is not viewed as a uniform notion (WHO, 2010). It is contested whether social capital should be identified as a property of communities, groups, networks, or the individual, and where it should be placed in the social order (WHO, 2010).

Within the region of Peel, almost two-thirds of the residents reported having very strong or somewhat strong sense of community belonging; interestingly, however, the Peel residents with less than secondary education reported having a greater sense of community than those with higher education (Region of Peel, 2011). As for civic engagement, just over one-third of Peel residents were a member of a volunteer organization, but those between the ages of 12 to 19 were more engaged than those in older age groups (Region of Peel, 2011). Furthermore, civic engagement showed no relationship with income or education in Peel (Region of Peel, 2011).

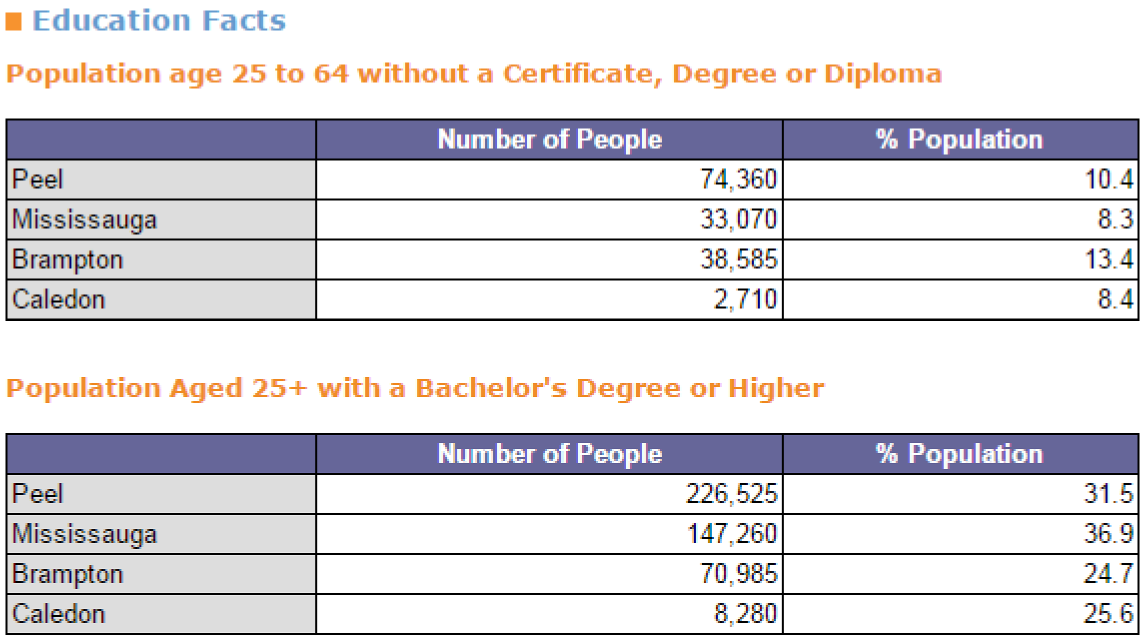
Education

Health status also improves with increased levels of education (WHO, 2010). Because education provides people with knowledge and skills for problem-solving and a sense of control in circumstances of life, it promotes prosperity and health (PHAC, 2009). Education increases job opportunities, job satisfaction, and income security; therefore, education becomes a close tie to socioeconomic status (PHAC, 2009). The valuable education that children receive and the ongoing learning through adulthood impact their ability to access and understand information that will help them stay healthy (PHAC, 2009).

It can be measured in years of completed education, a continuous variable, or in categorical variables looking at educational milestones such as, completion of primary or high school, educational diplomas or degrees (WHO, 2010). Even though education is used as a generic measure of socioeconomic position, the following are a few ways to explain its specific association with health outcomes:

- Education allows a transition from parents' socioeconomic position to one's own, adulthood socioeconomic position; it's a strong factor for future employment and income
- The knowledge gained through education could affect cognitive functioning, making a person more willing to receive health education messages, and better enabling them to access and communicate with health service

The 2011 Census revealed the following educational facts about Region of Peel (Peel Data Centre):



■ **Education Facts**

Population age 25 to 64 without a Certificate, Degree or Diploma

	Number of People	% Population
Peel	74,360	10.4
Mississauga	33,070	8.3
Brampton	38,585	13.4
Caledon	2,710	8.4

Population Aged 25+ with a Bachelor's Degree or Higher

	Number of People	% Population
Peel	226,525	31.5
Mississauga	147,260	36.9
Brampton	70,985	24.7
Caledon	8,280	25.6

The above charts show that while Brampton has a greater concentration of people without certifications or degrees, Mississauga has a greater concentration of people with higher education.

Income

Income is recognized as an important determinant of health as it is still the best single indicator of material living (WHO, 2010). With each step up the income and social hierarchy, health status improves. High incomes allow for better living conditions such as, safe housing and the ability to buy enough healthy food (Public Health Agency of Canada, 2009). In societies, the healthiest populations are those that have an equitable distribution of wealth and are prosperous (PHAC, 2009).

