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An Intersectionality-Based Policy Analysis Framework

Edited by Olena Hankivsky

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An Intersectionality-Based Policy Analysis Framework

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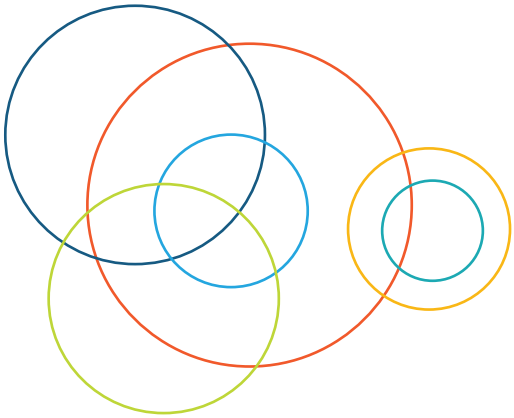

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RESEARCH AND POLICY

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Table of Contents

Introduction:
Why Intersectionality Matters for Health Equity and Policy Analysis 7
Olena Hankivsky, Daniel Grace, Gemma Hunting, and Olivier Ferlatte

Intersectionality-Based Policy Analysis 33
Olena Hankivsky, Daniel Grace, Gemma Hunting, Olivier Ferlatte, Natalie Clark, Alycia Fridkin, Melissa Giesbrecht, Sarah Rudrum, and Tarya Laviolette

Policy Case Studies

An Intersectional Critical Discourse Analysis of Maternity Care Policy Recommendations in British Columbia 47
Sarah Rudrum

Intersectionality and the 'Place' of Palliative Care Policy in British Columbia, Canada 69
Melissa Giesbrecht

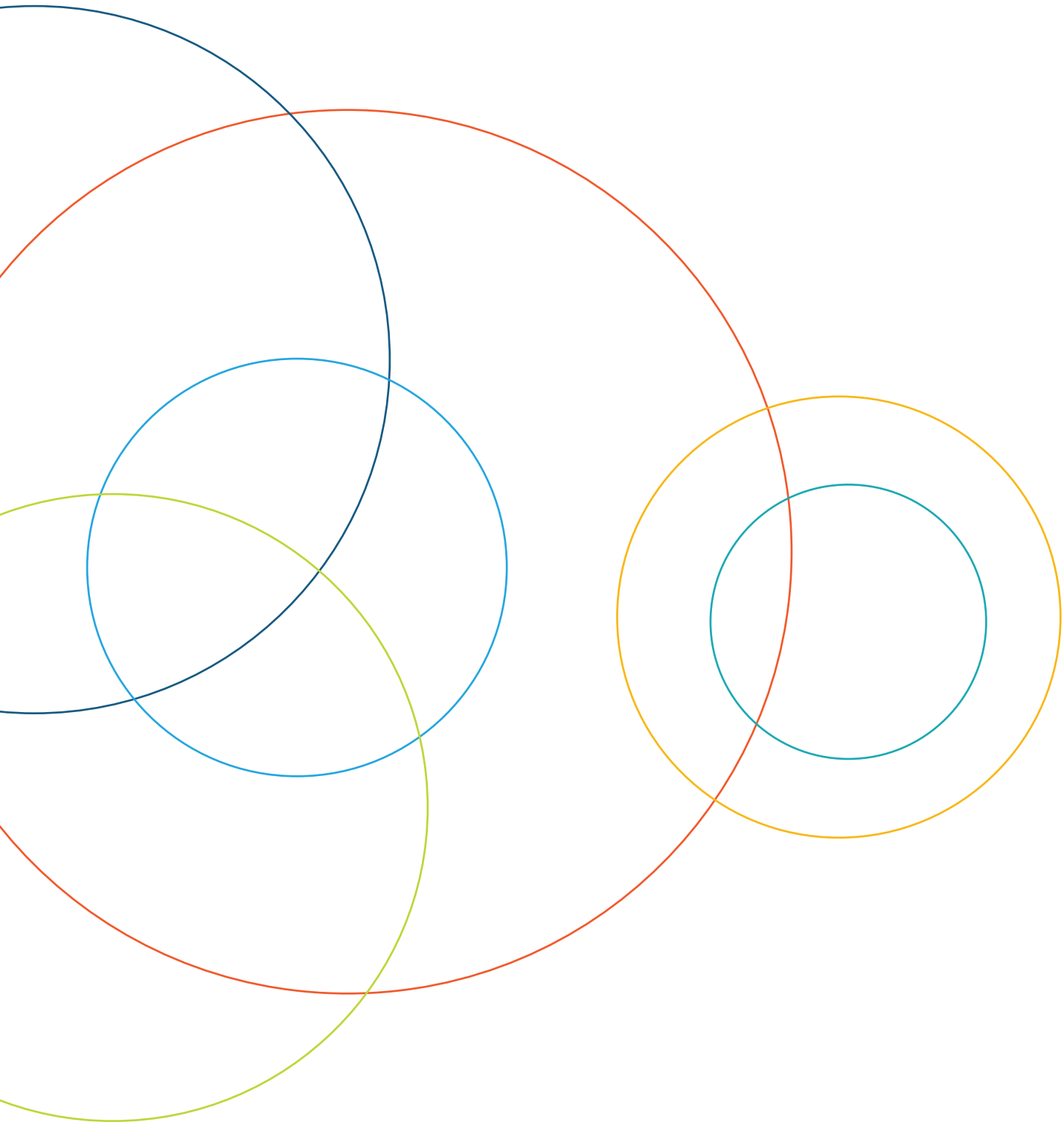
A Call for a Policy Paradigm Shift: An Intersectionality-Based Analysis of FASD Policy 93
Gemma Hunting

Decolonizing Policy Processes: An Intersectionality-Based Policy Analysis of Policy Processes Surrounding the Kelowna Accord 115
Alycia Fridkin

Perseverance, Determination and Resistance: An Indigenous Intersectional-Based Policy Analysis of Violence in the Lives of Indigenous Girls 133
Natalie Clark

Reconceiving the 'Problem' in HIV Prevention: HIV Testing Technologies and the Criminalization of HIV Non-Disclosure 161
Daniel Grace

Are There Enough Gay Dollars? An Intersectionality-Based Policy Analysis of HIV Prevention Funding for Gay Men in British Columbia, Canada 189
Olivier Ferlatte



Introduction: Why Intersectionality Matters for Health Equity and Policy Analysis

Olena Hankivsky, Daniel Grace, Gemma Hunting, and Olivier Ferlatte

As has been recognized elsewhere, the public policy world is in a constant state of flux (Orsini & Smith, 2007). Political, economic, environmental and health crises and events are creating new kinds of policy problems and challenges at international and national levels. Moreover, there is growing awareness that although policy alone cannot transform society, it does have an important but not yet fully understood role in the creation of more just and equitable societies (Bryant, Raphael, Schrecker, & Labonte, 2011; Hankivsky & Cormier, 2011; Ingram & Schneider, 2006; Stone, 2001). In light of such developments, existing policy tool kits need to be re-examined to evaluate the adequacy of information currently being generated to inform policy and, importantly, to more fully explore and determine what policy analysis is *supposed to achieve* (Orsini & Smith, 2007).

In the field of health, calls have been made for 'policy acumen' (Jones & Salmon, 2001) to deal with increasingly complex environments that shape and influence health. Although there is no shortage of approaches to health policy analysis (e.g., Collins, 2005; Dunn, 1981; Portney, 1986) there is little attention to 'meaty dialogue' around the kinds of theoretical frameworks that can improve policy analyses (Abelson et al., 2008) so that a broader and more accurate base of information about what makes people healthy or alternatively unhealthy can be generated.

The purpose of this introductory chapter is to advance this dialogue by critically examining existing approaches to health policy analysis, including their theoretical and practical utility, and, in the process, highlighting what important issues they fail to adequately confront in relation to health inequities. We then move on to make the case for why the theory of intersectionality holds so much promise in constructing an improved method for policy analysis that can generate knowledge necessary for achieving more inclusive, just, effective and efficient health policies. Arguably, intersectionality can significantly advance the operationalization of equity in public policy.

The chapter begins with a brief overview of public policy, health policy and a number of select approaches to health policy analysis, including sex and gender based analysis and health equity impact assessment tools, which, to date, represent the most promising 'state of the art' tools for determining the distributional effects of health policy. Our investigation reveals that despite progress made to date, there is still much work to be done to better understand how policy affects the diversity of populations, including precisely identifying who is benefiting and who is excluded from health policy goals, priorities and related resource allocation. In this collection, we follow Waldegrave (2009) in arguing that:

> We need to deconstruct the industries of . . . policy making from the perspectives of culture, gender, and socioeconomic status and enquire as to the reasons for their hegemony and practice. Are they . . . achieving equity? Do they enable the goals of social inclusion and well-being to be reached? Do they respect the breadth of citizenship in a country, and do they enhance or hinder the inspirations of all citizens? (p. 97)

Our central argument is that in drawing on the theory of intersectionality we can build on and improve existing equity focused tools, and specifically, health equity impact assessment tools. Our aim is lay the groundwork for an Intersectionality-Based Policy Analysis (IBPA) Framework that we present in detail in the next chapter (Hankivsky et al., 2012). The IBPA Framework facilitates the asking of questions that can capture the most important and relevant information about decision-making priorities, processes and policy outcomes.

In advancing a case for intersectionality in policy analysis our goal is to bring about a paradigm shift that foregrounds the complex contexts and root causes of health and social problems. Extending beyond gender-specific and social determinants frameworks, intersectionality focuses attention on a variety of multi-level interacting social locations, forces, factors and power structures that shape and influence human life. In the context of health – broadly conceived – the lens of intersectionality can better illuminate how policy constructs citizens' relative power and privileges vis-à-vis their status, health and well-being. As Bacchi and Eveline (2010) put it, "policies do not simply 'impact' on people; they 'create' people" (p. 52), including their social locations, and access to power and resources.

What is Public Policy? What is Health Policy?

Public policy can be understood as "a guide to action, a plan, a framework, [or] a course of action or inaction designed to deal with problems" (Pal, 2001, p. 5). In general, public policy is seen as an output from governments, namely "what public officials, within government, and by extension the citizens they represent, choose to do or not to do about public problems" (Kraft & Furlong, 2009, p. 5). But public policy is not only an observed phenomenon of what governments do or choose not to do. It also has a normative component because it raises questions about what governments *ought* or *ought not* to do (Simon, 2009). Public policy thus reflects the type of 'social contract' that is envisioned for society, including "the written and unwritten agreement that we continually rewrite stating what we want to do for each other collectively and what we want other members of society to do for us as individuals" (Simon, 2009, pp. 1-2).

Public policy is largely driven by arguments about whether something is a problem, whether it is a solvable problem, what the potential solutions are, what the costs of those solutions are, and whether the solutions will be wholly – or more likely, partially – effective (Birkland, 2011, p. 10). While it is ultimately governments' responsibility to create policies, the ideas that underpin these policies often emerge from outside government, including through interactions between government and non-governmental actors (Birkland, 2011). Indeed, civil society often plays a critical role in shaping policies, especially when governments try to manage public outcries or public dissatisfactions with current societal practices or the government itself (Varcoe, Pauly, & Laliberté, 2011). Thus the development of policies is often dependent on many factors, which may include, but are not limited to: the public interest, the effectiveness of the policy, cost, and whether a policy is socially acceptable and politically viable (Dye, 2010; Kraft & Furlong, 2009).

Although it is typically thought that policy is operationalized through constitutions, statutes, regulation, case law and legislation, it is also important to recognize that policies reveal themselves in different ways, including "through texts, practices, symbols and discourses that define and deliver values including goods and services as well as regulation, income, status and other positively or negatively valued attributes" (Schneider & Ingram, 1997, p. 2). Public policy is significant because it is a means by which societies regulate themselves and attempt to channel human behaviour (Birkland, 2011; Kraft & Furlong, 2009; Schneider & Ingram, 1997). In this way policies have profound and pervasive effects on individuals and populations. As Torjman (2005) put it: "We literally eat, drink and breathe public policy" (p. 1).

Yet each specific policy sector, including health, is also unique. Health policy refers to decisions, plans and actions undertaken to achieve specific health care goals within a society (World Health Organization [WHO], 2010). According to Coveny (2010), three features make health policy different from other areas: 1) the influence of the medical profession in health care in general; 2) the monopolistic nature of health care systems; and 3) the fact that health policy "involves life-and-death decisions, which are unparalleled in other areas of public and social policy" (p. 515). In this project, however, we move beyond the confines of narrowly defined health policy to embrace the concept of *healthy public policy*, that is, "public policies, outside the formal health sector, that have an impact on health, such as education, transportation, and fiscal policies" (National Collaborating Centre for Healthy Public Policy, 2007, para. 2).

Health Policy Analysis

Analyzing policy is of crucial importance in modern complex societies because "public policy is so vast, public problems are sophisticated and often inter-connected, and public policies have tremendous social, economic, and political implications" (Simon, 2009, p. 59). The task, however, is complicated because good policy analysis, as has been widely argued, is both an art and a craft (Dye, 2010; Kraft & Furlong, 2009). As Dye (2010) elaborates:

> It is an art because it requires insight, creativity, and imagination in identifying societal problems and describing them, in devising public policies that might alleviate them, and then in finding out whether these policies end up making things better or worse. It is a craft because these tasks usually require some knowledge of economics, political science, public administration, sociology, law, and statistics. (p. 8)

Health policy analysis (HPA) has been defined in various ways, including: "a multidisciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process" (Walt et al., 2008, p. 308); "an interdisciplinary field that investigates how health policy is made, what it is, what it might become, and what its effects are" (Abelson & Giacomini, 2003, para. 2); and as the "generic name for a range of techniques and tools to study the characteristics of established policies, how the policies came to be and what their consequences are" (Collins, 2005, pp. 192-193). In general, HPAs are intended to allow policy actors to learn from policy failures and successes so as to inform the future design and implementation of policies (Gilson & Raphaely, 2008; Walt et al., 2008).

In this collection, we define health policy analysis as a social, political and intellectual endeavor carried out by diverse stakeholders, including university-based researchers, bureaucrats, health professions and other policy actors, such as community-based groups and organizations. HPAs often take an interdisciplinary approach to understanding the (a) *production process of health policy* (how it is made), (b) *the product of health policy* (what it is), the (c) *the power of health policy* (what effects it has in the everyday world), and (d) *normative claims regarding future policy directions* (what policy should look like). This broad definition of health policy analysis involves a concern with examining complex power-laden policy processes, investigating policy content, determining policy outcomes across the population, and identifying effective and inclusive policy options (*see* Abelson & Giacomini, 2003; Bardach, 2000; Ham, 1991; Walt, 1994).

Analysis of Approaches to Date

According to Walt et al. (2008) little attention has been paid to how to do health policy analysis, including what research designs, theories or methods might best inform such analyses (p. 308). Techniques for conducting HPAs to date range from simplified step-by-step linear models specifically tailored for conducting HPAs (Bardach, 2000; Collins, 2005) to more specialized tools largely organized around conceptions of the policy making process and/or 'problem' definition (Bacchi, 1999), or focused on specific questions about the *nature and types* of policy, the *process of making* policies, and the *effects* of policy in the everyday world (Abelson & Giacomini, 2003).

In general, HPAs have prioritized efficiency, effectiveness and political feasibility of policy, while assuming that public policies are neutral and benefit all citizens equally. However, policy processes are imbued by power and privilege, and thus have differential effects across populations (Birkland, 2011). There is growing recognition that governments need to be measured by their ability to deliver policy that can advance social justice and equity (Marmot, 2012) correct power imbalances, and address damaging stereotypes and social constructions among stakeholders (Ingram & Schneider, 2006, p. 184). Moreover, there is increasing pressure to improve the measurement, analysis and monitoring of policies in order to better capture their differential and distributional health impacts on diverse populations (Braveman, 2003; Commission on Social Determinants of Health, 2008; Global Equity Gauge Alliance et al., 2008).

