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Health Inequities in Canada: Intersectional Frameworks and Practices

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An intersectional lens has great potential for improving the ways in which health care services are organized and provided to individuals. It can foster the development of more equitable services because of its focus on multiple forms of oppression and structural violence, which give rise to inequities, and because it provides direction for addressing multiple sites of oppression versus sites of oppression as singular dimensions. Such a lens can contribute to more effective care by exposing the consequences of fragmentation and divisions in care that fail to address intersecting forms of marginalization.

Our research on primary health care services conducted in partnership with two urban Aboriginal health centres – whose mandates are to provide primary health care to Aboriginal and non-Aboriginal people in the inner city areas of two Western Canadian cities – serves to illustrate this potential. The purpose of this chapter is to draw on insights from this research to illustrate the ways in which intersectionality can generate knowledge about how health services could be more responsive, particularly to the needs of women marginalized by poverty, racism, neo-colonialism, and the politics of place, including how rural, urban, and inner city spaces are shaped. We draw on our research with women who attend the health centres to show how an intersectional lens shapes understandings of the intertwining issues of interpersonal and structural violence, chronic pain, and addictions, which often underpin women’s experiences of social suffering, and to reveal how such understandings provide direction toward more effective, responsive, and equitable care. Because discussions of how to apply intersectionality have been limited in health research (Hankivsky and Christoffersen 2008; Hankivsky and Cormier 2009), we aim to make visible how we operationalized an intersectional approach to understand how health services might better meet the complex needs of Aboriginal and non-Aboriginal women marginalized by poverty, racism, and colonialism. We consider the analytical “value-added” of using an intersectional perspective informed by postcolonial feminist perspectives, illustrate its concrete implications for women’s
health research, provide insight into the application of intersectionality to health services research, and thus aim to bridge the gap between intersectional theory and practice.

In drawing on the term “marginalized,” we are wary of reifying women’s subject-positions as necessarily marginalized or disadvantaged. Indeed, an intersectional interpretation of marginalization or vulnerability directs us otherwise - to acknowledge the fact that social locations are fluid and shifting, depending on context. Caution is warranted whenever labels or classifications are applied - whether pertaining to ethnocultural groupings or health conditions (as in “injection drug user,” “addict,” or “homeless person”). Because an intersectional approach challenges categories of analysis and how they are used, it forces us to question the language we employ to classify people and the act of categorizing itself - both of which tend to reduce people to labels or constitute them according to single static identities in ways that obscure the complexity of their lives. For example, the women in Canada who identify as Aboriginal, indigenous, First Nations, Métis, or Inuit are tremendously diverse (Native Women’s Association of Canada 2007). Aboriginal women’s self-identities also intersect with state-defined identities according to the Indian Act, which subcategorizes socio-legal statuses of “Indians” based on a series of exclusionary criteria (Fiske 2006). This is one example of how “the power of the State seeps into the very essence of individual identity and personal well-being,” dynamics that intersectional perspectives can help us to better understand (ibid., 248).

In attempting to respond to the challenge inherent in analyzing health or social issues that may be relevant to particular groups of women while at the same time acknowledging diverse and individual social locations, we draw on Leslie McCall’s (2005, 1773) notion of intercategorical complexity within intersectionality, in which socially constructed categories (such as “women who experience marginalization” or “Aboriginal women”) are provisionally adopted in order to “document relationships of inequality among social groups and changing configurations of inequality along multiple and conflicting dimensions.” In this chapter, “marginalization” therefore refers to the processes by which some people and groups are affected by historical, structural, and social inequities in particular ways and in local contexts (Adelson 2005), and is also inclusive of people’s agency, resistance, and resilience in the face of structural violence and inequities.