The relationship between income and health can be first looked at how much actual income that an individual or family receives (Mikkonen & Raphael, 2010). Studies show Canadians with low-income are more likely to die earlier and suffer more illnesses than Canadians with higher income despite the sex, age, and place of residence factors (PHAC, 2009). For instance, lower-income Canadians are also more likely to wait five days or more to see a physician and have greater difficulty seeing a medical specialist (Bryant et al., 2011). Income, overall, is not a straightforward variable (WHO, 2010). It has various components that include wage earnings, pensions, dividends, interest transfer payments, child support and alimony (WHO, 2010).

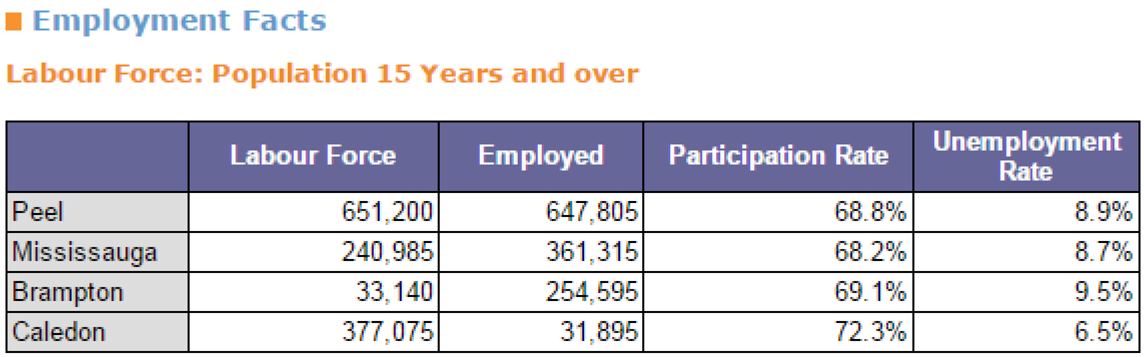
While Peel has the second highest percentage of people living in low-income in the GTA, 31%, it also has the third highest medium after-tax household income of $68 000 (2011 Census). Moreover, Peel has the highest median monthly cost for housing: $1587 for owned dwellings and $1053 for tenant households (2011 Census). Such contrasts can be, in part, attributed to the participation, employment and unemployment rates in Peel.

Occupation

Numerous aspects of occupation can lead to decreased health—low-paying occupations, unemployment, underemployment and unsafe or stressful work. Significant research shows the degrees to which an individual has control over life circumstances, specifically stressful circumstances, and his or her discretion to act influences health greatly (PHAC, 2009). This control and discretion is permitted more so in higher paying occupations and social status, thus making income closely related to occupation.

Essentially, occupation is a mechanism used to determine people's place in the social hierarchy since it is a reflection of a person's intellect, income, and social standing (WHO, 2010). The occupation structures the working relations between employers and employees as dominant and subordinate and helps to identify people as exploiters verses exploited in class relations (WHO, 2010). Occupations can be classified into social classes by means of information on occupation title, skills required, leadership functions, and income pay-off (WHO, 2010). Because occupations reflect social standing, it is related to health outcomes and privileges such as, having easier access to good health care, health information, education, and residential facilities (WHO, 2010).

The following chart from the 2011 Census (Peel Data Centre) shows Brampton as having the highest unemployment rate in the Region of Peel, while Caledon as having the highest participation rate.