Although the effects of a broad-based policy may be associated with an improvement in overall population health, such traditional approaches often make use of static conceptions of 'sub-groups' and concomitant 'risk factors.' As a result they may not effect meaningful change in the health of those situated at intersecting axes of disadvantage

(Brëdstrom, 2006; Eek et al., 2010; Fetene & Dimitriadis, 2010; Fiske & Browne, 2008; Greaves et al., 2006; Paterson, 2010; Thomson, Murtagh, & Khaw, 2005). Health and health related policies need to be closely interrogated to determine how they signal who is important and who is not, specifically through how different publics are involved, positioned and affected. Such policies need to be evaluated in terms of how different perspectives of problems are recognized as legitimate or ignored, and whether certain populations experience burdens or benefits from policies, including the effects of policy on the health and well-being of populations. Arguably such lines of questioning are especially pressing and relevant given the recent global financial crisis and economic slowdown, which have created budgetary constraints and placed pressure on policy actors to undertake broad policy reforms that exacerbate social and health inequities (Hacker & Pierson, 2010; Navaro & Muntaner, 2004; Neysmith, Bezanson, & O'Connell, 2005; Unger, De Paepe, Ghilbert, Soors, & Green, 2006).

While many international jurisdictions have worked to develop equity-focused policy analysis tools, in Canada there are two specific types of analysis that have emerged as 'best practices' for capturing the differential effects of policy on the population: (1) sex and gender based analysis (SGBA), which is informed by gender theories of inequity; and (2) health and health equity impact assessments (HIAs/HEIAs), which are underpinned by social determinants of health frameworks. Each of these has been applied to various stages of the policy cycle, but has been considered most effective when applied prospectively to inform the development of policy and to ensure that analysis of policy effects are determined prior to any implementation. And while each has made important contributions to understanding how policy actually affects differently situated populations, a closer examination illustrates shortcomings that are directly linked to their theoretical underpinnings and highlights the need and importance of an intersectional perspective for effective health policy analysis.

Sex and Gender Based Analysis

On April 1, 2009, Health Canada introduced the Sex and Gender Based Analysis (SGBA) Policy to respond to evidence that "biological, economic and social differences between women and men contribute to differences in health risks, health service use, health system interaction and health outcomes" (Health Canada, 2010, para. 7). The underlying premise of this approach is that "sex and gender are fundamental influences on the identities and experiences of both women and men" (Clow, Pederson, Haworth-Brockman, & Bernier, 2009, p. 157) and that sex and gender should be placed front and centre

in order to ascertain the gendered implications of research, policies and programs. Clow et al. (2009) also assert that SGBA recognizes the variations among women and among men, as well as between them, and that both the theory and practice of SGBA emphasize the intersections of multiple aspects of individual identity and experience.

Arguably, however, SGBA is underpinned by a type of gender theorizing that highlights binary differences between men and women, with a strong focus on the needs and experiences of women. Consequently SGBA tools are not designed to ensure that the differences *between* different groups of women and men are examined or that different types of population groups are interrogated. Clow et al. (2009) claim that:

> From its roots as a white, middle-class urban women's movement, based largely in North America and Europe, sex and gender-based analysis has become more inclusive and expansive, embracing both the analysis of diversity and an understanding of global perspectives on the health and well-being of women and girls as well as for men and boys. (p. 158)

However, the consequence of giving primacy to sex and/or gender differences, and of assuming the stable categories of male and female as a binary is to inhibit a full interrogation of the complexity of health experiences and needs. Not surprisingly then, the theoretical foundations of SGBA have been deemed inadequate for tackling the diversity of health inequities in research and policy (Canadian Research Institute for the Advancement of Women, 2006; Hankivsky, 2012; Hankivsky & Cormier, 2009; Wolf, 2011).[1]

Health Impact Assessment Tools

The World Health Organization has defined HIAs as "a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population" (1999, p. 4). Although HIAs have been subject to a variety of interpretations and applications, their general aim is to determine the potential negative or positive effects of policy in terms of increasing or reducing health inequities across different population groups in the move to create healthier societies (Scott-Samuel & O'Keefe, 2007; Simpson, Harris, & Harris-Roxas, 2004). Most recently, Health Equity Impact Assessments (HEIAs) and their outgrowths namely Equity Focused Health Impact Assessment Frameworks (e.g., Harris-Roxas, Harris, Maxwell, Thornell, & Peters,

[1] It is important to acknowledge that in the spring of 2012, Status of Women Canada introduced a new federal policy tool: GBA+ (Gender-Based Analysis Plus) – a method for examining the intersection of sex and gender with other identity factors, such as age, education, language, geography, culture and income. It is expected that new approach will influence all federal departments including Health Canada.

2011; Mahoney, Simpson, Harris, Aldrich, & Stewart Williams, 2004) have emerged in the literature and seek to more explicitly place equity at the forefront of policy impact analysis.

The main difference between SGBAs and HIAs/HEIAs is that the latter are anchored within social determinants of health frameworks that recognize a plethora of structural and social factors that affect health and do not automatically give primacy to any one factor (e.g., gender) in their analysis.

Social determinants frameworks have become increasingly popular in recent years within the field of health and policy for use in understanding and addressing health inequities – i.e., avoidable, unnecessary and unjust differences in the health of diverse groups of people (Braveman, 2003; Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001). Various frameworks of social determinants have been suggested, both nationally (Mikkonen & Raphael, 2010; Public Health Agency of Canada, 2011) and internationally (Dahlgreen & Whitehead, 2006; WHO, 2007), all emphasizing similar factors and social conditions as the causes of health and illness. Within the Canadian health and policy fields, the most widely recognized social determinants of health framework is that of the Public Health Agency of Canada (2011), which lists the following determinants:

- Income and Social Status,
- Social Support Networks,
- Education and Literacy,
- Employment/working Conditions,
- Social Environments,
- Physical Environments,
- Personal Health practices and Coping Skills,
- Healthy Child Development,
- Biology and Genetic Endowment,
- Health Services,
- Gender, and
- Culture (Key Determinants section)

Grounded in a social determinants of health framework, HIAs have been invaluable for underscoring the variety of factors that influence and shape health. For example, they have been recognized for their ability to promote equity, sustainability and healthy public policy; improve the quality of decision-making; promote social and environmental justice; encourage public participation in public policy; prioritize both quantitative and

qualitative evidence; make values explicit and open for discussion and debate; and bring attention to how policy – in all sectors, including but not limited to health – affects health (Scott-Samuel & O'Keefe, 2007, p. 212). According to the National Collaborating Centre for Healthy Public Policy (2010) in Canada, HIAs are currently the most structured practices available to actors working in the area of healthy public policy.

Not surprisingly, the appeal of HIAs and, in particular, HEIAs has grown over the last decade, especially in New Zealand (Ashton, 2007; Public Health Advisory Committee [PHAC], 2005), Australia (Harris, Harris-Roxas, Harris, & Kemp, 2007; Simpson, 2009), Canada (Haber, 2010; Handel, Ambtman, & Mohamed, 2010), and throughout much of the European Union (EU) (Harris et al., 2007; National Health Service, 2010; Welsh Health Impact Assessment Support Unit, 2004; *see* Birley, 2011 and Gunther, 2011 for important overviews). Work has also been done to determine the commonalities and differences of key HIA guides internationally to determine the plausibility of consensus guidelines in the field (Hebert, Wendel, Kennedy, & Dannenberg, 2012).

At the same time, HIAs have also been critiqued for their lack of attention to policies outside of those directly affecting the internal operations of nation states (e.g., foreign policy) (Ingram, 2006). Others have noted that there is a lack of guidance to ensure that equity is fully integrated into HIAs (Harris-Roxas, Simpson, & Harris, 2004; Simpson, Mahoney, Harris, Aldrich, & Stewart-Williams, 2005). According to Scott-Samuel and O'Keefe (2007) HIAs need to expand their focus on what actually determines health. They argue that, "HIA can be pursued using a lens of increasing width that tracks the factors that have an impact on health" (p. 215). From an intersectionality perspective, such critiques can be extended by also acknowledging the following five limitations that impede the potential of HIAs/HEIAs.

First, there is no systematic integration of the fact (and extent) that conceptualization, prioritization, and evaluation of both desired and actual policy effects are largely shaped by the values, experiences and expertise of policy actors (McCaughey & Bruning, 2010; Overseas Development Institute, 2009; Sabatier, 2007). One positive exception is New South Wales' *Health Impact Assessment: A Practical Guide* (Harris et al., 2007), where the scoping process of an HIA includes the formation of a steering committee with expertise surrounding "the proposed topic, the potential population(s) affected, community involvement, public health evidence and research, negotiation skills, policy analysis, equity issues and the social determinants of health" (p. 12). Nevertheless, policy actors and researchers conducting HIAs must be reflexive in order to help ensure clear and consistent recognition of the inherent biases in decision makers' worldviews.

Second, while many HIAs recognize that policies and their lived effects cannot be separated from social, economic, cultural and historical factors that determine health, they fail to fully explicate the *relationality* of such factors and the ways in which they are connected. For example, grounded within social determinants of health frameworks, HIAs prioritize socioeconomic status (SES), along with a range of other inequities, such as gender, ethnicity, geographic location and ability (PHAC, 2005; Signal, Martin, Cram, & Robson, 2008; Simpson, 2009) without fully understanding how these interact or are co-constituted (Hankivsky & Christoffersen, 2008). Moreover, while HIAs do not ignore the contexts of people's lives, they typically view social locations like gender, 'race' and class as homogenous, unconnected and static rather than as dynamic, intersectional and fluid (Manuel, 2006). This can lead to categorizing people as specific most-at-risk populations (MARPs) or 'target' populations (Ministry of Health and Long-Term Care, 2011). Policies that are focused on 'at risk' identities (e.g., women, Aboriginals) or behaviours (e.g., men who have sex with men (MSM), injection drug users (IDUs)), do not consistently addresses important within and between group differences and may eclipse or erase individual and group identities and social locations (Grace, 2012; Young & Meyer, 2005).

Third, even though HIAs highlight structural causes of health inequities, they fall short in drawing together the complex operation and effects of processes of differentiation and systems of domination across different societal levels (e.g., macro, meso and micro) (Dhamoon & Hankivsky, 2011; Grace, 2011). It is clear that an analysis of policy processes and their effects must be contextualized within the broader *multi-level* relations of power in which these processes and effects are situated. Accordingly, *both* social locations and the processes of power that influence and determine them (e.g., patriarchy, capitalism, heterosexism, imperialism) – including policy processes themselves – need to be considered as important, *interrelated* structural determinants of social experience and health. To date, HIAs and HEIAs have failed to do this.

Fourth, HIAs do not leave room for analyzing the effects of resistance and resilience on equity in the context of health policy. This undermines the ability of researchers and policy actors to understand that policies that label populations as inherently marginalized or vulnerable undermine the reality that there are in fact no 'pure victims or oppressors' in society (Collins, 1990; Dhamoon & Hankivsky, 2011). The complexity of the human condition means that in all instances – including in the context of health and healthy policy – people have varying degrees of privilege and penalty. Importantly then, even from so-called marginalized spaces and locations, oppressive values, norms and practices can be questioned and challenged. For example, one principle mechanism of resistance from subordinated groups has been collective actions to destabilize dominant ideologies (Dhamoon, 2011). However, the focus of HIAs on categorical approaches

to social identities obscures similarities between population groups and their shared relationships to power. Such a focus prevents coalitional work as it reinforces differences and distinctions based upon specific categories.

Finally, HIAs fail to consistently prioritize the voices and participation of people that may be intentionally or inadvertently affected by policy processes. Though community and stakeholder participation are acknowledged in some HIA frameworks (Kemm, 2007), particularly HEIAs (e.g., Haber, 2010; Harris et al., 2007), such participation is typically not considered central to policy analysis. Often the tendency for HIAs is to consult with representatives of particular 'categories' of people in ways that a) appear very paternalistic or tokenistic (Kemm, 2007, p. 7), and b) obscure the diverse perspectives and needs of people within and across social categories/locations.

These enumerated limitations demonstrate that, despite making important headway in bringing equity to the forefront of health policy analysis, HIAs require further advancement. As the following section elaborates, such shortcomings can be addressed by drawing on the paradigm of intersectionality, which has as its core aim to understand, analyze and respond to multiple, complex and interacting inequities.

Intersectionality

Rooted in a long and deep history of Black feminist writing, Indigenous feminism, third world feminism, and queer and postcolonial theory (Bunjun, 2010; Collins, 1990; Crenshaw, 1989, 1991; Van Herk, Smith, & Andrew, 2011), intersectionality has emerged as a widely respected, albeit variously defined research and policy paradigm (Hancock, 2007b). Nevertheless, there are a number of central tenets that capture the unique nature of this paradigm. These are:

- human lives cannot be reduced to single characteristics;
- human experiences cannot be accurately understood by prioritizing any one single factor or constellation of factors;
- social categories/locations, such as 'race'/ethnicity, gender, class, sexuality and ability, are socially constructed, fluid and flexible;
- social locations are inseparable and shaped by interacting and mutually constituting social processes and structures, which, in turn, are shaped by power and influenced by both time and place; and
- the promotion of social justice and equity are paramount (Hankivsky, 2012; Hankivsky & Cormier, 2009).

Intersectionality is concerned with bringing about a conceptual shift in how researchers, civil society, public health professionals and policy actors understand social categories, their relationships and interactions. It requires a consideration of the complex relationship between mutually constituting factors of social location and structural disadvantage so as to more accurately map and conceptualize determinants of equity and inequity in and beyond health (Grace, 2010).

Intersectionality encourages critical reflection that allows researchers and decision-makers to move beyond the singular categories that are typically favoured (e.g. gender, 'race' and class) in policy analysis to consider the complex relationships and interactions between the aforementioned trinity and other social locations and identities, such as Indigeneity, sexuality, gender expression, immigration status, age, ability and religion. This enables an examination of the simultaneous impact of and resistance to systems and structures of oppression and domination, such as racism, classism, sexism, ableism and heterosexism (Hankivsky & Cormier, 2009).

Importantly, intersectionality is founded on what HIAs commonly overlook: reflexivity, relationality, processes of differentiation and accounting for resistance/resilience – tenets outlined in more detail below. As Ferree (2009) explains elsewhere, intersectionality warns us of the risks of policies that, by privileging the treatment of some inequities and ignoring the fact that inequalities are often mutually constitutive, end up marginalizing some people, reproducing power mechanisms among groups, and failing to address the creation of categories that are at the root of the constitution of inequities. Applying intersectionality in the context of policy can thus be considered a political action, as it demonstrates a commitment to ameliorating inequitable relations of power that maintain inequity – relations that often remain unquestioned in dominant policy approaches.