**Conceptualizing Intersectionality from a Post-Colonial Feminist Perspective**

“Intersectionality” refers to the extent to which differing aspects of social identity, and various forms of structural oppression, are mutually constructed at the level of individuals, organizations, and broader social systems in complex and interdependent ways; consequently, women experience
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differing constellations of inequities due to their social positioning within hierarchies of power relations (Collins 2000). Beyond these definitional features, there are wide variations in the conceptualization of intersectionality, related methodologies, and analytical tools (Weber and Parra-Medina 2003; Brah and Phoenix 2004; Hulko 2009). For example, intersectional analyses are inherent to research that draws on post-colonial feminist theories. More specifically, these theories focus particular attention on gender, socio-economic status, and ethnocultural identity as key aspects of social identity, and on racialization, historical subjugation, and colonialism as forms of structural oppression (for example, see Gandhi 1998; Narayan and Harding 2000; Reimer-Kirkham and Anderson 2002). In several of our studies, post-colonial feminist perspectives have been particularly useful in examining how historically mediated institutionalized racism has intersected with gender and economic marginalization to shape health for Aboriginal people in Canada (see Browne et al. in press; Browne 2007; Browne, Smye, and Varcoe 2005, 2007; Smith, Varcoe, and Edwards 2005; Varcoe and Dick 2008). We are particularly drawn to the emphasis in post-colonial feminist theorizing on disrupting “race”-based thinking and processes of racialization, and on understanding and responding to ongoing lived experiences of colonialism and neo-colonialism. Intersectionality, informed by post-colonial feminist perspectives, has therefore been relevant in our research, which focused on the consequences of intersecting structural and historical inequities on health and social suffering.

As with any theoretical perspective, it is important for researchers to engage critically with underlying epistemological assumptions, to consider the social locations of scholars affiliated with particular schools of thought, and to avoid theoretical imposition or appropriation of particular perspectives. For example, distinguishing post-colonial feminist theories, as a strand of Western theorizing, from post-colonial indigenous knowledge is critical. The latter is founded on indigenous ways of knowing and indigenous research processes; importantly, indigenous scholars point to the ways in which indigenous voices have long been excluded from academic and research circles (Battiste 2000). Linda Smith (1999, 98) is particularly concerned that the notion of “post-colonial” carries the message that “colonialism is finished business.” When working with intersectional and post-colonial feminist perspectives, therefore, we must fully recognize the ways that neo-colonial discourses, policies, and practices intersect to exert their effects in current times.

With these cautions in mind, an intersectional perspective informed by post-colonial feminist perspectives and indigenous knowledges can be useful in understanding how the consequences of racialization, historical injustices, classism, and gendered inequities are inextricably interrelated, particularly as they influence women’s lived experiences of health. Our primary analytical
goal is to understand the processes through which multiple social inequalities and social locations are simultaneously generated, maintained, and challenged at the institutional, organizational, and individual levels, thus shaping the health of societies, communities, and individuals (Weber 2006). Four features of intersectional scholarship are particularly salient to our research: an intersectional perspective is driven foremost by the pursuit of social justice; the goal of applying an intersectional analysis is to understand and address the multiple dimensions of social and health inequalities manifest at the macro level of institutions, systems, and organizations, and the micro level of individual experiences of women who live at the intersections of multiple inequalities; inequalities are conceived as social constructions situated in social and historical contexts, and in structures beyond the individual — in societies, institutions, communities, and families — and are characterized as power relationships, not simply as resource disparities between dominant and subordinate groups; and broad intersecting systems of inequality become the targets for intervention, including systems outside of the health arena such as the economy, employability, housing, education, and justice systems (ibid.).

**The Intersecting Consequences of Health and Social Inequities**

The current Canadian context exacerbates the need for intersectional analyses. Following several decades of neo-liberal policies in Canada, social and health inequities are deepening, and social welfare reforms, along with declining social support services, have had detrimental effects (Raphael 2007, 2009). From an intersectional perspective, issues affecting health and health care inequities are viewed in their historical, political, economic, and social contexts. This is salient for women marginalized by poverty, racism, place, violence, ability, and other forms of oppression as they intersect with gender.