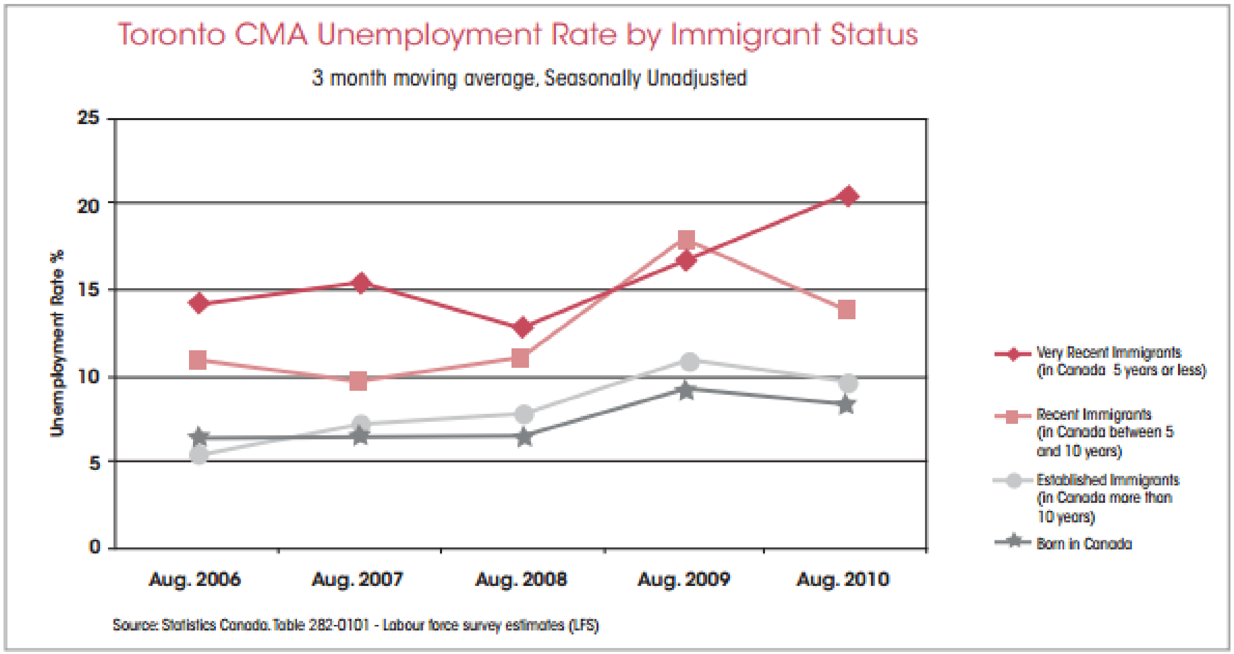


Employment Facts

Labour Force: Population 15 Years and over

	Labour Force	Employed	Participation Rate	Unemployment Rate
Peel	651,200	647,805	68.8%	8.9%
Mississauga	240,985	361,315	68.2%	8.7%
Brampton	33,140	254,595	69.1%	9.5%
Caledon	377,075	31,895	72.3%	6.5%

Immigrants to Canada face challenges in employment, despite their qualifications. Nearly 60 % of newcomers to Canada do not work in the same field of occupation as they did before coming here (Portraits of Peel, 2011). Furthermore, the contribution of newly, educated immigrants is often overlooked and unrecognized; interestingly, research shows a 1% rise in the share of immigrant engineers and scientists increases patenting at least by 41 percent (Portraits of Peel, 2011).



(Portraits of Peel, 2011)

Social Class and Economic Status

Social and economic status appear to be of the most important determinants of health due to the strong and growing evidence that an increase is status is associated with better health (PHAC, 2009; Veugelers & Yip, 2003). Socioeconomic status is defined by the relations of power, ownership, and control over productive financial, physical, and organizational resources (WHO, 2010). Individuals' standard of living is determined by their practices and methods dedicated to attain income, which is dependent on the scope of their legal right and power to control productive assets (WHO, 2010). This further goes to explain how economic inequalities are produced and impact health and how a person's social class has significant consequence on his or her life (WHO, 2010). Lower socioeconomic status has been linked with receiving fewer health tests such as, diabetic eye examinations, mammograms, childhood and influenza immunizations, and lower quality ambulatory and hospital care (Fiscella et al., 2000). Furthermore, socioeconomic status determines the employment relations and conditions of occupation. For instance, low socioeconomic status decreases access to resources (Veugelers & Yip, 2003) essential for healthy life such as, nutritious food, good housing, and opportunities for physical activity. All this combined creates high stress levels and consequently poor health outcomes (Levy et al., 2013).

Social disadvantage refers to the unfavourable conditions which people experience in relation to the differences in social and economic resources and in regards to opportunities in income, education, and occupation; greater social disadvantage increases an individual's chances of exposure to direct or indirect violence within the family or community (Egerter et al., 2011). Even though violence occurs across all socioeconomic groups, it is more frequent and severe in lower groups across diverse settings that include United States, Nicaragua, and India (Jewkes, 2002). People with limited social and economic resources have higher levels of daily chronic stress due to the struggle of facing everyday challenges with inadequate resources (Bravemen et al., 2009; Jewkes 2002). When the social networks also fail to provide any material and emotional support—as they may also be limited in their resources—the growing feelings of hopelessness, frustration, and anger cause some more to resort to violence in times of conflict (Egerter et al., 2011).

Whether violence causes a drop in socioeconomic status or a low socioeconomic status causes domestic violence is still difficult to establish. While poverty is *associated* with higher vulnerabilities to violence, the causal link between the two is not confirmed; the consequences of domestic violence—separation, becoming a single mother, barriers to employment, ex-partner debts, psychological health—may be all factors that push women into poverty, as opposed to poverty itself being the risk factor for gender violence (Humphreys, 2007).

Distal Determinants of Health

Racism

Three types of racism can impact people's experiences of daily life; the first one being institutionalized racism. This type of racism is engrained into the basic structures of society that include institution, policies, laws, and social processes, altogether which "tolerate, reproduce, and perpetuate judgments about racial categories and produce inequality in access to life opportunities and treatment" (Galabuzi, 2006, p.253). Personally mediated racism is discrimination and racism, demonstrated in forms of suspicion, scapegoating, dehumanization, and disrespect (Mikkonen & Raphael, 2010). Lastly, internalized racism occurs when those that are suppressed and stigmatized begin to accept these degrading messages about their own self-worth and capabilities, ultimately leading to helplessness and hopelessness (Mikkonen & Raphael, 2010). Racial discrimination is a powerful factor that creates unjust consequences across society, including unjust consequences in health.