Intersectionality and Policy

Though the evidence base supporting the differential effects of policy across multiple axes of diversity is in its infancy, intersectionality-based analyses have been leading this line of inquiry (e.g., Bishwakarma, Hunt, & Zajicek, 2007; Bose, 2012; Collins, 1990; Crenshaw, 1991, 1989; Hancock, 2007a, 2007b, 2011; Hankivsky, 2011; Hankivsky & Cormier, 2011; Hankivsky et al., 2010; Iyer, Sen, & Östlin, 2008; Lombardo & Verloo, 2009; Manuel, 2006; Reid, Pederson, & Dupere, 2007; Schulz & Mullings, 2006; Varcoe, Hankivsky, & Morrow, 2007). For Lombardo and Agustin (2009) a 'good' intersectional policy analysis has the following components:

> *explicitness* and *visibility* of certain inequalities as well as the *inclusiveness* of a wide range of multiple inequality categories in the policy documents; the extent of *articulation* of intersectionality which implies both the mentioning of the intersecting categories and the way they are dealt with in the documents (e.g. as separate or mutually constitutive categories for examples);...the appearance of lack of *transformative approach* to the issue of intersectionality; a *structural understanding of* power hierarchies and the dimensions of inequality, also in relation to addressing both individual and group dimensions; awareness/challenging of *privileges* and internal inequality biases in the policy documents; avoiding the potential *stigmatization* of people and groups at different points of intersection; and the *consultation* of civil society actors in the policy making process. (p. 4)

However, only a handful of tools have been developed for applying intersectionality to public policy. For example, Bishwarkarma et al. (2007) have developed questions and criteria for an intersectional analysis in four stages of policy making, including agenda setting (problem structuring), policy formulation (alternatives and recommendations), policy implementation (monitoring) and policy assessment (evaluation). Meanwhile, Parken and Young (2007) have developed a multi-strand model that seeks to move beyond silo approaches to policy by focusing on a policy field and then showing the steps involved in capturing relationships between different forms of inequity as well as resulting individual and group disadvantages. Their multi-strand model has four distinct stages: mapping, visioning, road testing, and monitoring and evaluation. The model involves a range of expertise in the areas of policy, equality, and human rights, and it is intended to engage with all relevant stakeholders. It is "based upon the collection, collation, analysis and synthesis of equality evidence for all equality 'strands' and human rights and those outside of 'strands'" (Parken & Young, 2007, p. 50; Parken, 2010). Finally Rönnblom (2008) has developed the concept of spatial dimensions to advance the contextualization of intersectionality-informed analysis so that different and intersecting power relations in policy can be better understood.

Emerging methods for operationalizing intersectionality in policy acknowledge the inherent difficulties of this work. The incremental and reductionist nature of policy and the short-term horizons of its making are often incompatible with the demands of an intersectionality-based analysis. All the efforts to date also signal the highly exploratory nature of the work being undertaken. While critical evaluations of such nascent approaches have been performed elsewhere (see for example Hankivsky & Cormier, 2011), existing tools represent important foundations on which to build more effective and concrete methodological approaches to intersectionality-informed policy. As Manual

(2006) puts it, "intersectionality theory represents an incredibly useful analytical lens for policy scholars who wish to strengthen the explanatory power of policy models that evaluate policy impacts and outcomes" (p. 175).

A pressing and ongoing challenge in advancing this line of work is the further development of explicit and user-friendly methods than can more effectively translate intersectionality theory into practical approaches that can be used by decision-makers and policy researchers. There is widespread acknowledgment that the meaning and essence of intersectionality for contemporary policy debates needs further clarification, that more concrete policy guidance is required to assist in dealing with the multifaceted ways in which human experience is shaped, and that any effective and transformative intersectionality-informed methods and frameworks must capture the complexities, nuance and reality of policy processes, decisions and outcomes. It is also important that efforts are made to build on and link to well-known equity informed policy tools – namely HIAs – to increase the chances of uptake and widespread application in public policy discourses.

The Goal of this Collection

While the purpose of this chapter is to provide the policy context and rationale for an intersectionality-informed policy analysis, the remainder of this collection is focused on the 'how-to' of taking on the 'messy' policy work of capturing complexity and variation in human lives.

The Intersectionality-Based Policy Analysis (IBPA) Framework and related case studies presented in this collection were developed and refined through an iterative, participatory process (2011-2012). The final Framework reflects not only the efforts of the listed authors, but comments and feedback received from emerging and established scholars in the field at roundtable discussions and learning institutes. Based on a series of meetings and peer feedback, as well as on critical reflection into current gaps and trends in equity-promoting public policy analysis, the group collaboratively devised a draft IBPA Framework from which to guide the development of our case studies. This draft was further revised near the completion of the case studies, as the intention of the group was to engage in an ongoing process of refinement to ensure that the IBPA is a usable and practical guide for policy analysis.

The following chapter – *Intersectionality-Based Policy Analysis* – outlines our framework for an IBPA, including key principles and guiding questions to inform policy analysis.

The remainder of the collection consists of seven policy case examples, grounded in each respective author's program of research. Each case study applies the IBPA Framework to a specific health related issue. The focus of these case studies is on British Columbia, Canada, but the discussion of the policy issues is pan-Canadian, and potentially applicable in other geopolitical contexts. In applying IBPA to a broad spectrum of issues using a variety of methods, the authors illustrate the inherent flexibility of IBPA for a range of policy applications. At the same time, each case study is grounded in key intersectionality principles to ensure IBPA's transformative effects on how policy problems and issues are understood and responded to. Collectively the case studies demonstrate –concretely and persuasively – the added value of engaging with intersectionality for analyzing social and health inequities.

The first two case studies focus on policy issues typically understood as highly gendered phenomena. Both authors, however, draw on IBPA to illustrate the importance of multiple social locations and structures of power, including but not limited to gender, that influence the availability and delivery of health services. To begin, Rudrum examines current maternity care policy, revealing inequities in access to high-quality appropriate care for differently situated women across geography, ethnicity and socioeconomic status. In the process this author challenges the idea that there are fixed norms or standards in the care that women require in pregnancy and childbirth. Next, Giesbrecht focuses on palliative care policy, revealing the current inequities in access to services and supports, and demonstrating the extent to which 'choices' at the end of life by those who need and provide care are inextricably linked to interactions between socioeconomic status, service provision, cultural discourses, and emotional, spiritual and relational factors infused with physical and social aspects of place.

Three of the case studies specifically touch on issues related to Aboriginal health. Hunting's examination of Fetal Alcohol Spectrum Disorder (FASD) shows why Aboriginal populations continue to experience health inequities in relation to current policies. She argues that a sole focus on women as a category, a narrow conception of risk, and a lack of attention to intersecting processes of oppression within FASD policy discourse undermine the development of IBPA-informed policy processes and reforms that can more effectively address the diverse experiences, needs and perspectives of those affected by substance use. Second, in reviewing policy processes of the Kelowna Accord – a national Aboriginal health policy initiative that was developed but never implemented – Fridkin demonstrates how IBPA can be applied to issues in Aboriginal health policy to promote the inclusion of Aboriginal peoples in policy making and contribute to agendas of decolonization. Fridkin illustrates how IBPA can be used to analyze not just policies themselves, but policy processes, thus highlighting the potential of IBPA to expand what is typically

constituted as policy analysis. Third, using an IBPA lens, Clark shows that even policies that forefront Aboriginal needs fall short because they often fail to consider the multiple and intersecting layers of Indigenous identity, such as age, rurality, gender-expression and experiences of trauma, including interactions with multiple policy systems. Clark's contribution is also important in that she draws significant parallels between intersectionality and Indigenous ways of knowing, while raising critical questions about the relationship between IBPA and Indigenous epistemology.

The final two case studies in the collection tackle various issues relating to HIV. First, Grace draws on IBPA to advance understandings of complex issues facing sexual minority populations by considering both current understandings and testing technologies surrounding HIV and the criminalization of HIV non-disclosure. He makes a persuasive argument for using IBPA to advance an equity-focused understanding of the 'problem' of HIV transmission that places front and centre the structural drivers that produce differential vulnerabilities among affected populations. Lastly, Ferlatte uses an intersectionality lens to evaluate HIV prevention funding for gay men. The examination includes consideration of discourses around HIV, funding application processes and funding decision outcomes. His analysis highlights the structural barriers involved in securing support for HIV prevention. Importantly, Ferlatte discusses possible alliances with other groups, such as sex workers, to work for policy change rooted in understandings of the power dynamics that currently shape the HIV funding system.

Conclusion

This chapter has demonstrated the importance of utilizing intersectionality when addressing matters of policy and equity so as to improve upon existing tools. We have positioned intersectionality as a research and policy paradigm that can make visible complex issues of inequity obfuscated by previous frameworks. In the remainder of the collection, we present the Intersectionality-Based Policy (IBPA) Framework and case studies that apply IBPA.

The case studies model uses of IBPA with the goal of bringing issues of equity to the fore and ultimately inspiring others to use this approach in their own policy work .The IBPA Framework is intended to be a living document that will change and evolve over time as a range of end users pilot test and provide feedback on how the Framework can be improved and made more effective and precise. The intended audiences for this collection include analysts working in a range of policy sectors but especially those working within health and health related policy sectors, community organizations engaged in healthy policy advocacy and development, and health researchers seeking improved methods for understanding the health and social effects of policy. The collection is thus intended to contribute to emerging literature in the field by expanding current paradigms of policy analysis and allowing policy actors to see themselves as critical players in the development, implementation and evaluation of policy.

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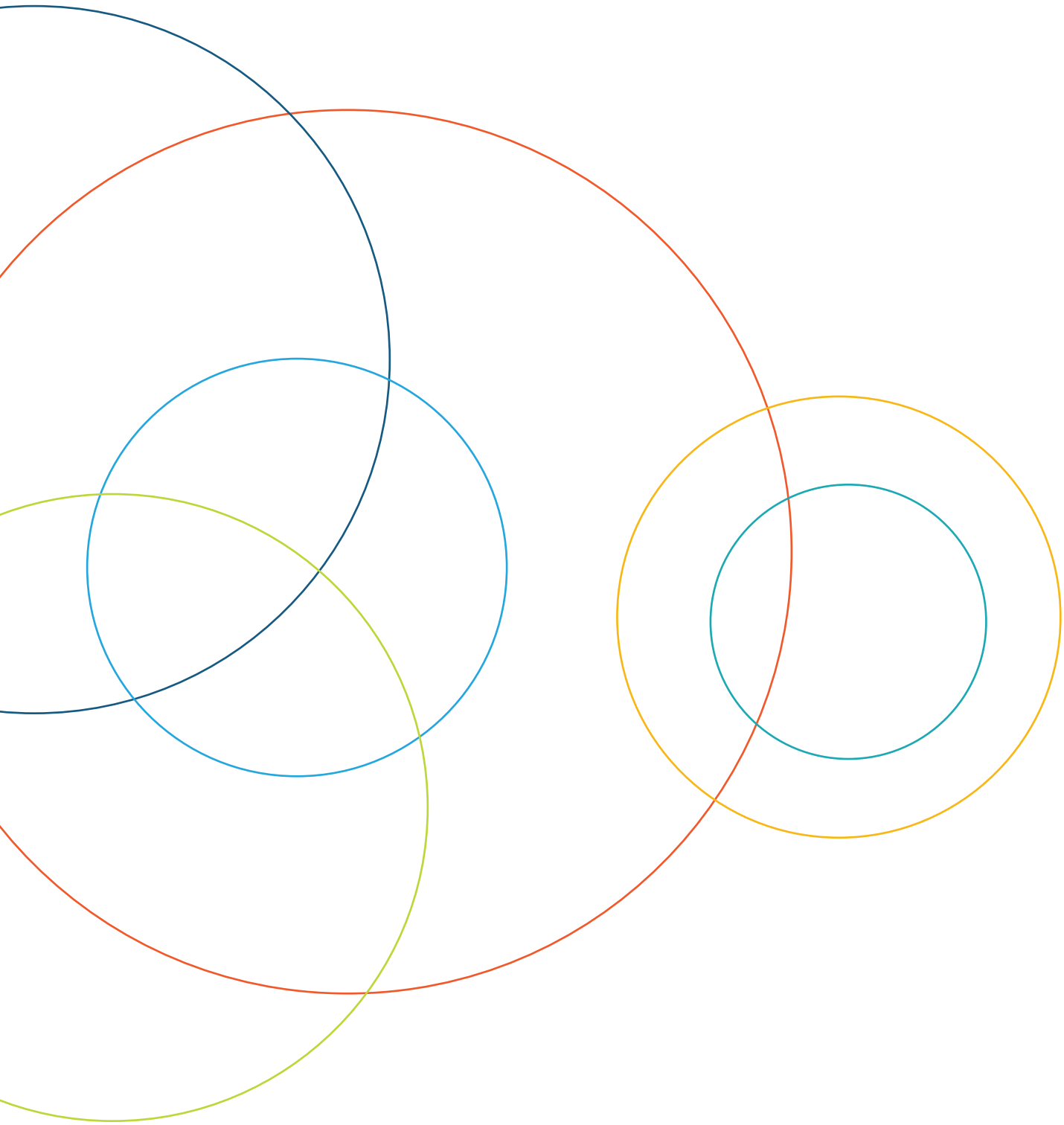

Intersectionality-Based Policy Analysis

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About the Framework

Intersectionality-Based Policy Analysis (IBPA) aims to enhance the decision-making capacity of a wide range of stakeholders, including analysts working in the health and health-related policy sectors, community organizations and researchers. IBPA provides a new and effective method for understanding the varied equity-relevant implications of policy and for promoting equity-based improvements and social justice within an increasingly diverse and complex population base. This Framework was developed and refined through an iterative, participatory process between 2011-2012 (see Hankivsky, Grace, Hunting, & Ferlatte, 2012 for more detail about the Framework's development).

IBPA is intended to improve current tools for evaluating the differential effects of policy on populations and in particular, health impact assessments (HIA), which seek to tackle health inequities when making health and health-related decisions at the level of policy and programming (Hankivsky, Grace, Hunting, & Ferlatte, 2012; Gunther, 2011; Haber, 2010; Signal, Martin, Cram, & Robson, 2008). Specifically, IBPA is founded on what HIAs commonly overlook: reflexivity; relationality; processes shaping power differentiation within and among populations; and accounting for resistance and resilience (see tenets outlined in more detail below in the 'Guiding Principles' of IBPA).

The IBPA Framework presented here has two core components:

- **a set of guiding principles, and**
- **a list of 12 overarching questions to help guide/frame/shape the analysis.**

The IBPA Guiding Principles are intended to ground the 12 key questions, including their supporting sub-questions, in order to ensure that each is asked and answered in a way that is consistent with an intersectionality-informed analysis. Put succinctly, the principles are designed to be used in concert with the questions.

The questions are divided into two categories: *descriptive* and *transformative*. Their combined effect is intended to expand and transform the ways in which policy problems and processes are understood and critically analyzed in order to ensure fine-tuned and equitable policy recommendations and responses.

The first set of *descriptive* questions is intended to generate critical background information about policy problems in their full context, with specific attention to the processes and mechanisms by which policy problems are identified, constructed and addressed. Their purpose is to reveal assumptions that underpin existing government priorities, the populations targeted for policy interventions, and what inequities and privileges are created by current policy responses.

The second set of *transformative* questions is intended to assist with the identification of alternative policy responses and solutions specifically aimed at social and structural change that reduce inequities and promote social justice. The questions in this section prompt users to consider actions that will ensure meaningful uptake of equity-focused policy solutions as well as the measurement of the impacts and outcomes of proposed policy responses.

While the examples in this collection use an IBPA Framework to examine a broad range of health and health-related policies and programs, the Framework can be used across all areas of policy, using a variety of methods. It can be used prospectively or retrospectively to consider questions of equity across all stages of the policy process.

Simplicity and flexibility are key features of the Framework. While some users will ask all 12 questions to help guide their analysis, others may focus on certain questions, tailoring them to specific policy contexts. Some questions may be more or less relevant depending on the policy under examination, its history, and its stage of development and implementation.

It is therefore unnecessary to work through all of the IBPA questions in any single policy analysis exercise. This being said, all users are strongly encouraged to begin by asking the first question to help inform their use of the Framework and position the knowledge, values and experiences they bring to their analysis.

Guiding Principles for IBPA

It is essential that any and all questions of the IBPA Framework are informed by the guiding principles detailed below, which advance the central tenets of intersectionality.

Intersecting Categories

From an intersectionality perspective, human lives cannot be reduced to singular and distinct categories, and policy analysis cannot assume the primary importance of any one social category for understanding people's needs and experiences. Nor does intersectionality promote an additive approach – e.g., examining the collective impact of gender, 'race,' sexuality, age and class – as the sum of their independent effects (e.g., gender+class+race) (Hancock, 2007). Instead, intersectionality conceptualizes social categories as interacting with and co-constituting one another to create unique social locations that vary according to time and place. It is these intersections and their effects that are of concern in an intersectionality analysis (Hankivsky & Cormier, 2009).