For example, using an intersectional approach to consider the high levels of violence and HIV infection experienced by Aboriginal women reveals how health problems are shaped by colonial and ongoing neo-colonial policies, neo-liberal state policies, racism, and urbanization (Brownridge 2008; Varcoe and Dick 2008). Growing evidence reveals how histories of violence and trauma are intertwined with women’s experiences of chronic pain and addiction (see Pearce et al. 2008; Salomon, Bassuk, and Huntington 2002; Sullivan and Holt 2008; Wuest et al. 2008). The cumulative effects of poverty, addictions, violence, and racism are also manifested in the very high rates of HIV among Aboriginal women in Canada: women represent nearly half (45.1 percent) of all positive HIV test reports among Aboriginal people, compared to 19.5 percent in the non-Aboriginal population (McKay-McNabb 2006). Despite these disturbing indicators of social suffering, little attention
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has been given to the causes of vulnerability and overexposure of Aboriginal women to sexual exploitation, violence, and murder that have historically been, and continue to be, the reality in Canadian society (Amnesty International 2004; Razack 2008).

Overview of the Research

Our research, which was conducted in partnership with two urban Aboriginal health centres, provides an opportunity to apply an intersectional perspective to the particular institutional context of health care. The health centres’ mandates are to provide primary health care services to Aboriginal and non-Aboriginal people who are most significantly affected by poverty, historical trauma, social exclusion, racialization, and discrimination. Both centres are located in inner city areas – one is in a northern regional city, and the other is in what is recognized as one of Canada’s poorest neighbourhoods. Many of the people accessing the health centres are poor or living in poverty, often residing in single-room-occupancy hotels; many live on or near the street and have significant mental health and addictions issues; and many have experienced the interrelated traumas of violence, childhood abuse, and sexual exploitation. The broad aims of our study are to explore how health care services are organized to explicitly address the needs of people affected by marginalization and racialization, and to develop primary care “performance” indicators that adequately reflect the impact of such services on people’s health and well-being.

Both health centres include a medical clinic staffed by physicians, nurses, and nurse practitioners, and outreach services aimed at supporting people’s health and social needs, drug and alcohol counselling services, and social work services. Services vary depending on location, but examples include hot lunch programs for people living with HIV/AIDS, access to elders who are employed part time, and support services for women with small children. One of the health centres has recently attempted to strengthen services for women who are relatively underrepresented there, in part because of the conditions that create vulnerability to violence and exploitation, and also because of their marginal positioning within male-dominated health care settings and community spaces. This took the form of a women’s wellness program, which operates one afternoon per week and aims to enhance Aboriginal and non-Aboriginal women’s access to primary health care and related health-promoting services. The program offers a safe place for women to rest and interact with other women if they choose; it also provides lunch (many women have not eaten for days when they come) and priority access to physicians, nurses, and elders in the health centre (on afternoons devoted solely to women). Each week, the program is attended by approximately thirty to sixty women from diverse social locations, including older women,
those living in poverty, working in the sex trade, raising children or grandchildren, living with addictions, and in violent relationships. Unanticipated benefits of the program include increasing and expanding women’s social support networks and reducing the stresses and harms associated with poverty, addictions, and violence, thus supporting women to respond in constructive ways to challenges encountered in their everyday lives. Drawing on examples from both health centres, and from the women’s wellness program in particular, we highlight the insights that can be gained by applying an intersectional lens to health services research.

Insights Gained from Research: The Value of Drawing on Intersectional Perspectives

In relation to health services research, there are three interrelated analytical advantages to using an intersectional perspective. First, it provides a tool through which to consider how health and social “problems” are framed. Second, it focuses attention on how health and social issues are intricately interrelated – and in the context of this chapter, how “categories of analysis” such as poverty, addictions, violence and trauma, and chronic pain often intersect in ways that compound their effects. Third, intersectional analyses direct us to think critically about the efficacy of conventional approaches to service delivery and prompt us to reimagine how services could be better tailored to meet women’s intersecting health and social needs.

Critically Considering What Is Constructed as “the Problem”

I was put on Tylenol #3 when I was 12 … I have pain every single day ... So, I’ve been in and out of the hospital lots, you know, being addicted to morphine and pills and everything.