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). Some would argue that colonialism is still ongoing and the history of colonialism is linked with continuing colonial policies and unequal relationships from which communities are continuing to recover (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). Excluded groups lack power and are more and more so being segregated into certain neighborhoods causing such personal experience and living conditions that are threatening to health (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). For instance, these life changes entail normal life transitions like pursuing education, securing employment, finding housing, raising children, and planning for retirement (Mikkonen & Raphael, 2010). They can also include unexpected life events such as family break-ups, accidents, unemployment, and onset of mental or physical disability (Mikkonen & Raphael, 2010). The negative life events provoke economic insecurity and psychological stresses. Overall, a social safety net hinders negative health consequences, while social exclusion aggravates them.

PART 2: INTERSECTIONALITY OF SOCIAL DETERMINANTS OF HEALTH AND WELL- BEING

Although Diagram 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 & Christoffersen, 2008). As a result, a wholesome understanding of unjust disparities in health and social inequalities is still lacking.

When understanding societal factors impacting health, it is not as simple as A leads to B. It cannot merely be said that all people, each coming from various backgrounds, will suffer the same exact health consequence of B due to A. 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).

Intersectionality is a theory that provides this understanding by acknowledging that at each intersection of two or more axes of oppression (e.g. race, ethnicity, class, gender) a new status or experience is created (Hankivsky & Christoffersen, 2008). Intersectionality does not accept that the new experience is merely a sum of the identities but that it is the actual *combined* experience that results in a new status. Because this model calls to look beyond single categories of identity, it does not assume importance of one category of social identity over another and recognizes that health outcomes are *always* a result of numerous factors (Hankivsky & Christoffersen, 2008; McGibbon & McPherson, 2011). Thus, 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?* A health and well-being determinants analysis needs a more centered focus on power (Hankivsky & Christoffersen, 2008). 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 3. Intersectionality of Social Determinants of Health and Well-being

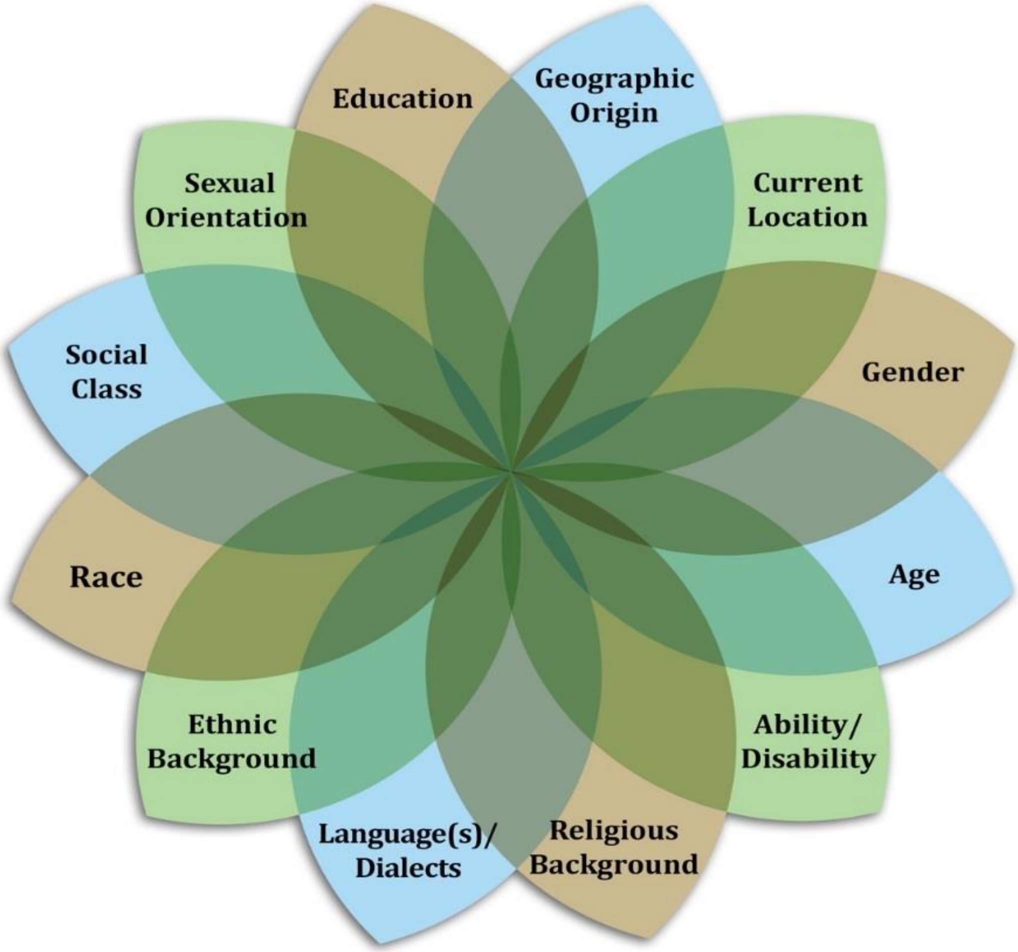


Table 1. Intersectionality in Region of Peel

Inequity in Determinant of Health and Well-being	Resulting Situation
Education Race	44% of recent immigrants have bachelor degrees or higher **vs.** 19% of Peel-born residents 60% of newcomers do not work in the same occupational field as they did before coming to Canada Recent immigrants settle for survival jobs, increasing chances of poverty
Socioeconomic Status Race	33% of Peel's recent immigrants live in poverty This is three times the poverty rate of non-immigrant population About 20% of Peel's visible minorities live in poverty That is about double the rate of non-visible minorities
Gender Violence	Between 2005 and 2009 Peel Regional Police responded to 40% more cases of domestic disturbances