Multi-level Analysis

Intersectionality is concerned with understanding the effects between and across various levels in society, including macro (global and national-level institutions and policies), meso or intermediate (provincial and regional-level institutions and policies) and micro levels (community-level, grassroots institutions and policies as well as the individual or 'self'). Attending to this *multi-level* dimension of intersectionality also requires addressing processes of inequity and differentiation across levels of structure, identity and representation (Dhamoon & Hankivisky, 2011; Winker & Degele, 2011). The significance of and relationship between these various levels of structure and social location are not predetermined in an IBPA, but rather reveal themselves through the process of research and discovery.

Power

Attention to power – a central concept in intersectionality – highlights that: i) power operates at discursive and structural levels to exclude particular knowledges and experiences (Foucault, 1977); ii) subject positions and categories (e.g., 'race') are constructed and shaped by processes and systems of power (e.g. racialization and racism); and iii) these processes operate together to shape experiences of privilege and penalty between and among groups (Collins, 2000). It is important to recognize the relational nature of power – i.e., that a person can simultaneously experience both power and oppression in

varying contexts and at varying times (Collins, 1990). These relations of power include experiences of *power over* others, but also that of *power with* others (power that involves people working together as collective actors) (Guinier & Torres, 2003). In recognizing the shifting intersections in which power operates, intersectionality moves beyond what Martinez (1993) terms the "Oppression Olympics," which occur when groups compete for the title of 'most oppressed' in order to gain political support, economic resources, and recognition. Intersectionality thus rejects an additive model of oppression that leaves the systems that create power differentials unchanged (Hancock, 2007). Within an IBPA, the focus is not just on domination or marginalization, but on the intersecting processes by which power and inequity are produced, reproduced and actively resisted (Dhamoon, 2011).

Reflexivity

One way that intersectionality attends to power is through reflexivity. Reflexivity acknowledges the importance of power at the micro level of the self and our relationships with others, as well as at the macro levels of society. Reflexive practice recognizes multiple truths and a diversity of perspectives, while privileging those voices typically excluded from policy 'expert' roles (Bolzan, Heycox, & Hughes, 2001). Practicing reflexivity when conducting an IBPA requires researchers, policy actors and stakeholders to commit to ongoing dialogue and deconstruction of "tacit, personal, professional or organizational knowledges" and their influences on policy (Parken, 2010, p. 85). The transformative potential of reflexivity is found within practices that bring critical self-awareness, role-awareness, interrogation of power and privilege, and the questioning of assumptions and 'truths' in policy processes (Clark, 2012). For example, it is important to utilize reflexive practices that consider individual connections to colonization and facilitate the interrogation of policy and practices in the colonization of Indigenous peoples in Canada (Blackstock, 2005).

Time and Space

Intersectionality emphasizes the importance of time and space in any analysis. Experiences and understandings of time and space are highly dependent upon when and where people live and interact in addition to their epistemological frames, or ways of knowing, and the cultural frames of meaning they use to make sense of the world (Warf, 2008). Importantly, it is within these dimensions of time and space that knowledges are situated, our understandings of the world constructed, and social orders of meaning made (Saraga, 1998). Moreover, privileges and disadvantages, including intersecting identities and the processes that determine their value, change over time and place (Hulko, 2009). Thus, time and space are not static, fixed or objective dimensions and/or processes, but are fluid, changeable and experienced through our interpretations, senses and feelings, which are, in turn, heavily conditioned by our social positioning/location, among other factors (Tuan, 1977).

Diverse Knowledges

Intersectionality is concerned with epistemologies (theories of knowledge) and power, and in particular, with the relationship between power and knowledge production. Including the perspectives and worldviews of people who are typically marginalized or excluded in the production of knowledge can work towards disrupting forces of power that are activated through the production of knowledge (Dhamoon, 2011). For example, the inclusion of colonized peoples' traditional knowledges in the production of knowledge generated by policy analysis can work to shift dominant colonial or racialized discourses in policy and can thus have decolonizing effects (Fredericks, Adams, & Edwards, 2011). Given IBPA's focus on addressing inequities and power, knowledge generated through IBPA can and should include the perspectives and knowledges of peoples who are typically excluded in policy analysis. IBPA expands understandings of what is typically constituted as "evidence" by recognizing a diversity of knowledges, paradigms and theoretical perspectives that can be included in policy analysis, such as knowledge generated from qualitative or quantitative research; empirical or interpretive data; and Indigenous knowledges. Users of the IBPA Framework must consider how power influences the privileging of certain knowledge traditions to the exclusion of others, and reflect on how diverse knowledges are taken up in policy analysis and the implications this uptake has for different groups of people.

Social Justice

Intersectionality places an emphasis on social justice (Grace, 2011). Approaches to social justice differ based in their focus on the redistribution of goods (Rawls, 1971) or on social processes (Young, 1990); however, all approaches share a concern with achieving equity (Sen, 2006). Theories of social justice frequently challenge inequities at their source and require the interrogation of complex social and power relations. For example, according to Potts and Brown (2005) social justice is about: "transforming the way resources and relationships are produced and distributed so that all can live dignified lives in a way that is ecologically sustainable. It is also about creating new ways of thinking and being and not only criticizing the status quo" (p. 284). A social justice approach to health equity has the potential to transform social structures, which is essential in addressing the root causes of inequities (Farmer, 2005).

Equity

Closely tied to the social justice principle of intersectionality, equity is concerned with fairness. As expressed by Braveman and Gruskin (2003), equity in public policy exists when social systems are designed to equalize outcomes between more and less advantaged groups. The term *equity* is not to be confused with *equality*. For example, where *inequality* may refer to any measurable difference in outcomes of interest, *inequities* exist where those differences are unfair or unjust. This principle should be familiar to many policy actors; sex and gender based analysis (SGBA), which asks analysts to consider policy through a gender equity lens, is commonly applied to many areas of Canadian policy (Hankivsky et al., 2012). The IBPA Framework extends this practice by prompting analysts to consider policy issues through an intersectional lens, looking not only at gender equity, but also at the impacts of the intersections of multiple positions of privilege and oppression.

IBPA Questions

Descriptive

1. What knowledge, values and experiences do you bring to this area of policy analysis?

- What is your experience with policy and policy analysis? What type of policy areas have you worked in?
- What are your personal values, experiences, interests, beliefs and political commitments?
- How do these personal experiences relate to social and structural locations and processes (e.g., gender, 'race' and ethnicity, socio-economic status, sexuality, gender expression and age; patriarchy, colonialism, capitalism, racism and heterosexism) in this policy area?

2. What is the policy 'problem' under consideration?

- What assumptions (e.g., beliefs about what causes the problem and which population(s) is/are most affected) underlie this representation of the 'problem'?

3. How have representations of the 'problem' come about?

- What was the process in framing the 'problem' this way?
- Who was involved and why was the 'problem' defined in this way?
- What types of evidence were used?
- How has the framing of the 'problem' changed over time (e.g., historically) or across different places (e.g., geographically)?

4. How are groups differentially affected by this representation of the 'problem'?

- Who is considered the most advantaged and who is the least advantaged within this representation? Why and how?
- How do the current representations shape understandings of different groups of people?
- What differences, variations and similarities are considered to exist between and among relevant groups?

5. What are the current policy responses to the 'problem'?

- Who has responded to the 'problem' and how? For example, how have governments and affected populations and communities responded to the framing of the 'problem'?
- What are the current policy responses trying to achieve?
- Do current policies focus on target groups? If so, are they seen as homogenous or heterogeneous? Are they stigmatized by existing policy responses?
- How do existing policies address, maintain or create inequities between different groups?
- Do existing responses create competition for resources and political attention among differently situated groups?
- What levels or combination of levels of analysis exist (e.g., micro, meso, macro) in relation to the policy 'problem'?

Transformative

6. What inequities actually exist in relation to the problem?

- Which are the important intersecting social locations and systems? For example, how do 'race', ethnicity, class, sexuality and other social locations and systems of inequality (racism, colonialism, classism, heterosexism) interact in relation to this policy problem?
- Where will you look to find necessary information to help you answer this question (e.g., evidence from academic sources, grey literature and policy reports focusing on intersectionality-informed analyses)?
- What potential approaches can be used to promote discussion of the problem across differently affected groups (e.g., Parken's (2010) *Multi-Strand Method,* which lays out a process for understanding intersecting inequities in the evidence gathering phase of policy)?
- What are the knowledge/evidence gaps about this problem across the diversity of the population?

7. Where and how can interventions be made to improve the problem?

- What are the logical entry points? What are the available policy levers (e.g., research/data, political champions/allies, laws/regulations/conventions, resources)?
- What are other examples of successes? How could policy interventions build on these examples?
- Who is part of the proposed intervention? Who is positioned to influence and implement the intervention?
- What role can diverse communities play in these interventions? How will they be meaningfully engaged and supported in providing input?
- At what level or combination of levels (e.g., micro, meso, macro) can interventions be made?

8. What are feasible short, medium and long-term solutions?

- How can solutions be pragmatically positioned and promoted in relation to government policy priorities (e.g., budget allocations, ministerial priorities and departmental plans)?
- How can proposed solutions be synthesized into a clear and persuasive message?

9. How will proposed policy responses reduce inequities?

- How will proposed options address intersectional inequities and promote social justice? How will you ensure that the proposed options do not reinforce existing stereotypes and biases or produce further inequities for some populations?
- How will the solutions interact with other existing policies?
- What might be the challenges and opportunities for proposed policy solutions?

10. How will implementation and uptake be assured?

- Who will be responsible (and who is best positioned) to ensure the implementation of the policy recommendations?
- What time frames and accountability mechanisms are identified for implementation?
- How do the policy solutions encourage solidarity and coalition building across divergent interests and groups?

11. How will you know if inequities have been reduced?

- How will you measure policy implementation and outcomes?
- What intersectional factors will be measured in the evaluation process? How will they be measured?
- How will affected communities be meaningfully engaged in assessing the reduction of inequities?
- What will be the measure of success?

12. How has the process of engaging in an intersectionality-based policy analysis transformed the following:

- Your thinking about relations and structures of power and inequity?
- The ways in which you and others engage in the work of policy development, implementation and evaluation?
- Broader conceptualizations, relations and effects of power asymmetry in the everyday world?

* The IBPA questions have been informed by a diverse range of sources, including Abelson & Giacomini (2003), Bacchi (1999), Hancock (2007), Hankivsky & Cormier (2009), Harris, Harris-Roxas, Harris & Kemp (2007), Parken (2010), Parken & Young (2007), Signal et al. (2008), Urbanek (2009) and Weber & Parra-Medina (2003).

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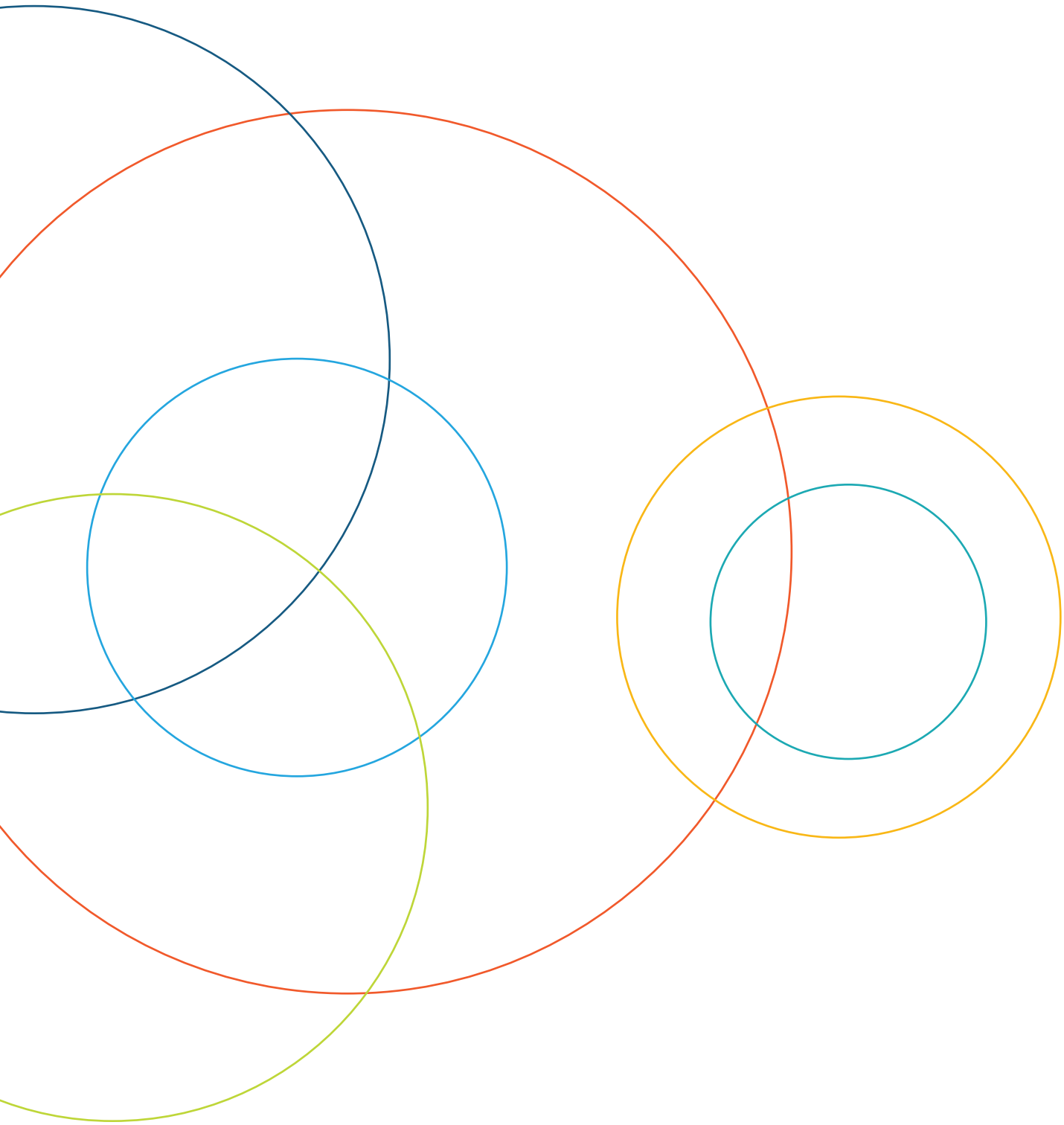

An Intersectional Critical Discourse Analysis of Maternity Care Policy Recommendations in British Columbia

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While maternity care policy tends to treat women as a generic group, in practice, differences among women are reflected in the diversity of their maternity care needs. To ensure equitable access to quality care, maternity care policy needs to attend to these differences. However, despite publicly-funded Medicare, access to high-quality, appropriate care is not equally available to birthing women in British Columbia (BC). The relatively new inclusion of midwifery as a funded option has been a policy success, but has come with its challenges; other related policy areas include the provision of rural maternity health care and the shortage of care providers. This chapter analyzes policy recommendations and resulting documents as they shape approaches to maternity health care delivery in BC, with attention to the implications for health inequities. In particular, I focus on the report, "Supporting Local Collaborative Models for Sustainable Maternity Care in British Columbia," published in 2004 by the Maternity Care Enhancement Project (MCEP), as well as two documents published as a result of this report, "Aboriginal Maternal Health in Canada: A Toolbox" (BC Aboriginal Maternal Health Project [BCAMHP], 2006), and the "Obstetric Guideline 19: Maternity Care Pathway" (BC Perinatal Health Program [BCPHP], 2010a). The "Toolbox" was written to guide research and consultation on Aboriginal maternal health in British Columbia, while the "Pathway" offers guidelines to those providing maternity care. I outline two major critiques of the policy recommendations: first, that human resource shortages are addressed in a manner that reinforces physician privilege while failing to contest gendered and racialized power imbalances within the health care professions; and second, that the approach to difference among maternity care clients does not adequately address differences among women or health inequities. In discussing these shortcomings, I identify how an intersectional approach can refocus policy discussions in a manner that promotes equity. Before turning to this task, however, I want to briefly discuss my methodological approach and provide some background on the context of maternity care in British Columbia.