- Woman, age thirty-one

An intersectional perspective helps to widen the scope of what is conventionally identified as the “problem” in health services delivery and in women’s health research. As Jacqueline Oxman-Martinez et al. (2002) have argued, viewing social problems through an intersectional approach fundamentally alters the ways in which they are identified, understood, and experienced; this also has the potential to alter how health services and health care providers respond.

In constructing problems, intersectionality offers a more useful approach than one that allows problems to be framed by dominant media, public, and health care discourses. Such discourses are often driven by interests other than concerns for women’s health and well-being. For example, writing
about Vancouver’s inner city, the Downtown Eastside, Dara Culhane (2003, 594-95) argues, “predictably, national and international media ... offer the virtual voyeur disturbing – or titillating – images of emaciated heroin, crack cocaine, and prescription drug users buying, selling, injecting, and smoking,” reflecting a “preference for exotic and spectacular representation of drugs, sex, violence, and crime rather than the ordinary and mundane brutality of everyday poverty.” Such images bring a certain framing of problems into the foreground – such as drugs, addictions, and sex work. In the process, individual people themselves are constructed as “the problem.” This focus on the individual as the source of the problem downplays the root causes of people’s issues, including historical trauma, poverty, unemployment, abuse, racism, and medical involvement such as prescribing practices, and further ignores the ultimate causes of these, such as global economics, ideologies of racial superiority, capitalist priorities, ongoing clawbacks to social welfare systems, welfare colonialism, and state policies regarding resource distribution.

Through the dynamic relations among media, public opinion, and policy (see Chapter 17 this volume), such a framing of problems is reflected in policy priorities and health services delivery. The wider health services sector in both inner cities include needle exchanges, HIV treatment programs, addictions treatment, and so on, but little is done at the municipal, regional, or provincial policy levels to address poverty, lack of safe and affordable housing, violence and trauma, or racism, particularly as they intersect. Thus, health care providers in the two health centres expend considerable energy on addressing these root causes of addiction but often as an “add on” to the program work for which they are funded. An excerpt from fieldnotes recorded at a “clinical rounds” meeting at one of the health centres is illustrative:

Throughout the clinical rounds meeting I was struck by the emphasis on housing. For 9 of the 15 patients discussed, the quest for housing was a key focus. The workers were all strategizing how to get housing or improve the housing for each person, sometimes to help them get out of hospital, sometimes to avoid having the patients ‘discharged to the street’ from hospital. The clinic staff waited until their counterparts from other agencies left to discuss some possibilities. Housing is at such a premium that healthcare agencies have to compete with each other to get the best possibilities for their clients. (Fieldnotes 2008)

Problems such as addictions, HIV, or hepatitis C are prioritized in health care funding, policy, and service delivery structures, challenging leaders within the health centres to find ways to fund programs that address the intersecting issues of violence and trauma, chronic pain, and the backdrop
of poverty in which these are experienced. Consequently, service providers contend with very limited resources to address underlying problems, such as histories of trauma – and issues related to poverty and housing are structured by the health care system (and in funding arrangements) as falling outside of dominant conventional notions of health programming.

By pointing to underlying intersecting factors, an intersectional lens reminds us that problems such as addictions, HIV, or hepatitis C are highly stigmatized; when these health issues are understood in ways that are de-contextualized from their underlying causes, people who experience them are often blamed or held responsible for engaging in problematic behaviours (such as unprotected sex and injection drug use). Such a decontextualized understanding fuels the perception held by many Canadians that those who are affected by these health conditions are the source of the problem. Women who participated in our research were well aware of these wider public perceptions and discourses; one woman, who identified as First Nations, explained her sense of trepidation about being identified as “one of them”: “I’ve heard comments on the bus, like when we’re driving by and you see people waiting outside for the clinic to open ‘oh my god, look at all those junkies, ooooh.’ Like, ‘I wonder how often they bathe,’ and ‘oh, it must just stink there where they’re waiting’” (Woman, age forty).