(Portraits of Peel, 2011)

Intersectionality and Violence

In the social movement to support survivors, the constant assertion has been that violence against women cuts across all classes, races, and professional groups in order to prevent stereotyping gender violence with any culture, class, or race (Humphreys, 2007). 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.

The following is a look at the intersection or the interplay of various determinants of health and well-being with violence.

Example 1: Intersection of Gender, Income, & Violence

A repeated number of findings demonstrate that low-income women have a particular vulnerability to domestic abuse (Romans 2007; Winnersjo et al., 2012; Breiding et al., 2008; Nerøien & Schei 2008; Rennison & Planty, 2003). For example, a population based Intimate Partner Violence study on Canadian men and women reported association between intimate partner violence and low-income levels for women alone (Romans, 2007). In Canada, spousal abuse rates have been higher in households with incomes less than $30,000 relative to households with income greater than $60,000 (Pottie Bunge, 2000); Berger (2002) also reports 16 percent spousal abuse for Canadians living with less than $20,000 household income compared to 4 percent spousal abuse for Canadians living with greater than $75,000.

The actual factors related to low income levels that lead to greater use of violence still needs to be explored. It can either be the stress directly related to the lack of monetary resources, or it is a collection of factors in the community, such as poverty, unemployment, drug and alcohol use, that create the social context that allows the use of violence in settling disputes (Rennison & Planty, 2003; Benson et al., 2003).

Example 2: Intersection of Gender, Occupation Status & Violence

Overall, families experiencing unemployment or under-employment are at risk for intimate partner violence (Jewkes, 2002). Income gaps between partners, or differences in employment status, are particular risk factors of domestic violence against women. Interestingly, employment can be a protective factor or a risk factor for women, depending upon their partner's employment status (Jewkes et al. 2002). On the one hand, employment is shown to be a protective factor against abuse for women as it allows them to have greater financial resources and keeps them less isolated (Humphreys, 2007). This financial independence can provide the means to leave abusive partners and take hold of financial needs of their children and themselves, whereas, low levels of employment and income among women can increase stress and reduce the opportunity to leave an abusive relationship (Gill & Theriault, 2005).

On the other hand, if the woman's partner is unemployed while she is working, it increases her risk of abuse. According to Canadian Centre for Justice Statistics (2004), women whose spouses were looking for employment were more likely (10%) to experience spousal abuse compared to those whose partners were working (4%). Unemployed partners have been noted to use greater aggression against their employed partner compared to those couples that may be simultaneously employed or simultaneously unemployed (MacMillan & Gartner, 1999). Findings of Benson et al. (2003) suggest that employment instability has an even greater impact than household income and is the driving force between economic distress and domestic violence; furthermore, employment instability is not merely about lacking resources, but more about the impact it has on the men's perceptions of their self-worth and their masculinity. Frustrations of not living up to society's concept of "masculinity" can translate into violence against their partners. Violence is, thus, a product of inequality rather than just merely a difference in the level of incomes and employment status (Jewkes, 2002).

Example 3: Intersection of Gender, Social Exclusion, & Violence

A sense of isolation, regardless of ethnic background, makes women quite vulnerable to violence (Vives-Cases et al., 2011). This occurs by means of the abuser or the context of the surrounding environment. In the first case, by isolating the woman, the abuser aims to take more control over her decisions, increase her dependency on him, and keep her from people that are a potential source of support (Vives-Cases et al., 2011; Jewkes 2002). Second, some researchers (Benson et al.,2003; Ross et al., 2000) suggest disadvantaged neighbourhoods can also place women in social isolation by limiting their residential mobility. Other factors that result in isolation are language barriers, fear of racism, immigration problems, and lack of access to support services (Humphreys, 2007). This highlights the great need to address barriers in seeking help and support services that are centred in isolation.

Example 4: Intersection of Colonization, Social Exclusion & Violence

In Canada, the Aboriginal population is 1.2 million, or 3.8 percent of the Canadian population, and constitutes the following communities—First Nations, Dene, Inuit, and Metis (Mikkonen & Raphael, 2010). The long history of colonization of the Aboriginal people has resulted in injustices in social determinants of health and well-being and ultimately adverse health outcomes (Mikkonen & Raphael, 2010). For instance, a study on the First Nations people of British Colombia found that suicide rates changed greatly and were associated with cultural continuity, which is the degree of cultural and social cohesion within a community (Reading &Wien, 2009). The low rates to nonexistence of suicides in a community seemed to be linked to self-government, land title, control of education, cultural and security facilities, and control of the practices and policies of health and social programs (Reading &Wien, 2009). Traditional intergenerational connectedness is also an integral part of cultural continuity that is preserved through connected families and engagement of elders, who pass traditions to next generations (Reading &Wien, 2009). Unfortunately, the ongoing social exclusion and poverty that is excessively experienced by Aboriginal people increases the chance of family instability, which often results in divorce and single parenthood (Reading &Wien, 2009).