Methodological Approach

My analysis draws on intersectionality and critical discourse analysis to address health inequities linked to current maternity care policy. As well as having its initial roots in feminist and women's studies responses to racial exclusions and marginalizations, intersectionality has developed from other bodies of social theory, including queer theory, disability theory and postcolonial theory. An intersectional approach posits that the multiplicity of our social locations means that accounts of power must connect multiple social dimensions. Beyond acknowledging complexity, intersectionality examines the processes through which various forms of social marginalization shape each other, and how interventions that take these intersecting marginalizations into account can be generated. While critical approaches to social theory are all informed by an attention to social power and oppression, intersectionality stands out for its explicit inclusion of multiple interwoven dimensions of power and oppression as well as its stance that no oppression can be identified as 'the worst.' It is these insights that I apply to the study of maternity care policy.

In addition to being guided by the principles and questions of an Intersectionality-Based Policy Analysis (IBPA) Framework (*see* Hankivsky et al., 2012), my methods draw on critical discourse analysis (CDA), which is consistent with an IBPA. All policy interventions set out to address a 'problem' that is seen as requiring policy action. Carol Bacchi (2000) describes how a "policy-as-discourse" approach conceptualizes 'the problem' in policy as created through policy, rather than as existing independently of policy. Quoting Ness Goodwin, Bacchi writes: "a policy-as-discourse approach 'frames policy not as a response to existing conditions and problems, but more as a discourse in which both problems and solutions are created'" (p. 48). Bacchi goes on to argue that CDA works to "encourage deeper reflection on the contours of a particular policy discussion, the shape assigned a particular 'problem'" (p. 48). In the IBPA Framework, the 'contours' or 'shape' of a policy problem are discussed in terms of how policy problems are 'defined' or 'framed'. A CDA approach overlaps with intersectionality and the IBPA questions (which were inspired, in part, by Bacchi's reflections elsewhere). Both pay particular attention to the role of power and knowledge (discussed in the IBPA principles) and to issues of representation, such as which evidence is drawn on and how problems are framed. Bacchi has reservations about how a "policy-as-discourse" approach conceptualizes power in relation to various categories of political actors. In particular, by focusing on those who create policy, the "policy-as-discourse" approach can lead to a dichotomy between powerful ideologues and helpless victims, neglecting the fact that "there are real bodies and real people living the effects of discursive conventions, and it is essential to attend to the harms they experience" (Bacchi, p. 55). The IBPA approach is strongly oriented towards these real bodies and people, while at the same time remaining critical of how

realities are shaped by social processes that can lead to harm. As such, an intersectional approach can address the shortcomings identified by Bacchi of reading policy as discourse identified, while still making use of the strengths of critical discourse analysis.

Policy debates are shaped by the framing of social problems, the foregrounding of certain issues (and corresponding lack of attention to others), and by implicit and explicit arguments, as Russell, Greenhalgh, Byrne, and McDonnell (2008) identify. These researchers see rhetoric and argument as essential to policy making, defining policy making as "the formal struggle over ideas and values, played out by the rhetorical use of language and the enactment of social situations" (2008, p. 40). They suggest that "a rhetorical perspective highlights the struggle over ideas, the 'naming and framing' of policy problems, the centrality of audience and the rhetorical use of language in discussion to increase the audience's adherence to particular framings and proposals" (2008, p. 40). Attention to how policy problems are named and framed allows us to interrupt the processes through which values and preferences are constructed as evidence-based. The IBPA Framework encourages those examining policy discussions from an intersectionality perspective to pay attention to the framing of policy problems by asking: *What is the policy 'problem' under consideration? What assumptions (e.g. beliefs about what causes the problem and which population(s) is/are most affected) underlie this representation of the 'problem?'*

With regards to maternity care, an intersectional approach to CDA helps to focus on differences and inequities among women. This approach conceptualizes gender as only one discourse and structure among many through which social relations are organized. It also foregrounds a broad range of overlapping and mutually-constituted factors that, in addition to gender, are important to making sense of and constituting social relations. Attention to multiple analytical dimensions moves beyond identifying how each one separately reflects or constitutes social practice, and towards theorizing how they support or contradict one another in this process. This attention to multiplicity is important to the study of maternity care policy because of gendered and racialized hierarchies and differences among women.

British Columbia's Maternity Care Context and the Role of Intersectional Social Locations

Maternity care in BC is currently shaped by three important and interrelated issues: the relatively new inclusion of midwifery as a publicly funded profession, rural access issues exacerbated by the closure of services, and human resource shortages among maternity care providers and affiliated specialists. Responses by policy makers to these challenges have implications for equitable care provision, and an intersectional attention to issues such as power, social justice and intersecting categories can help inform an equitable approach. The shortage of maternity care providers is a growing problem throughout Canada, as fewer physicians choose to provide this type of care and current providers retire without sufficient new practitioners to replace them (Peterson, Medves, Davies, & Graham, 2007, p. 881). As Peterson and colleagues describe, rural populations are particularly affected by shortages, often having to leave their home communities to birth, while in urban centres, shortages impact women's access to choice of care providers. These factors intersect with human resource shortages, the status of midwifery and the degree of rurality, and vary significantly among the provinces and territories. Regulated midwifery is now the norm in Canada, with PEI and Yukon as exceptions, but provinces such as New Brunswick and Newfoundland have only regulated midwives since 2010.

In BC, in principle, pregnant women have funded access to a range of practitioners, including obstetricians, general practitioners and certified midwives. Since 1998, midwifery has been formally recognized as a profession and is funded through provincial insurance (the Medical Services Plan [MSP]). However, midwives currently provide care for only approximately 5% of births province wide (MCEP, 2004).

Access to a range of provider groups is significant to equitable maternity care because practitioner groups vary in their expertise and philosophies of care. One survey of providers found that "midwives and obstetricians often have significantly divergent views on key issues in maternity care" (Reime et al., 2004, p. 1392). Family physicians occupy a middle ground in comparison to the marked contrast between midwives' and obstetricians' beliefs. Areas of divergence include attitudes towards induction and caesarean section, with midwives relatively wary of interventions that obstetricians generally support. While respondents in this survey differed little by age, the group comprised mostly of midwives was almost all women, the group comprised of mostly family doctors was balanced by sex, and the group of mostly obstetricians were 66% male.[1] The afforemen-

[1] There was some overlap of practitioner type within the groups.

tioned differences in opinion correspond to differences in training, as obstetricians are trained in a medical model, while midwifery training focuses on social as well as medical aspects of care.

In comparing midwifery care with physician care, Diana Parry (2008) suggests that Canadian midwifery values include shared responsibility, the importance of women's role in decision making, and choice of birth location (p. 789-790). Parry contrasts these with the values of the medical model, in which doctors are viewed as experts who determine the course of care, leading to medicalization or the over-use of medical outlooks and interventions (p. 790). Benoit et al. (2005) label midwifery as an "alternative" health service, emphasizing professional rivalry with doctors as a key context surrounding midwifery's regulation in Canada, but also noting that midwifery is continually "redefined in relation to medicine" (p. 13). Of course, the differences between professions are not static. Right now in BC, areas of difference are that midwives can attend home births and see clients more frequently and for longer visits than is typical for physicians. For birthing women, these differences in care can be significant.

Another major policy issue is that rural and small communities are disproportionately affected by lack of access to care that is local, comprehensive and appropriate. The closure of hospitals in small communities and the shortage of physicians and other providers impede access. The lack of local resources acts as a stressor and a disincentive for physicians to work in maternity; many now characterize maternity care as being in crisis, with closures a major factor (Kornelsen & Grzybowski, 2010, p. 34). Some communities have no local care, while others lack meaningful access; women do not have options of care providers or birth location, and have to travel from their home communities for specialist services or to birth if their pregnancy is identified as high risk (Kornelsen & Grzybowski, 2006; Sutherns & Bourgeault, 2008). Additionally, ethnicity and power overlap with these rural concerns: Aboriginal communities, including reserves, are often rural, and smaller communities have less access to health care decision-making bodies (Benoit, Carroll, & Millar, 2002). An intersectional approach is best able to address rurality as a location where issues of power, time/space and equity are implicated.

In addition to the issue of rurality, other intersectional social locations play a role in maternity care needs among BC women. Aboriginal women have poor perinatal outcomes relative to the population at large (Adelson, 2005; Luo et al., 2004). As mentioned above, this intersects with the problem of lack of rural access, since many Aboriginal women live outside of urban centres. However, urban Aboriginal women also experience barriers to care (Benoit et al., 2002). As well, neighbourhood disparities in birth outcomes related to socioeconomic position are evident in Canadian cities (Luo, Wilkins, & Kramer, 2006).

Further, young single women are subject to social stigma, and are susceptible to risk labelling and accompanying surveillance and interventions. Yet, these young mothers may need additional services that are not available universally. Refugee women also often have social and health concerns that can make pregnancy a uniquely vulnerable time (Gagnon et al., 2006). Lack of appropriate care is evident both in the overuse of interventions, such as induction and caesarian section, and in the parallel under-utilization of health services among socially or geographically marginalized groups of women (Benoit et al., 2002).

The Maternity Care Enhancement Project: Policy recommendations

"Supporting Local Collaborative Models for Sustainable Maternity Care in British Columbia" (MCEP, 2004) presents the most recent set of policy recommendations addressing maternity care delivery concerns in the province. The report originated in the perceived need for a business and provision plan that would encourage physicians to participate in maternity care provision.[2] It is an influential document in that it has been the catalyst for: a set of guidelines for maternity care providers; a toolbox for providers working with Aboriginal women; and a passport[3] for women to track their own care during pregnancy.

To briefly summarize, the MCEP report focuses on a lack of sustainability in BC's maternity care provision, identifying several problems in this area. These include a lack of care providers in each category (including nursing, midwifery, and physicians), strained relationships among providers and regionalization (with attendant hospital closures). The report advocates for collaborative care as essential to resolving human resource challenges, and advocates a women-centred philosophy of care. From the issues raised to the solutions suggested, the report reads as practical and current. However, there are substantial shortcomings in the way human resource issues are addressed and in the conceptualization of differences among maternity care recipients. In the discussion of these two problems as they appear in the MCEP recommendations, I also consider information presented in the two resulting documents, a set of *Guidelines* for care providers across the province and a *Toolbox* for those working with Aboriginal women.

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[2] The report's introduction states that it "arose from the 2004 Working Agreement between the British Columbia Medical Association (BCMA) and the Ministry of Health Services (MOHS) calling for the development of a practice and business model to encourage physicians to provide maternity care services" (MCEP, 2004, p. 2).

[3] The *Passport* (BCPHP, 2010b) is for pregnant women to track their care. For the sake of brevity, I have not included it in this discussion.

Problem #1: How human resources are addressed and how intersectionality helps

As the title suggests, "Supporting Local Collaborative Models" contains recommendations that focus on collaboration as a solution to a lack of sustainability in maternity care, which is primarily conceptualized as a human resources challenge.[4] Of the report's seven recommendations, four mention collaborative care. The merits of a collaborative approach, according to this document, are that it develops a common purpose, recognizes complimentary skills and increases women's satisfaction with care. It is also described as cost-effective. However, doctors appear to be the 'winners' among the health care providers considered in the report. Changes to salaries and workload are recommended so as to improve doctors' participation in maternity health care delivery, yet the rate of delivery by midwives is envisioned as remaining largely unaltered. Addressing one group of providers' concerns while neglecting another restricts access to quality care by promoting growth in one provider group while restricting growth in another in a way that does not necessarily coincide with the needs of birthing women. Since choice in provider type and birth location is an important element of quality care, and since midwifery care is so unevenly available outside of urban areas, failing to address midwifery's low numbers is also a failure to address a gap in quality service provision.

The IBPA Framework offers ways to identify and describe this problem. In particular, Descriptive Question 3, *How have representations of the 'problem' come about?,* reveals that the focus on physicians' concerns is rooted in the initial definition of the problem addressed through these recommendations. The report is described as resulting from consultation to address the "sustainability of maternity care services in British Columbia" and emerging from an agreement "between the British Columbia Medical Association (BCMA) and the Ministry of Health Services (MOHS)" (p. 2). The BCMA is a physicians' organization, and this agreement stated that there was a need to develop a "practice and business model" that would encourage the provision of maternity services by physicians. While collaborators from other health disciplines were brought into the project, the original goal of creating a business model for physicians continues to frame 'the problem' in the MCEP report in limiting ways. An IBPA would expand an understanding of the policy problem.

The report's recommendations do not always use the language of a business model, but in many instances, such as the consideration of remuneration discussed below, this framing of the problem is evident. Judy Segal identifies the metaphor "medicine is a

[4] This approach echoes policy recommendations at the federal level: The Multidisciplinary Collaborative Primary Maternity Care Project, which wrapped up in 2006, was an initiative to relieve human resource shortages through multidisciplinary collaboration. Like British Columbia's MCEP report, this initiative also aimed to relieve human resource shortages through multidisciplinary collaboration.

business" as one that limits the contents of health policy debate. She writes, "the fact that the "health care crisis" is most often represented in public discourse as a crisis of money itself forecloses—by its own terms—the very policy debate it promises to engage" (1997, p. 220). Therefore, she argues, "in spite of the apparent fit of the metaphor, the goals of business are at odds with the goals of health care" (p. 226). Clients should be the prime beneficiaries of health services, whereas owners should be the prime beneficiaries of businesses (Segal, 1997). The business model framework of the MCEP shifts attention away from the needs of pregnant women and towards the working conditions of care providers, particularly physicians. Since a business model is oriented towards costs, it is easy within this framework to neglect consideration of potentially costly areas of care, such as care in remote areas.

Throughout the recommendations, collaboration is envisioned in such a way that doctors benefit to the detriment of other groups. This becomes clear when considering IBPA Descriptive Question 4, *How are groups differentially affected by this representation of the 'problem'?* and the sub-questions, *Who is considered the most advantaged and who is the least advantaged within this representation? Why and how?*. The report suggests that "funding systems are perhaps the biggest barriers to shared care models" (p. 33); the solution offered to this barrier is to increase physicians' remuneration. There is a long (five-page) section dedicated to improving financial incentives for physicians. In comparison, there are only three short paragraphs on "valuing midwives" and two that concern nurses. In contrast to the proactive consideration of doctors' remuneration, the section on midwives identifies problems with the expansion of provision of midwifery care, discussed below, but makes no recommendation for change. The only reference to midwives' remuneration identifies their current pay as part of the problem: "midwives are paid on a case basis rather than fee for service and are paid at a higher rate per birth compared to physicians, which has led to a degree of interdisciplinary tension between the providers" (p. 83). This is used to bolster the argument that revising physicians' pay for maternity services is a way of addressing "sustainability" in maternity care. To answer the IBPA questions stated above, it is clear that as well as maternity care clients, care providers are affected by this representation of the problem, and physicians are the group whose advantage is being advocated for. Taking a proactive approach to physician participation while neglecting to address factors that could increase the numbers of midwives both reinforces a gendered hierarchy in which physicians are professionally dominant, and ignores women who would prefer midwifery care but cannot access it due to midwives' low numbers and urban concentration. We can also reflect on how these recommendations address physician concerns over those of midwives or maternity care clients by turning to IBPA Descriptive Question 5 sub-question: *Do existing re-*

sponses create competition for resources and political attention among differently situated groups? The answer is evidently that tensions will increase.