Whereas popular discourses tend to construct people with cancer and other less stigmatizing health conditions as heroes fighting for their lives, strength and courage are underplayed in depictions of people contending with the intersecting challenges of violence and trauma, poverty, and substance use. Representations of disease, self-destruction, and despair dominate, and media, public, or health care discourses pay little attention to the agency and resistance of those who, despite profound constraints on life opportunities, struggle daily to survive and thrive (Culhane 2003). The hyper-visibility of people in inner cities who are living in poverty, affected by addictions, or involved as sex workers fuels this narrow, fixed view of people's social locations and identities. In contrast, an intersectional perspective prompts us to scrutinize taken-for-granted assumptions that categorize particular neighbourhoods as essentially destitute or residents of such neighbourhoods as singularly despairing. Rather, intersectional perspectives remind us that inner cities are often sites of activism, anti-poverty movements, and organizations that provide safe spaces for women such as social housing, shelters, and transition houses (Benoit, Carroll, and Chaudhry 2003). Similarly, our fieldwork and interviews at both health centres show another side to those vilified by media and public discourses – people who offer support and friendship to one another in spite of the most harrowing of life circumstances. An intersectional approach therefore challenges how particular groups and individuals are problematized, critically questions how problems are framed,
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and draws attention to broader social issues underlying and intersecting with health problems.

**Intersections among Poverty, Addictions, Violence and Trauma, and Chronic Pain**

Just as intersectional perspectives enable us to challenge what becomes constructed as the problem in health services settings, they further enable us to dispute assumptions about which categories of analysis are relevant to understanding women’s health needs. This area of critique is particularly important given the predominance of biomedical perspectives in health care and the tendency to view issues such as poverty, violence and trauma, addictions, and chronic pain as fairly separate entities. In contrast, we are particularly concerned with understanding the intersecting effects of these issues on people’s lives and well-being; this understanding also sheds light on the limitations of conventional health care responses and the tendency in health care to address these categories of analysis in isolation from each other and from broader social and political contexts.

Health researchers using an intersectional lens have typically focused on how various “categories of analysis” and social locations (such as race/gender/class, and more recently, age, immigrant status, disability/ability, religion, and sexual orientation) intersect to affect health outcomes (see, for example, Donaldson and Jedwab 2003; Collins, von Unger, and Armbriester 2008; Purdie-Vaughns and Eibach 2008). Intersections among health issues such as addictions, violence and trauma, and chronic pain are emblematic of the intersections of systemic oppressions yet have received less attention. For Aboriginal women in particular, the cumulative experiences of racism, intergenerational trauma, colonization, and poverty compound such intersections. Further, the health care system’s response to these intersecting issues warrants analysis. Interventions aimed at addressing the intersecting issues of violence and trauma, chronic pain, and substance use are not well integrated, particularly in ways that are meaningful in the context of women’s lives. For example, poverty is rarely analyzed as a factor that fosters and exacerbates addictions or as a condition that gives illicit drug use in inner cities its “public” character (Culhane 2003). Rather, the prevailing tendency in health care is to reduce and medicalize multiple intersecting issues to the singular problem of “addictions.” This is consistent with dominant legal and medical discourses, which tend to locate the problem of addictions within the individual psyches of those affected by mental illness or those involved in criminal activity.

The medicalization of addictions also comes with an implicit assumption that there are known treatments for addictions. The evidence showing the extensive co-occurrence of addictions with trauma, violence, and chronic
pain suggests that addictions are unlikely to be treatable without addressing underlying histories of trauma and pain. However, addiction is often treated in isolation from such histories. It is assumed that solutions or treatments exist for addictions but not for the poverty, racism, and historical or personal trauma that often underlie patterns of addiction. Therefore, if treatment for addiction fails, the individual, not the original definition of the problem, is faulted. From an intersectional perspective, we are prompted to see the limitations of these dominant approaches to addiction, to turn our attention to how multiple problems intersect and compound each other, and to further consider their complex and intersecting root causes.