The colonization, systemic racism, and discrimination against the Aboriginal people have prevented them from accessing resources and conditions needed to maximize socioeconomic status (Reading &Wien, 2009). The disadvantage is now evident in rare economic opportunities, high unemployment, poor housing, inadequate community resources, and low literacy and educational attainment (Reading &Wien, 2009). For example, preschool programs have shown the most promising "return on investment" in Aboriginal children, yet programs like Aboriginal Head Start are often under-funded (Reading &Wien, 2009).

Among Aboriginal people, self-determination is acknowledged to be the most important determinant of health as it impacts other determinants of health, like safety, housing, education, and health opportunities; however, this requires equal political participation in the decision-making, along with control over their economies, land, and education, social, and health systems (Reading &Wien, 2009). This has not been the case; the restrictive colonial agenda has implemented such systems within the Aboriginal communities that are not self-determined (Reading &Wien, 2009). Equal and fair opportunities for everyone will remain far from reach as long as freedom and authority are continued to be systematically denied (Reading &Wien, 2009). Overall, post-colonial changes led to increased rates of alcohol and drug abuse, low self-esteem, depression, and suicide among Aboriginal men, but similar rates were also noted in Aboriginal women and were accredited to socio-economic and cultural changes due to colonization (Moffitt et al., 2003; Korhonen, 2004).

PART 3: 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 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 & 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 regarded in cases such as the following (Gulliford et al., 2006):

- Client-centredness
    - *Barriers to seeking health services may be reduced not only by addressing class inequities, but gender inequities as well by improving understanding of women's health issues among health professionals. In Canada, the process of redefining women's health and healthcare by scholars and community organizations "revealed various elements of women's health including the fact that the training of health professionals has often contributed to the marginalization of women's health issues" (Vissandjee et al., 2001, p. 59).The atmosphere* in *which services are offered and the attitudes of health professionals delivering them are important factors for users when seeking*

    - *services, and an environment that is sensitive to gender and cross-cultural issues may be more effective in adequately responding to the priorities, needs, and concerns of their diverse clientele (Vissandjee et al., 2001).*

- Quality of care/service in chronic or long-term cases and conditions
    - *As in the case of victims of violence, the greater inequity lies in interaction with the healthcare system than in the access of the system itself. Women with history of intimate partner violence are just as much, if not more, likely to be present in the primary and special healthcare settings; however, they are less likely to get the care that is needed (Plichta, 2004). The reason being is that perhaps most intimate partner violence is undetected by health care providers as it* is *not routinely screened for in women (Chamberlain et al., 2002; Lapidus et al, 2002; Love et al. 2001; Plichta, 2004). As a result, undetected intimate partner violence damages patient-provider relationship as abused women report less satisfaction in the communication with their health providers (McNutt et al., 2000; Plichta, 2004).*

- Fragmentation in delivery of care and services
    - *Not only do physicians report possibly being uncomfortable discussing the issue and holding negative beliefs about abused women, but also find this work to be difficult because it is often not supported by systems of their workplaces (Plichta, 2004; Garimella et al., 2000)*

Different organizations have defined continuity of care/service in various perspectives; while some definitions concentrate on the relationship between patients and physicans 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 the patient'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)

Health and social service providers have different perceptions of continuity of care than the recipients of those services. To alleviate the tension caused by the two different types of continuity of care/service, multidimensional models of continuity of care have been developed that accommodate the potential for interpersonal continuity within models aiming for seamless service delivery or coordination of care across sectors (Gulliford et al., 2006). A recent review for the Canadian Health Services Research Foundation condensed multiple dimensions of continuity of care into the following three types of continuity of care:

- Relational: Built on accumulated knowledge of patient/client's circumstances and preferences which is rarely recorded in formal records and interpersonal trust based on experience of past care/service and positive expectations of future competence and care

- Management: Shared management plans or care protocols, and explicit responsibility for follow-up and coordination, provide a sense of predictability and security in the future for both clients and health and social service providers

- Informational: Formally recorded information is complemented by tacit knowledge of clients' preferences, values, and context that is usually held in the memory of professionals with whom the client has an established relationship (Guthrie et al., 2008)

Although the above are found in most settings of care, one may be more relevant than the other, depending upon the context of the setting. Freeman introduced the concept of *experienced continuity*, which is the experience of a 'coordinated and smooth progression of care from patient's point of view' (Freeman et al., 2003) and believed that the other dimensions of continuity support the success of experienced continuity (Gulliford et al., 2006). Experienced continuity is essentially composed of patients'/clients' satisfaction with both core concepts of care—the interpersonal aspect and the coordination of care (Gulliford et al., 2006). This is also reflected in Haggerty' et al.'s (2013) analysis of thirty three studies on patients' experience with care. The qualitative metasummary revealed how patients view and experience continuity:

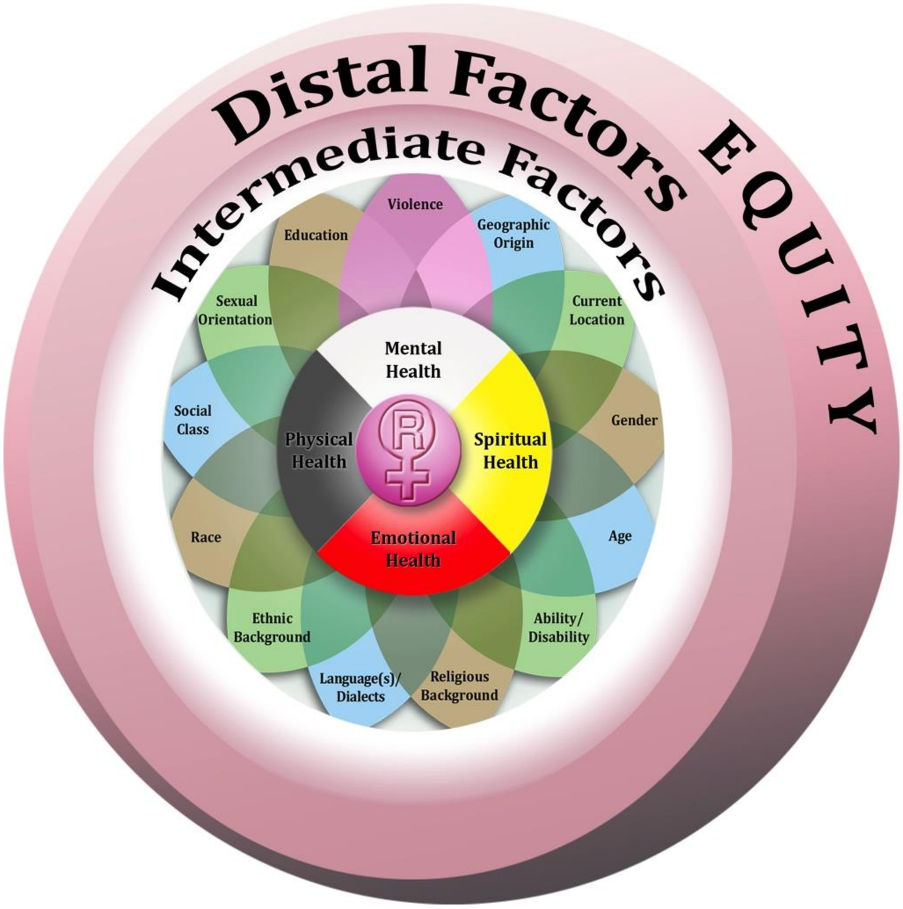
- Continuity of care is experienced as confidence and security rather than seamlessness
    - Security is provided by knowing what to expect and having contingency plans
    - Desire for connectedness between health and rest of the individual's life (well-being)
- Experience continuity directly through:
    - Receiving information especially to support an active role in own health and well-being such as in self-management and monitoring
    - Having relationship with one most-trusted clinician
- Coordination and communication among professionals are assumed until proven otherwise through failures or gaps; care plans help coordination but rarely recognized by patient

Overall, an understanding of the right relations between continuity and access is still lacking as is the agreement about which dimensions of continuity matter the most (Gurthrie et al., 2008). Guthrie et al., (2008) argue that an effective organization of services has to embody all dimensions of continuity, along with good access and good systematic care. Continuity of care and service or the level of satisfaction with them can be measured by distributing surveys to those receiving health and social services, while assessment of coordination will require objective measurements and evaluation of effectiveness and efficiency in the view of the professionals or managers (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.

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 4. Equity Framework



Monica Riutort, Peel Institute on Violence Prevention , 2015
Adapted from: Integrated Life Course and Social Determinants Model of Aboriginal Health. Charlotte Loppie 2009

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. For instance, a study done by Settles concluded that the intersected black-woman identity was more important than the individual identities of being a woman and being a black person, and the combined identity offered both positive (i.e., racialized gender socialization), as well as, negative experiences (i.e., racialized sexual harassment) (2006). Levin et al., (2002) find it consistent with other previous research that race was a more important factor than gender in the black-woman identity. Disturbances in the black women's enactment of their race, but not their gender, have negative psychological impacts since race-related difficulties by women are experienced at interpersonal levels, such as in their communities and social networks, as opposed to behavioural levels (Settles, 2006).