In addition to remuneration, a second focus of the short section "Valuing Midwives" is the scope of practice, which is identified as a barrier to midwives' collaboration with physicians. Midwives' "scope of practice":

> does not include vacuum delivery, surgical assistance in the case of a cesarean section, the induction of labour or other services that a family physician practicing obstetrics is able to provide. This division of practice areas serves to undermine the ability of midwives and family physicians to work together in a collaborative manner. (p. 83)

The value placed on overlapping scope of practice counters the goal of recognizing the contributions of each group of care providers. For many women seeking midwifery care, midwifery's focus on non-surgical delivery is an important element of their care. Yet in concert with the report's perspective, in 2009 the scope of midwifery was in fact expanded to include the initiation of labour induction and assisting physicians with C-sections (Ministry of Health Services, 2009). The MCEP report states that "unless the current barriers to practising maternity care in an equitable manner among these two providers are dismantled, the goal of a sustainable maternity care system may be unattainable" (p. 43). While this argument appeals to the principle of equity, the redress suggested here would increase physicians' pay while expanding the scope of practice for midwives to mimic doctors' which has to an extent occurred. An IBPA of equity would attend to existing hierarchies of power. The recommendations diminish the unique contribution of the midwifery profession to maternity care, thereby reducing access to appropriate care for those women who prefer the non-interventionist approach that has characterized midwifery in the province.

Identifying midwives' scope of practice and rate of pay as factors working against collaboration seemingly blames midwives for any lingering lack of collegiality between the groups. The report acknowledges that:

> while relationships are now more positive at an inter-professional level, there is still evidence of strain. Barriers exist among professionals with different educational backgrounds and maternity care is still practised in a somewhat hierarchical system. Physicians historically maintain the most power and status and have generally not welcomed new practitioners to the system. (p. 27)

However, in the section addressing "Resource Allocation to Support Collaborative Care," the recommendations highlight doctors' perceptions of pay inequality and lack of overlapping scope of practice with midwives, rather than other inequalities. This reinforces existing power roles and diminishes the status of midwifery, a female-dominated profession in BC Referring to the IBPA Transformative Question 6, *What inequities actually exist in relation to the 'problem'?*, draws attention to issues of professional dominance and power as they shape maternity care policy debates.

The focus on remuneration is unsurprising given that one purpose of this set of recommendations is, at least initially, to create a more lucrative business model for physicians. As we have seen, the framing of the problem leads to this focus. Limited family doctor participation in maternity care is a real problem in BC, and increased income incentives is one means of encouraging participation. But, as Ingram and Schneider (2006) write, "policies are revealed through texts, practices, symbols and discourses that define and deliver values including goods and services as well as regulation, income, status and other positively or negatively valued attributes" (p. 2). If income reveals policy, it is possible that part of the physicians' apparent grievance over pay, contextualized as it is in this report in comparison to midwives' remuneration, relates to fears that the relatively new professionalization of midwives is a threat to physicians' professional dominance. An IBPA perspective, which would examine power issues before framing a policy problem, would likely interrupt the very way the problem of sustainable care delivery has been framed. Benoit et al. (2005) argue that "while the boundaries between midwives and physicians are being successfully challenged and renegotiated, the latter still wield enormous power over the direction that the country's maternity system will take" (p. 733).

Such a "territorial" concern could explain why the current limited role of midwifery (about 5% of births province wide) is projected to stay relatively constant, rather than being treated as a limitation to be addressed through policy intervention. The latter understanding could only be achieved if the framing of the policy problem were broadened; asking the IBPA Descriptive Question 1 *What knowledge, values, and experiences do you bring to this area of policy analysis?* and the follow-up, *How do these personal experiences relate to societal/structural locations and processes (e.g., gender, 'race' and ethnicity, socioeconomic status, sexuality and age, patriarchy, colonialism, capitalism, racism and heterosexism) in this policy area?* would assist in this broadening. The territorial element of physician dominance has been identified by Peterson et al. (2007), who describe a Canadian "maternity care culture characterized by interdisciplinary rivalry based on turf protection" (p. 883). The MCEP report notes that midwives are valuable in providing care, yet states that "their ability to play an even larger role in supporting the

sustainability of the maternity care system is currently limited" (p. 44), due to barriers such as limits to the number of training spaces available and the number of births each midwife can attend annually. Given that the problem addressed through these recommendations is a lack of sustainability due to human resource shortages, it is problematic that increasing the capacity of midwifery is not part of the recommendations, especially as family doctors' participation is also needed in other aspects of health provision. Since the number of current and graduating midwives in BC is a limitation to the number of pregnancies cared for through midwifery, relevant interventions might include enabling a larger number of students to graduate by expanding or duplicating the University of British Columbia's midwifery program, or improving the Prior Learning Assessment (PLA) through which foreign-trained midwives could practice. In its policy brief on "Solving the Maternity Care Crisis: Making Way for Midwifery's Contribution" (Kornelsen, 2003), the British Columbia Centre of Excellence for Women's Health also recommends a focus on education and PLA as a way forward for maternity care in the province. A lack of policy interest in PLA limits the participation of immigrant women in midwifery, thereby limiting racial, cultural and linguistic diversity among care providers. In turn, this limits the availability of care in the first language of birthing women from various immigrant communities and the opportunity for women to receive care from providers of their shared ethnicity where this is preferred.

The practice of addressing shortages by increasing the scope of practice of health providers in less powerful professions is addressed by Bourgeault and Mulvale (2006). They note that there is an increased interest in collaborative, interdisciplinary care as a response to "real, perceived or projected shortages of physician human resources and in turn access to health care services" (p. 481). Creating more flexible care provision by breaking down barriers between provider types, including by having overlapping scopes of practice, is one means of addressing this problem (Bourgeault & Mulvale, 2006). While this often means nurses expanding their scope of practice to include work previously performed by physicians, it seldom expands physicians' scope to include work previously performed by nurses. This trend is also evident when the narrow scope of midwifery practice is identified as a barrier to collaborative practice, as it is in these recommendations. Elsewhere, these authors have identified midwives as a relatively successful example of a woman-centric field advocating for income equity (Bourgeault & Mulvale, 2006); this is a reminder that power dynamics operate to shape salary policies.

In considering the IBPA Descriptive Question 3, *How have representations of the 'problem' come about?,* an assumption that human resource issues can be addressed without challenging gendered and racialized hierarchies within the medical professions becomes evident. While the provision of health care is often seen as neutral, in fact it is deeply

gendered and racialized. Its gendered nature is evident in the debates over work duties and salaries, and as intersectionality informs us, gender is not a stand-alone discourse and structure. Gender and racialization processes intersect in the lack of attention to potential policy options of expanding midwifery education programs and the Prior Learning Assessment program. Ignoring these policy options limits the expansion of midwifery and limits racial, linguistic and cultural diversity among midwives. This limitation speaks to the power differential between immigrant midwives, practicing midwives and doctors, who are the top of the hieracrchy (as the report itself states). Thus, the report recommendations fail to disrupt power to the detriment of sustainable maternity care One purpose of the IBPA is to attend to power. This analysis would allow us to see the power at play behind this government report.

Problem #2: How differences among women are conceptualized in maternity care and why intersectionality helps

The second overarching critique of the recommendations in the MCEP report focuses on how patient perspectives and needs are addressed, and how differences among patient groups are conceptualized. In particular, I examine a poorly defined 'women-centred' approach to care, the shortcomings of a 'diversity-sensitive' approach that ignores inequities, and a tendency to individualize social concerns through the creation of risk groups. This critique is guided by considering the IBPA Descriptive Question 4 in relation to the current maternity policy context: *How are groups differentially affected by this representation of the 'problem'?*

While women-centred maternity care can be variously defined, it does not adequately attend to the differences among women. Horiuchi, Kataoka, Eto, Oguro and Mori (2006) found that four attributes define women-centred care: respect, safety, holism and partnership. Other definitions foreground continuity of care, shared decision-making and choice regarding the type of provision and location of birth (Stevens & McCourt, 2001). A women-centred approach is associated with a midwifery philosophy of care more than with that of other health professions (Spoel & James, 2006), a point that is not acknowledged in the report.[5] While a women-centred approach is preferable to a paternalistic or neutral approach, it can tend to universalize the category 'women' or values such as respect and safety, neglecting the differences among women that may be shaped by religion, culture, geographic location (e.g., rural-urban) and sexuality. This is evident when considering a sub-question of the IBPA Descriptive Question 4, *What differences, variations and similarities are considered to exist between and among relevant groups?*

[5] By identifying itself as taking a "first-step" down the path to women-centred care, the MCEP refers to women-centred care as a new development, rather than something that is being expanded from midwifery traditions. This is another instance where the report contradicts its own advice that collaboration includes recognizing the contributions of each professional group.

The Maternity Care Enhancement Project (MCEP) report defines a women-centred approach as one in which "the mother and her baby are placed at the centre of care and services are planned and provided to meet their needs. This approach means that maternity care service requirements must drive the workforce requirements" (p. 24). It also defines women-centred care as viewing birth as a normal event in the majority of cases. However, the report's definition of women-centred care does not take into account differences among women or address health inequities, and therefore does not elaborate on recommendations related to health inequities or the range of maternity care needs among diverse groups of women in British Columbia. As such, it acknowledges 'women' as a group affected by maternity policy, but does not address intersectional subject positions or the relationship between individual and institutional factors. A women-centred approach is valuable in identifying that women should have a degree of choice, autonomy and control regarding their care and birthing practices. However, such an approach cannot address how choice and autonomy are constrained by systems of privilege and oppression, in contrast with the intersectional approach, which emphasizes differences within groups and power relations.

The guiding principles advocated by the report address such concerns as equity, choice and empowerment, yet they do not live up to the exhortation mentioned above that "maternity care service requirements must drive the workforce requirements" (p. i). The principle regarding choice of location and method states, "Give women the right to choose how and where they give birth, depending on available human and financial resources" (p. 25). The caveat about the availability of human and financial resources contradicts the first guiding principle of the report, which provides for equity of access. It also limits choice. Women who live in communities where midwifery care is unavailable (most rural areas and many smaller towns) are unlikely to be supported in the choice to birth at home. Women who live in smaller and/or rural communities where obstetricians and other staff are less available than in major centres are also unlikely to be supported in a decision to have an unindicated non medically-indicated caesarean. In contrast, a range of care professionals are more readily available in urban centres, but access can depend on language, immigration status and other factors. Hence, in both smaller and larger communities, intersections of difference are relevant to the experiences of women and access to maternity care.

The report identifies equitable care as "diversity-sensitive," a term that obfuscates where inequities currently lie. "Diversity-sensitivity" is similar to "cultural sensitivity," an approach to health care that Annette Browne and Colleen Varcoe criticize for its reliance on a static and apolitical notion of culture and its conflation of culture with race and ethnicity, a critique that has been made by intersectionality scholars. These practices are

'othering' and contribute to a process of racialization (Browne & Varcoe, 2006). As such, Browne and Varcoe (2006) contend, cultural sensitivity promotes a liberal discourse of tolerance. In order to be equity-oriented, rather than "diversity-sensitivity" what is required is an overall shift in perspective towards the needs of maternity care recipients and genuine attention to differences that challenge, rather than reproduce, prejudices and stereotypes. This might include examining the dearth of midwifery care outside of urban centres or the lack of any local care in many small communities; this requires a shift in focus away from diversity to resources and power as they organize and shape intersectional social locations. By facilitating a shift in focus to power, an intersectional approach improves on both women-centred and diversity-sensitive approaches.

Within the report and guidelines, while it is noted that health problems in pregnancy are related to addiction, experience of intimate partner violence, youth and poverty, these different factors are mostly presented as if affected women are part of a cohesive group. At the same time, the concerns of these women are also individualized as 'lifestyle' issues. This process of creating risk groups or individualizing social problems is relevant to another sub-question of IBPA Descriptive Question 4, *How do the current representations shape understandings of different groups of people?* Despite the good intentions of including guidelines related to various social factors, the potential benefit of these recommendations to groups experiencing health inequities is diminished by this tendency towards creating risk groups and individualizing health concerns whose dimensions are largely social. IBPA would instead attend to the patterns and differences among affected women by locating them in contexts of power, and this focus on differentials would travel throughout the policy process on maternity care.

The brief discussion in the report of different factors, like age, ethnicity, poverty, violence and addiction takes place under the heading "Escalating Provider Workload Trends." Raising these factors within a discussion on workload orients the "problem" of social difference to a health provision perspective, instead of towards the perspectives and needs of birthing women experiencing these social locations or oppressions. An intersectional approach infused with CDA would require attention to how power operates in relation to the problems of poverty, drug use and violence experienced by differently positioned women; instead, the orientation is towards how the presence of such problems is difficult for care providers to manage. This perspective is evidenced in the statement, "providers are also faced with trying to care for women with lives characterized by poverty, hunger, unstable living conditions, histories of violence and substance misuse" (p. 18). Unfortunately, this is one of the few places any of these concerns are even mentioned in the recommendations. And this mention places them together in a problematic fashion, since, it is important to note, these factors do not always, or generally, overlap. Group-

ing them may give policy makers or care providers the wrong impression that drug use or violence are inherently linked to individuals with low-income, leading to stigma for women in some social groups and lack of intervention for others. For example, if providers are encouraged to associate poverty with violence, this may mean additional scrutiny for women perceived to be poor, while signs of violence might be overlooked in patients perceived to be middle-class or wealthy. An IBPA would allow these various issues to become evident in the policy process through multi-level analysis, which "requires addressing processes of inequity and differentiation across levels of structure, identity and representation" (Hankivsky et al., 2012, p. 35)."Intersectionality-Based Policy Analysis," this collection).

These shortcomings in the approach to social difference and stigmatized aspects of health, such as violence and addiction, are also evident in the "BCPHP Obstetric Guideline 19 Maternity Care Pathway" (BCPHPa, 2010). This *Guideline* was created as a pathway for doctors to follow in providing care and identifies various concerns that might arise at each stage of pregnancy. One concern with how the *Guideline* conceptualizes difference among women is its treatment of 'vulnerability' and the creation of individualizing and normalizing discourses. For example, under the heading "Women with the following conditions in the current pregnancy may require additional care or services or referral to a specialist," there is one bullet point for "Women who are particularly vulnerable (such as adolescents, women living in poverty or women with language barriers) who lack social support" (p. 4). In contrast to this large grouping of disparate "vulnerabilities" as one bullet point, biomedical factors are each listed as separate bullet points under the same overall heading about additional care. This grouping of 'vulnerable women' is problematic as it belies the complexity of each concern mentioned, creating a group among women whose experiences and concerns are likely to be quite different. Rather than creating such a group, an attention to IBPA Transformative Question 6, *What inequities actually exist in relation to the problem?* for example, might be useful in identifying interventions that would address existing gaps in care. Further, this part of the document does not in fact provide doctors with a path to follow. The section has a separate bullet point for intimate partner violence (IPV); however, the only other place IPV is discussed is under "lifestyle advice". Substance use is also categorized as lifestyle, as though it were an issue of consumer choice rather than a health issue. This approach does not address the concern raised in the MCEP report over the challenges providers have in working with women with "lives characterized by poverty, hunger, unstable living conditions, histories of violence and substance misuse" (p. 12). Instead, it extends the stigmatizing sense that some people's lives are just out of control. An intersectional perspective would see a concern such as poverty, for example, not as an individual characteristic, but as a situation shaped by social and political forces.