The health services policy environment also influences the framing of addictions as the primary focus of treatment. For example, the assumption that addictions can be treated in isolation from the wider contexts of people's lives is perpetuated by the process of diagnosing and referring patients for addiction treatment (as opposed to treating the root causes of addiction) and also by the process in which health care agencies must identify separate and distinct billing codes for singularly defined health problems. Although staff at the health centres recognized that addictions cannot be decontextualized from the realities of women's lives, dominant biomedical approaches to diagnosing and treating addictions tend to prevail. In response, staff expend considerable energy on negotiating with patients regarding drug use and approaches to harm reduction, and women are often referred for addiction treatment in settings outside the inner city (informally referred to as "geographic treatment"). Thus, women are supported to contend with their addictions but not with the effects of trauma, ongoing exposure to violence, chronic pain, and the consequences of living in dire poverty.

Because the health care system tends to medicalize addictions and underlying issues, health care interactions often focus on negotiating contracts for methadone use, managing people's frequent requests for opiate and other prescription drugs, and referring them for addictions treatment. Consequently, addiction becomes the primary entry point for addressing women's complex health and social issues. When chronic pain is treated, it is primarily through pharmacological means, with health care providers aiming to balance pain management with concerns about the possible misuse of narcotic medications, the potential for pain medications to fuel addictions, and the potential for "drug seeking" or diversion of drugs. In the process, as is consistently the case with biomedical perspectives, non-pharmacological approaches to pain management, strategies for addressing the violence and trauma, and associated grief and loss that often underpin chronic pain receive less attention. From an intersectional perspective, the co-constructed factors that contribute to addictions are understood as requiring a range of strategies aimed at helping women address these intersecting issues. However, the
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health care system, as it is currently designed, has few tools at its disposal to do so.

**Responding to the Needs of Women Who Are Marginalized and Racialized**

They want me to go off [narcotic medications], but what am I supposed to do about my pain?

- Woman, age thirty-two

As we continue to argue, intersectional perspectives can illuminate the ways in which health services might be structured to be more responsive to women’s intersecting needs. Specifically, an intersectional analysis draws attention to the individualistic ideologies underlying health services and to structural and funding constraints. Thereby, it points to two key features of more responsive health care: addressing both the social conditions and determinants shaping women’s lives and women’s need for safety.

Intersectional analyses call into question the individualistic ideologies that underpin the biomedical focus of most health services. For example, if an elderly woman with osteoporosis who is living in poverty breaks her hip, the fracture may be dealt with competently, but her need for safe housing, nutritional support, transportation, and assistance with the activities of daily living may be ignored, often with further cost to both the health care system and the woman herself (Varcoe, Hankivsky, and Morrow 2007). Similarly, as we have argued, health care tends to focus too narrowly on substance use or addiction; even when health care providers and researchers acknowledge the importance of macro-social forces on women’s health, responses within the health care system focus on the more “proximate issues” such as health behaviours (the need to reduce or quit using substances), cultural values (supposed cultural barriers to accessing care), or the need to develop better ways of coping (Weber 2006, 24). These proximate issues become the primary targets for health interventions – leaving broader systems of social inequality underanalyzed and unaddressed.

An intersectional perspective prompts us to look further, to consider what possibly could be done to be more responsive to the wider contexts of women’s lives and the intersecting factors that exacerbate and mitigate the health effects of social suffering. Such consideration requires an examination of what supports the enactment of individualistic ideologies. For example, broader funding structures and budgetary-reporting requirements are organized in ways that oblige the health centres to “streamline” their services to fit conventional notions of essential health services – often narrowly defined
in accordance with biomedical conceptualizations of what counts as legitimate. Residential school healing programs, mental health services (other than psychiatric services, which are very limited), dental care, and violence prevention are not viewed as eligible core-funded programs by the existing funding structure. Despite these limitations, the health centres have become adept at piecing together short-term funding from a variety of sources and arguing for flexibility in how they use their funds, so that they can treat the issues that often underlie women’s presenting health or illness concerns. For example, time is devoted not only to treating the physical manifestations of illness but to helping women complete social welfare applications, disability forms, and social housing applications, and to access meal programs and food banks. One woman, who described herself as First Nations, HIV positive, and “clean for the past 3 months,” described the profound effect that obtaining stable housing had on her overall health and sense of self:

I got the subsidy from them [the nurse and social worker at the health centre] for housing and I got the kids back now ... That really made me look in the mirror at myself ... I knew that I wanted to go to rehab. I’ve been thinking about it for a whole year since I got the subsidy ... [Other people] don’t realize the vacancy rate, the homelessness, living in the inner city hotels, the infestations of bugs. [With the subsidy] the thought, I’ve really got to smarten up, pull up my socks and start really watching the company I keep and start getting my life on track. And it’s getting there. (Woman, age forty)

Although these strategies and programs for supporting women’s health are essential features of the work at the health centres, they are supported on shoestring budgets or implemented within unstable one-time funding sources and are often coordinated or managed “off the sides of the desks” of staff.

Attending to women’s needs for safety begins with acknowledging that most of the women who use the health centres have experienced violence, historical and/or emotional trauma, and often childhood sexual abuse; this stance underpins concerted efforts to ensure that the spaces created inside and outside the health centres are safe for women. In one of the centres, this has involved creating a separate area for women and children to sit while they wait for a clinic appointment. In the other centre, the space and activities offered as part of the women’s wellness program are provided in ways that are welcoming to diverse groups of women. For example, women who are actively using drugs are treated with respect and welcomed rather than turned away, as might happen in other health care settings. There is an intentional use of unconditional positive regard to foster both emotional and cultural safety for women who are routinely exposed to violence, discrimination, racism, and dismissal. Staff and volunteers also make a concerted effort to connect respectfully, non-judgmentally, and safely with women.
through the use of activities such as music therapy, art projects, manicures, haircuts, and shoulder or hand massages. Although at first glance such activities might seem to fall outside the health care jurisdiction, a closer look reveals that they permit staff to listen therapeutically to women's discussions about their lives and intertwining health and social needs, and to use touch in ways that are safe, accepting, and comforting – experiences that many of the women rarely have. Some women partake in the women's wellness activities while waiting to see a health care provider at the medical clinic, and others come specifically for the health-promoting aspects of safe and accepting social contact. One woman who described herself as struggling with addictions and unstable housing explained how the extreme challenges of life on the inner city streets made the simplest of caring acts invaluable:

Because you're missing so much on that connection, not connected to anybody. Those kinds of just simple gestures, just that little bit of, you know, good human touch, you know, once in a blue moon, can really help somebody get to the next step, right? Good human interaction and connections ... That's lifesaving, life changing, literally, it's that valuable. It's life changing because when I was out there it was not good, it was always for something, you know, you were selling your body or you're giving up a piece of yourself daily, right? And then to have somebody want to do something for you just to help you, like oh my god, it's like, 'oh shit there's still people like that out there, you know?' And then it just gives you a whole new perspective. (Woman, age thirty-eight)

Operating from a stance that problematizes social structures, structural violence, and social suffering, rather than locating the source of problems within the psyches of individual people, allows the health centre staff to create a sense of belonging and community, and to actively convey non-judgmental acceptance to those accessing services.

Providing health care from a stance informed by intersectional perspectives, staff at the health centres recognize that many women – because of their experiences of being exploited, marginalized, and racialized, and because many struggle with addictions – encounter dismissal on many levels: in the health care system, the justice system, and the social services sector, as well as with child welfare authorities to negotiate access to their children, and so on. Receiving health care that is philosophically committed to conveying unconditional positive regard is particularly powerful, as a First Nations woman who frequently accessed one of the health centres described: “Well if you judge them [patients], then they go back out ten times worse, right? Because they feel like they’re nothing. And I’ve felt like that. I know how it feels. You feel lost, empty and that you have no one” (Woman age, 37).
Using an intersectional lens, staff view people who attend the health centres, and people from the surrounding community, in ways other than those provoked by the ubiquitous negative media and public portrayals commonly assumed to accurately represent people living in both inner city areas. As a nurse at one of the health centres explained, “I see other parts of their life other than the street life, and that helps me [in my work with people who access the centre] ... I see despair, I see hopelessness, but on the other side of things, I see a community; I see that this is their community.”