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). Furthermore, it found being a female and from an ethnic minority had consistent and statistically significant associations with poor health outcomes; while low-income was clearly associated with poor health outcomes for men, it was not as clear for women since women born outside of Sweden who came from high-income households had the worst health outcomes (Wamala et al., 2009). Clearly here, 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). As for racialized people, their employment income is 15 percent lower than the national average (Galabuzi, 2006). When race intersects with gender, it creates even higher rates of unemployment among women who are Indigenous, African Canadian and immigrant; upon attaining employment, immigrant women of colour will still earn less than the average for Canadian women (McGibbon & McPherson, 2011). Women's relative higher poverty rates are a result of inadequate structural systems of Canadian society. For instance, women are often reluctant to accept full-time employment due to the lack of flexibility in the Canadian labour market to allow the balancing of primary care responsibilities with full-time employment (McGibbon & McPherson, 2011). Due to the neo-liberalism, the poverty-wealth gap has increased; this is possibly decreasing the social provisions for a growing number of people in poverty and middle class (McGibbon & McPherson, 2011). 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 also 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.

A significant amount of research indicates that due to the intimate nature of women's relationship with their abusers, women suffer both physically and psychologically as a result of violence and abuse by their partners. Violence against women results in both acute and long-term health impacts such as, injuries, poor quality of life, poor health status, gynecological conditions, chronic pain, substance abuse, gastrointestinal disorder, depression and post-traumatic stress disorder (Campbell, 2002; Coker, 2002; Plichta, 2004). Some studies even indicate gender-based violence as perhaps the greatest risk factor to women's overall physical health (WHO 2002; Humphreys, 2007); for instance, intimate partner violence has been noted as the highest risk factor in determining the physical health of women less than 45 years of age by VicHealth (2004). Most importantly, victimized women's health is poorer compared to non-victimized women (Winnersjo et al., 2012; Nerøien & Schei, 2008; Danielsson et al., 2005; Romito et al., 2005; Coker et al., 2002). Finding of Staggs and Riger (2005) find that health problems have a direct proportionate relation to the amount of abuse women experience over time and that chronic abuse has a negative impact on health beyond that of poverty.

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. A closer look is needed at disentangling the causes and consequences of gender violence (Humphreys, 2007).

The relationship between race and gender-violence is even more contested and ambiguous than the relationship between social class and violence. Benson et al. (2003) argue that despite the numerous studies that have found higher levels of domestic violence among blacks than whites, the results are contradictory. These studies had not taken into account that black and white populations often live in different types of neighbourhoods, and individual level correlations between crime and race can systematically be confounded with significant differences in contexts of community (Benson et al., 2003).

For instance, an important factor in health disparities is the racialized inequities in socioeconomic status. Racialized groups have greater chances of experiencing socioeconomic disadvantages relative to non-racialized groups (Levy et al., 2013). Inequities in socioeconomic status are a manifestation of systemic, institutional racism in sectors of education and employment especially (Levy et al., 2013). For instance, 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 & Planty, 2003).

Rennison and Planty (2003) suggest looking carefully at aggregated data, which although may provide an informative and simplified picture about the issue at hand, the data can be misleading when the generalizations are applied to subpopulations without looking at the confounding factors. For instance, they found different results looking at aggregated versus disaggregated data from the National Crime Victimization Survey of 1993-1999. Aggregated showed black women experiencing higher rates of intimate partner violence than white women, however, when race was controlled for, it was income and gender that became the bases upon which the rates differentiated. For instance, white persons of a household income of less than $7,500 had statistically an equal rate of victimization as a black person with the same level of household income; similarly both white and black households with income greater than $50,000 had the lowest rates of intimate partner violence (Rennison & Planty, 2003). Thus, minority ethnic groups may be over-represented as groups living in poverty, but they do not always show over-representation in the prevalence data on domestic violence and sexual assault (Walby & Allen, 2004).

In North America, being of a minority ethnic group has been believed to be associated with intimate partner violence, but the associations have been mainly due to the differences in income, as well as, educational levels between the majority and minority groups (Jewkes, 2002). These findings suggest race, on its own, cannot account for the poor health outcomes due to victimization without accounting for racialized inequities in multiple determinants of health and well-being that lead to health disparities.

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. According to Jewkes (2002), the two factors that are necessary for intimate partner violence are the unequal position of women in a relationship, or in a society, and the normative use of violence during conflict. As can be seen by examining some of the determinants of health, women can be empowered by many sources such as, high level of education, income, and community roles, but they all do not offer an equal or a guaranteed level of protection (Jewkes, 2002). For instance, an increase in woman's education can add a risk to interpersonal violence, which signifies the need to engage both women and men in the efforts to attain gender equality (Jewkes, 2002) and systemic changes towards equity.

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.

Example 1: Intersection of Gender, Race, & Violence

Current literature shows intimate partner violence or domestic violence as a serious concern among the Aboriginal community and especially for Aboriginal women (Brownsridge, 2003; 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). For instance, Inuit women were more likely to adopt schooling and employment outside of home in the post-settlement; similarly, the Dene women were more likely to have higher education, training, and become the wage earners relative to the Dene men (Moffitt et al., 2013). This all occurred as the traditional wage-earning roles of men such as, hunting and trapping, suffered a decline; post-colonial changes, as a result, brought power shift within gender roles and between genders, contributing to low self-esteem among Aboriginal men (Moffitt et al., 2013).

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 identify who 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 to identify 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 and to ensure that the Region of Peel is working towards a more equitable society.

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