I interpret the approach to grouping divergent issues and social locations as an example of risk labelling, a practice of normalization, as described by Deborah Lupton (1999): "Risk is a pivotal discourse in strategies of normalization, used to gloss the potential for deviations from the norm. To be designated "at high risk" compared with others is to be singled out as requiring expert advice, surveillance and self-regulation" (p. 61). Categorizing women facing violence as needing "lifestyle advice" implies that with some words of encouragement women will be able to stop experiencing violence and, in doing so, normalize their health status. Labelling a health concern as lifestyle is an individualizing practice: it locates the concern within individual women's behaviours and experiences. However, as Olena Hankivsky (2007) writes, "Numerous factors may not be modifiable by the individual but instead require attention to the breadth of socioeconomic factors that affect women's health" (p. 73). The focus on interventions at the individual level is misplaced: many factors shaping negative outcomes are social, economic and political in nature. Intersectional approaches challenge normalization practices by resisting the notion that there is an archetypal average consumer of health, and instead acknowledging that attention to difference should shape health care delivery. This is evidenced in the IBPA principles on intersecting categories, diverse knowledges and time and space.

Finally, I turn to the document "Aboriginal Maternal Health: A Toolbox" (BCAMHP, 2006), which is exceptional in this group of documents for its nuanced approach to social factors as they shape health. The *Toolbox* outlines health disparities, situates them in the context of colonialism and identifies the potential for statistics on poor health to feed into derogatory stereotypes of Aboriginal people. As such, it appears to take a social determinants of health approach, identifying Aboriginal status and colonialism as factors shaping health. In acknowledging the significant role of social forces in contributing to health status, a social determinants approach makes an important contribution, yet social determinants approaches, unlike intersectionality-based analysis, often focus on single dimensions of the social. The *Toolbox* unpacks some challenges that were grouped together in the *Report* and *Guidelines*, including substance abuse and teenage mothers. In the case of teenage mothers, the *Toolbox* acknowledges that there is both risk and potential within this demographic, stating that with support, "teenage mothers can raise happy, healthy children and graduate from school, attend college, and have successful careers" (p. 9). The *Toolbox* outlines unequal access to services using particular examples, including lack of local care and the need for community support for low-risk pregnancies. This is preferable to the MCEP report's guiding principles, which employ the rhetoric of diversity but do not include examples of inequity. The *Toolbox* also focuses on the importance of quality care and the harmful impacts of poor care, quoting women speaking about their own experience. For example, while positive birth experiences are associated with improved health and social connections, lasting impacts of negative

experiences range from shame to Post-Traumatic Stress Disorder. This shift in focus from providers' perspectives to those of birthing women makes a compelling case for the importance of quality care.

The *Toolbox* also has elements of an intersectional approach. It addresses Aboriginal women's shared experiences not as originating from their Aboriginal status or their sex per se, but as shaped by histories of colonialism, rural or urban contexts, health services and public rhetoric about Aboriginal people and health. Unfortunately, the *Toolbox* has limited reach, as it is directed only to providers who have a focus on Aboriginal women's health. As Lori Wilkinson (2003) identifies:

> Programs that are designed to address problems faced by women, Aboriginal persons, and persons with disabilities cannot adequately account for more than one identity marker at a time. As a result, programs designed to alleviate poverty among women may not work as well for Aboriginal women given the fact that the intersection of Aboriginal status is not built into these programs. (p. 30)

And while it is of particular importance that care provision for Aboriginal communities be improved and culturally safe, the issues identified in the "Toolbox" are not unique to Aboriginal women. Many of the topics considered here, such as the impact of poverty and the types of support relevant to teen mothers, are also relevant to various groups. As Wilkinson argues, building intersectionality into interventions is a way to ensure that they address a more diverse group, as an IBPA approach guides policy makers to do. Therefore, from an IBPA perspective, the insights in the *Toolbox* could have been expanded to speak to these shared concerns among women besides Aboriginal women.

Conclusion

Maternity care in BC is deemed to be in crisis, as many communities struggle without local care and many women lack choice in how care is provided. In addressing these policy challenges, the particular contexts of various professionals offering maternity care services, rurality and regionalization, and shortages of providers need to be considered. Policy and services in this area also need to meet women's diverse needs; this requires an attention to the way systems of domination, such as patriarchy, colonialism, heteronormativity and class privilege, shape access to care. While a women-centred approach is valuable in identifying that women should have a degree of choice, autonomy and control regarding their care and birthing practices, such an approach cannot address how choice and autonomy are curtailed by the interlocking systems of privilege and oppression. Reviewing policy using our IBPA Framework, with its ability to better address issues of power and inequity, would benefit maternity care policy and delivery in BC At the level of frameworks for care providers, those working with the broader population would benefit from non-stigmatizing information about issues, including, for example, lack of local care, teen pregnancy and addiction. At the policy recommendation stage, we would also be prudent to move away from stigmatized understandings of 'groups requiring additional care' or vulnerable women, by starting from an understanding that there is no one norm for the care women may require in pregnancy. The principles and questions of our IBPA Framework provide mechanisms for policy actors to resist normalization, to link individual-level factors to institutional systems that shape them, to consider power relationships and to promote the development of more equitable policy. These critical tools are essential to building more equitable maternity health care policy.

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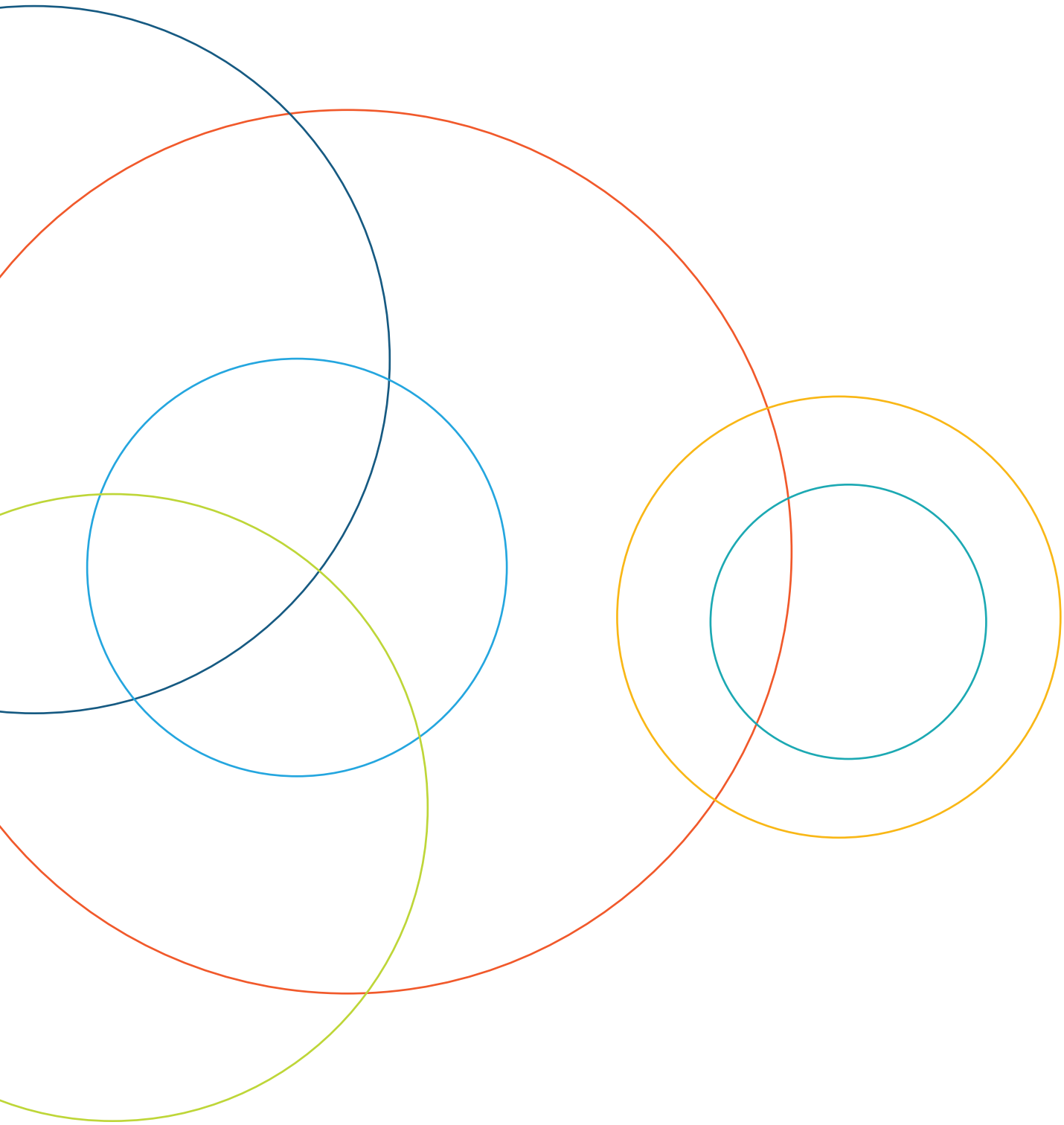

Intersectionality and the 'Place' of Palliative Care Policy in British Columbia, Canada

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At some time, in some way, we must all face the end of life. Many of us share the common desire that when death comes to us or a loved one, it will be peaceful and dignified and that we will be surrounded by those we love, feeling safe, comfortable and cared for. The ultimate goal of palliative care is to support and care for the most vulnerable in society: the dying and their family members. *Who* will be providing this care, however, is largely shaped by embedded socially- and politically-defined sets of expectations and practices regarding rights and responsibilities (Dyck, 2005; Milligan & Power, 2010). Within Canadian policy, concerns have increasingly emerged due to Canada's rapidly aging demographic and the inevitable expanding need for palliative care in the coming years. What continues to go unseen, however, is that those who require palliative care are not simply an homogenous group of 'aged' Canadians, but a diverse group who are complexly situated within a web of intersecting social, economic, cultural, political, historical, geographic and physical contexts that will dramatically shape their palliative care needs, the types of services and supports required, and ultimately their access to these supports and services.

The implicit goal of Canadian health care policy is to enable universal access for all through publicly insured and extended services, yet there exist great disparities in service access and provision (Romanow, 2002). Not only does place of residence determine levels of access to services due to underlying geographic, economic, demographic and cultural realities of particular regions (Milligan & Power, 2010; Robinson et al., 2009; Romanow 2002), but access is also highly dependent upon one's intersecting lived context and positions of privilege and disadvantage within the social hierarchy of power. Such positionality can shape one's opportunities, choices, beliefs, decisions and access to care and support services. Thus, policies that do not consider such lived realties, particularly *who* needs *what kinds of* supports, will only result in reinforcing existing inequities in access to care. Given the complexity of lived experience and how embedded issues of

power influence access, intersectional theory and the concept of 'place' have much to offer when examining policies that define and determine health and social care services. However, little research has applied intersectionality and the concept of place to palliative care policy research, or health and social care policy research more generally.

This chapter uses an intersectional lens and the concept of place as analytic frameworks to explore palliative care policy in British Columbia (BC), Canada, through reporting on the findings of key informant interviews conducted with palliative care providers and administrators in the province. Importantly, I did not set out with place as the pre-determined category of analysis for the interview data, but found that it continually emerged as a primary theme when exploring palliative care policy through an intersectional lens. The purpose of this study is to shed light on BC's current palliative care policy landscape while uncovering inequities in access to services and supports for those needing such care services. My relationship to this study lies in my academic background, which is in human/health geography and is informed by theories of feminism, political economy and social constructivism. Indeed, as feminists have long noted, private and public spaces are inherently interlinked and deeply political. As well, I see significant value in applied approaches to research. My interest in palliative care stems not only from personal experience, but from a desire to shed light on the often overlooked, yet invaluable work of both informal/family and formal palliative care providers in Canada. I begin this chapter by introducing the concept of place and how it relates to intersectionality. I then provide a descriptive overview of palliative care policy in BC, followed by a discussion of how I grounded my research and then present the findings from the key informant interviews. Overall, I seek to show the relevance of intersectionality and place to the study of palliative care policy in BC.

Intersectionality and 'Place'

The complex notion of place has garnered much attention from geographers since those inspired by the cultural turn in the discipline cast their gaze upon the concept during the 1990's. Today, place is commonly described as "a bounded entity, containing a unique assemblage of characteristics and within which, people forge profound attachments and identities" (Bondi & Davidson, 2005, p. 16). This description signifies that place is doubly constructed: built physically, but socially interpreted, narrated, perceived, felt, understood and imagined (Easthope, 2004). Thus, places are not simply physical constructs, but are infused with social dimensions. Building upon this definition, place, in the physical sense, can also be understood as a material artifact, a literal location or a setting for social relations, while the social dimensions of place include the meanings people attribute to places, the ways they engage in place-making activities or place-specific be-

haviours, how they understand their place in the social hierarchies, how they develop a sense of place, and how they create emotional attachments to places (Castleden, Crooks, Schuurman, & Hanlon, 2010). Although places hold significant meanings for people, a person's history and experiences will influence her/his perceptions and experience of places, while at the same time, places will affect that same person's opportunities and activities (Easthope, 2004). Therefore, places are complexly linked together in unequal ways through social relations of power (Easthope, 2004).

With this understanding of place, it becomes apparent how the concept could easily lend itself to intersectional research, particularly that which focuses on health and social care delivery; however, this link has received little attention from researchers. Intersectional scholars have long recognized the significance of 'geography' or 'place' in their research, yet the understanding and application of these dimensions tend to be relatively singular, usually denoting a 'physical' geographic location, while overlooking the infused social dimensions and relations of power embedded in these places. While feminist and critical geographers have often looked at particular socio-spatial interconnections (e.g., see Dolan & Thien, 2008; Kobayashi, 1994; Pratt 1998), the wider theoretical paradigm of intersectionality has not been widely adopted (Valentine, 2007).

For geographers, understanding place through an intersectional lens can enhance the sophistication of the concept by raising questions about how geographers situate themselves in their research and develop, categorize and understand relationships between various types of places. Intersectionality also enhances the complexity surrounding the extent to which identities are understood, made, unmade and simultaneously experienced in particular places. As well, a more sophisticated application of the concept of place to intersectional research may enhance intersectionality's appreciation of the social constructions and meanings of place and its role in shaping the processes of oppression and subject formation, while also showing how oppression and subject formation in turn shapes places. Furthermore, as places are infused with social constructions of meaning and power, they are also characterized and situated within a complex web of intersecting categories of difference (e.g., cultural, economic, historical, and political, among others) and are shaped by various intersecting macro-micro processes, which ultimately will shape social experiences and contexts for social interactions.

In this chapter, the intersectional approach I use is grounded in lived experiences, while providing a theoretical foundation for the pursuit of social justice (Hankivsky & Cormier, 2009). My study aims to "consider simultaneous interactions between different aspects of social identity as well as the impact of systems and processes of oppression and domination" (Hankivsky & Cormier, 2009, p. 3). In the following section, I provide

a contextual backdrop by explicitly addressing four Descriptive Questions drawn from the Intersectionality-Based Policy Analyis (IBPA) Framework (*see* Hankivsky et al., 2012): 1) *What is the policy 'problem',* or how has the need for palliative care been represented in BC policy?; 2) *How has this representation of the 'problem' come about?;* 3) *How are groups differentially affected by this representation of the 'problem'?;* and 4) *What are the current policy responses?* I have chosen to address these four questions as they provide an excellent starting point from which to explore palliative care policy in BC, to unpack underlying assumptions regarding who is experiencing death and dying, and to uncover existing beliefs surrounding their palliative care needs. I have chosen another IBPA question to direct the actual analysis of this study. This question was selected to assist in uncovering the real diversity that exists among families who require palliative care services and any unjust issues that may be overlooked in BC palliative care policy. This Transformative Question is: *What inequities actually exist in relation to the problem?* In order to answer this question, I have sought the valuable perspectives of those who are actively delivering palliative care support and services on the front lines in BC In my conclusion, I address one final IBPA Transformative Question, which asks: *Where and how can interventions be made to improve the problem* of achieving equitable access to meaningful palliative care services and supports for all British Columbians?