Because disconnection from self, family, and community is common among women who have experienced multiple forms of violence and trauma (McKeown et al. 2002), and because social inclusion is a key determinant of health, facilitating women’s connections to others is critical to their health and well-being. An intersectional approach thus brings the complexity of women’s lives into view and frames the facilitation of social inclusion as a legitimate health care priority and health-promoting service.

**Implications for Health Services Research:**

**Research as Praxis and Practice**

Patricia Hill Collins (quoted in Hankivsky and Cormier 2009, 3) has argued that an intersectional analysis is fully realized only “when abstract thought is joined with concrete action.” Basing health services research on an intersectional understanding of the lives of women affected by marginalization and racialization has implications for how research is conducted: it must be normatively oriented toward praxis, with fluid and permeable boundaries between research and practice. This emphasis on socially transformative research calls on researchers to be conscious of their power and positionality, and to use their positions of privilege in ways that directly advance social justice (Harding and Norberg 2005).

In the case of our research, the commitment to “give back” to the two Aboriginal health centres takes various forms. At the policy level, members of our research team collaborate with leaders within the centres to lobby for improvements to policy and funding arrangements. At the organizational level, team members responded to the continual need to piece together funding by using their academic resources to write funding proposals for the women’s wellness program. At the micro level of interactions, our engagement with the women’s wellness program involves a long-term commitment to developing relationships with women who attend and to doing volunteer work that helps to support the services provided.

In the context of health services, future research is needed to better understand how intersectional and biomedical perspectives can connect to generate new knowledge in complementary ways. Biomedical research, informed by intersectional analyses, is needed to apply emerging understandings of the
neurophysiologic basis of associations among, for example, childhood trauma, chronic pain, and addictions (Wuest et al. 2008), in order to design responses to health problems that intersect both with one another and with wider forms of oppression. Research is required at numerous levels (Edwards, Mill, and Kothari 2004) to study the impact of multiple interventions on intersecting health and social issues. Social epidemiological research will continue to be important to show the linkages between experiences of racism/discrimination/stigma and health conditions such as hypertension or cardiovascular disease (Krieger and Davey Smith 2004). Within these paradigms of research, intersectional perspectives will help to expand the depth and complexity of evolving knowledge. Knowledge development focused on expanding our understanding of the interrelatedness of health issues, social locations, and structural factors will in turn help us to improve responsiveness to these issues in health services, policy, and research.

Research is also needed to explore ways of incorporating intersectional perspectives into policies that shape the structure and organization of health care systems and the delivery of health care services. The intersectional literature identifies the importance of including intersectional perspectives in policy (Hankivsky and Christoffersen 2008), but more analyses are needed to explore how policies intersect to structure the organization and delivery of health care services in ways that profoundly affect health and access to responsive health services.

In summary, using an intersectional perspective in health services research aimed at analyzing and improving health care draws attention to the following: how health problems are framed; why particular problems are prioritized, and thus legitimized, over others; how multiple health and social issues such as violence and trauma, chronic pain, addictions, and poverty intersect; and the importance of structuring health services in ways that address the intersecting realities of people's lives. These areas of analysis will be critical to developing strategies for mitigating the ongoing marginalizing and racializing inequities that shape the lives and health of many women in Canada.

Note
1 This study, which is still in progress, uses an ethnographic mixed-methods research design. To date, we have collected the following data: in-depth interviews and focus groups with seventy-two patients (fifty-five of whom self-identified as Aboriginal and seventeen as non-Aboriginal); interviews with forty-four health centre staff; over 850 hours of participant observation at both health centres, including observations of clinical encounters between patients and staff, interdisciplinary staff meetings, the waiting room environments, and the general milieu; and analyses of the health centres' organizational and policy environments. The excerpts we present in this chapter are taken from interviews with women who attended the health centres and our fieldnotes recorded as part of participant observation.
References


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