BC's Palliative Care Landscape

When using an intersectional framework, it is important to simultaneously consider the multiple levels of systems and structures related to a particular 'problem.' At an international level, among 'developed' nations, neoliberal policies and resulting health care reforms have recently shifted the responsibility of care from the state to the voluntary and informal sector (e.g., voluntary organizations, family caregivers) (Chouinard & Crooks, 2008; Skinner & Rosenberg, 2005). This shift has had a profound influence on *where* such care now takes place. Specifically, the *place* where care occurs has been increasingly deinstitutionalized, moved out of formal institutions (e.g., hospitals) and into the community, especially the home (Burge, Lawson, & Johnston, 2003; Lilly, Laporte, & Coyte, 2007; Milligan & Conradson, 2006; Skinner & Rosenberg, 2005).

These reforms and policies directed at shifting care into the home and thus into the domain of private citizens, are based on a conventional division of labour that underpins policy and informal social expectations of who will bear the primary burden of care work (Dyck, 2005; Milligan & Conradson, 2006; Stajduhar & Davies, 2005). Providing care in the home means that those who formally and informally work within the home, largely women (who are often unpaid), are filling the gaps in labour and services that have been left by such neoliberal policy shifts (Armstrong, Armstrong, & Scott-Dixon, 2008; Dyck,

2005; Williams, 2002). But more complexly, the responsibility to provide this care is falling heavily upon the shoulders of untrained and unpaid informal caregivers (commonly referred to as 'family caregivers') who are not only primarily women, but complex beings who simultaneously inhabit other distinct socioeconomic, cultural, political and historical locations (Bondi, 2008; Dolan & Thien, 2008).

Within Canada, family caregivers and the care they provide have become the backbone of the health and long-term care systems (Canadian Caregiver Coalition, 2009; Friends of Women & Children in BC [FWCBC], 2003; Stajduhar et al., 2011). Various estimates indicate that 75% to 90% of all home care is now provided by family members, who save the formal health care system an estimated $6 billion a year in human resources costs and contribute up to $26 billion of unpaid care work (Hollander, Liu, & Chappel, 2009). In palliative care, it has been estimated that family caregivers contribute $6000 worth of unpaid hours in the last four weeks of life alone (Hollander et al., 2009). In this paper, I use the commonly referred-to definition of palliative care developed by the World Health Organization (WHO, 2011), which describes this care as:

> an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (para. 1)

Within Canada, palliative care is offered across a range of sites, including nursing homes, acute care hospitals, respite facilities and hospices, and by a variety of providers, who can include family doctors, nurses, specialists, community volunteers, spiritual leaders and family members (Carstairs, 2005).

By 2036, British Columbia will have the oldest population west of Quebec (Human Resources & Skills Development Canada, 2012). It is expected that approximately 24% of British Columbians will be 65 years of age or older, an increase of 9% in the next 24 years, which will have dramatic impacts on the need for palliative services. The Ministry of Health in BC has responded to this concern by identifying palliative care as an area of health policy priority (BC Ministry of Health [BCMH], 2006). The challenge the Ministry faces is how to "ensure quality services are consistently available so that British Columbians with a life-limiting illness, and their families, can experience the best possible quality of life during the transition to death" (BCMH, 2006, p. 16). The direction the Ministry is taking to achieve this goal, however, is towards enhancing services and policies that enable palliative care to be provided in the private homes of British Columbians, which

is reflective of overarching neoliberal trends. The 'problem,' according to the Ministry, is that while the majority of British Columbians would prefer to spend their final days at home, 60% still die in hospitals (BCMH, 2006). Thus, this definition of the 'problem' sees a disjuncture between British Columbians' preferred place of death (i.e., in the home or hospice) and where most deaths actually occur (i.e., in the hospital), and perceives that this disjuncture must be addressed while palliative care policies and practices are developed, modified, or enhanced in the face of impending increased need.

In 2009, a study by Crooks developed a timeline of palliative care policy and practice in BC. She found that the development of palliative care services in BC has been shaped by various social, political and geographical factors, and that government concerns and priorities regarding this care have shifted dramatically over time. Beginning in the 1980s, messages about palliative care were brought forth in the provincial legislature and, interestingly, personal stories about those who were not receiving needed palliative care were often used to initiate dialogue in legislative sessions (Crooks, 2009). In the 1990s, questions revolved around where palliative care should take place, who should be responsible for it, and how it should be funded (Crooks, 2009). In the 2000s, priorities shifted again towards developing and implementing specific initiatives, such as the BC Provincial Framework for End-of-Life Care (BCMH, 2006), the federal Compassionate Care Benefit Program, and the BC Palliative Care/Pharmacare Benefits Program. These programs mark a dramatic shift in government priorities away from building freestanding hospices, towards facilitating home-based palliative care (Crooks, 2009).

Considering current health care spending in BC, it should come as little surprise that the downloading of palliative care responsibilities onto communities and families is an attractive policy option (Hankivsky, 2004). Such a shift is seen as key to controlling health care spending by governments and is justified as a way to alleviate demand on the formal health care system while improving quality of care for recipients (Armstrong et al., 2008; Hankivsky, 2004). The provincial government's repeated tax cuts and aim of meeting deficit targets have resulted in major decreases in public health care spending. These cuts force regional health authorities to determine what they will trim, which directly and indirectly affects communities and social services that enable palliative care provision. As such, availability/eligibility of particular palliative services varies dramatically across BC, resulting in vast spatial inequities, especially when comparing BC's rural health authorities to more urban ones (Crooks, Castleden, Hanlon, & Schuurman, 2011; Milligan & Power, 2010). General trends, however, include the province-wide cutting of hospice beds, adult daycare and respite facilities, which ultimately increase the responsibilities of family caregivers (BC Nurses Union, 2009; Canadian Centre for Policy Alternatives, 2005). At the same time, support for family caregivers of the frail, elderly, (dis)abled

and dying is also being cut, for example, formal home care (e.g., nursing) and support (e.g., bathing, laundry, vacuuming, shopping and meal preparation) (FWCBC, 2003).

Although family caregiving can be an empowering, inspirational and fulfilling role, it is important to acknowledge that the demands and responsibilities may also come with associated burdens (e.g., mental stress, compromised physical health, financial costs). Like all populations, caregivers are complexly situated within intersecting socioeconomic, cultural, political and geographic realities. Thus caregiver burdens and associated stressors may weigh more on the shoulders of some than others. Choices, opportunities, decisions and ultimately one's ability to cope with the highly demanding caregiving role are complexly interrelated with one's place in the world and the access to resources one can draw from. For example, those who live in poverty may face greater stresses and challenges in meeting the financial costs associated with dying (Wakabayashi & Donato, 2006), while women face stronger societal expectations to take on the role of caregiver and its associated burdens (Dolan & Thien, 2008), and those who may be more geographically or socially isolated are likely to experience greater fatigue leading to an increased risk of anxiety and depression (Spencer, 2004).

Although BC has recognized palliative care as a core service in the provincial health care program, those who are providing the majority of palliative care, namely family caregivers and front-line workers, remain invisible in policy initiatives (Yantzi, 2009). This may be due in part to an inherent neoliberal 'expectation' that families and charitable community organizations are responsible for fulfilling this role. It may also be due to the constructed divide of the public and private spheres and, rooted in familialism, assumptions by policy makers that the family will automatically take over responsibility for care (Hankivsky, 2004; Siltanen, 2006). Such policies also assume that all citizens have a safe and healthy home environment suitable for caregiving (McKeever, Scott, Chipman, Osterlund, & Eakin, 2006; Milligan & Power, 2010) and that dying British Columbians have family members who are both willing and capable (e.g., financially, physically, mentally, emotionally) to successfully take on this role (Seale, 2000). As this section demonstrates, palliative care in BC has advanced over recent years, yet it remains an often overlooked and undervalued component of health care systems. Based on BC's current palliative care landscape, it is apparent that an intersectional approach could generate more accurate information to inform policy about who needs what kind of palliative services and supports. Thus, it is important to investigate palliative care in BC in order to shed light on how lived social/physical places impact opportunities, choices and decisions related to providing and accessing palliative care supports and services.

Study Overview

My exploratory study seeks to examine the perspectives of those working on the front lines of palliative care provision across BC. Twenty front-line workers were interviewed and purposely recruited from a variety of employment backgrounds, occupational settings and geographic regions across BC in order to capture employment and geographic diversity and bring about diverse discussions of experiences working with families with various needs. The inclusion criterion required participants to be actively providing direct palliative care to family caregivers and/or care recipients through their formal employment. Recruitment involved disseminating an information letter summarizing the study's purpose and inclusion criterion. The letter was sent via e-mail to a number of hospices, palliative organizations and hospitals across BC. Additionally, telephone calls were made to inform potential offices/organizations/participants about the study.

Data collection:

Semi-structured interviews were conducted by telephone in May/June, 2011. The interviews lasted on average 45 minutes and inquired into participants': 1) experiences of working with families experiencing death and dying; 2) perspectives on the diversity of families in need of palliative care supports and access to these supports; 3) perspectives on current palliative care policy in BC; and 4) suggestions for policy improvement. All participants were informed of their rights in the research study and provided verbal consent prior to the interview. Ethics approval was granted by Simon Fraser University's research ethics board.

The interviews were conducted with front-line workers from across BC, as shown in Figure 1. They worked in a variety of occupational groupings, including: home care/community nurses; social workers; social work consultants; acute care/emergency social workers; spiritual care providers; physicians; counsellors; and pharmacists. Participants' workplace settings were also varied, crossing hospice, hospital, clinic and community spaces. In order to protect anonymity and meet ethical standards, further demographic information (e.g., age, ethnicity, gender, etc.) of participants cannot be shared due to some of the low populations and rural/remote communities involved.

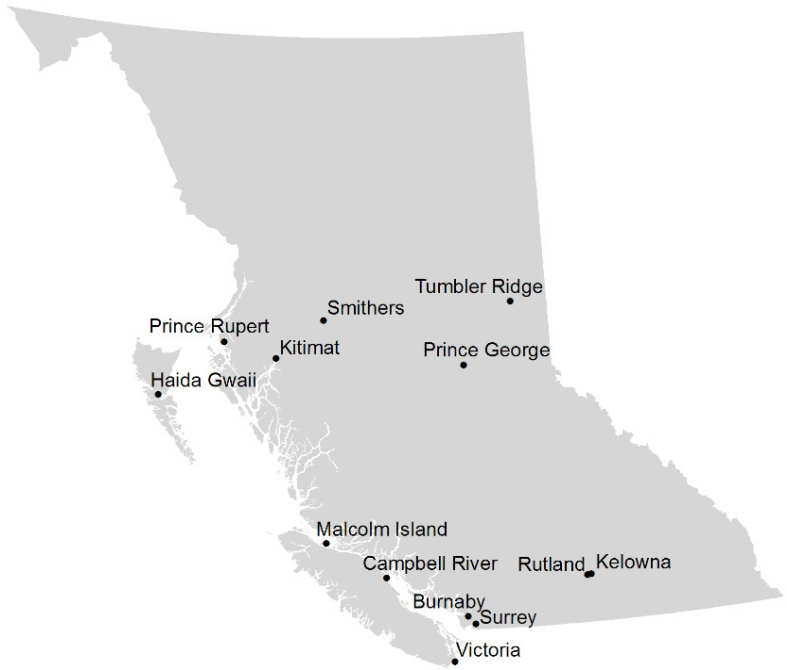

Figure 1: Participants' workplace locations in BC, Canada

Analysis:

The interviews were digitally recorded, transcribed verbatim and entered into N8™ data management software, after which thematic analysis was conducted. Thematic analysis involves reviewing and coding data both inductively and deductively in order to explore existing research goals as well as emergent themes from the dataset through the identification of patterns that become categories for analysis (Fereday & Muir-Cochrane, 2006). After reviewing three randomly-selected transcripts in order to start the analytic process, it became apparent that place, in both the physical and social sense, was a major emergent theme from the dataset. Considering the thematic finding of place, I decided to anchor my intersectional analysis here and to employ a framework developed by Castleden et al. (2010) that uses place as a tool for analysis in palliative care research. As such, development of the coding scheme was not only informed by intersectional-based themes, such as 'power', ' experienced injustice' and 'hierarchies of care', but also by Castleden et al.'s (2010) framework, which draws upon aspects of place, including 'location', 'proximity' and 'rural' or 'urban'.

Findings:

In keeping with intersectionality, 'place' did not carry a singular meaning or experience for participants. Three themes regarding place were found to be most prominent in the dataset: (1) site; (2) distance/proximity; and (3) location. Site refers to the actual places

where palliative care occurs, while distance/proximity refers to the relational aspect of place, for example, in terms of being near or far to services. Location refers to a socially 'positioned' or 'situated' sense of place. Although I have attempted to disentangle these into three thematic categories for organizational purposes and clarity, the theory of intersectionality reminds us that these categorical findings are highly fluid, relational and complexly interrelated across a variety of scales stretching from the body to overarching economic and sociopolitical structural systems.

(1) Site

The main sites of palliative care discussed by participants were the hospital, hospice and family home. However, their preferences for each site varied. Generally, the home and hospice were preferred, while the hospital was commonly perceived as being only a "*last option*." For example, participants described the hospital environment as being "*impersonal*" and not a comforting place conducive to quality palliative care. Intersecting with access to social resources, some participants stated that the "*people who end up in hospital are only the ones who have no support*." Interestingly, however, it was also stated by some participants that some families choose the hospital over others sites due to intersecting economic, cultural, geographic or social issues that influence their beliefs, choices and decisions (which will be discussed more in the following sections). Furthermore, some participants located in rural and remote regions where hospitals are very small (in some cases only 7 rooms) viewed the hospital as the most preferred site for palliative care, as the social environment there was more similar to a "*family*" than an institution. However, overall there seemed to be a general consensus among participants that palliative care in larger and more urban hospitals is not to quality standards.

Using an intersectional lens, I found that access and the preference for the hospice as a site of care varied among population groups. In general, hospices were seen as a more suitable site than hospitals, as their policies and culture are rooted in the philosophy of palliative care, which aims to ensure that all individuals die with dignity. Hospices also provide an alternative for families who do not wish to have a home death or do not want to spend their final days in a hospital. However, a number of barriers were mentioned by participants that limit some people's access to hospices in BC. First, as there are many BC communities that simply do not have a hospice house nearby, families in those areas are required to travel (in some cases, hundreds of kilometers from their home) for this service, which can create major social impacts, as families may be forced to separate and live at great distances during these time periods. Second, to be eligible for hospice, the care recipient must score below 40% on the palliative performance scale

(which measures for functionality). Using such strict medically-based eligibility requirements that do not consider other social contexts were a source of frustration for some participants:

> *...they* [hospice houses] *use the palliative performance scale...like it is gospel! And if you are 40% or less on the palliative performance scale, you can go to hospice. If you are anything above, doesn't matter any other extenuating circumstances, doesn't matter the context—nothing—zero—end of story, you don't get to go. So yeah. It's hard. I mean I know all about rules but there are people that do not fit into ticky boxes.*

Third, if and once care recipients become eligible for hospice they may face long waiting lists to be transferred, a concern that was raised by many participants. In addition to the physical location of hospices and individual medical prognoses, socioeconomic status was also found to intersect with and create barriers in accessing hospice care. Participants commented on the out-of-pocket hospice costs for patients and their families, which are tied to assisted living rates. Hospice costs in BC are roughly $30 per night, which was seen by many participants as unjust and an attack upon the dignity of dying individuals who cannot afford these rates.

Besides the hospice, the family home was the other preferred palliative care site of participants, as care in the home was generally believed to be more compassionate, while the environment was familiar and comforting. Importantly, however, any preference given to this site of care was largely dependent upon a range of intersecting contextual factors. In order to stay in the home, for example, participants stressed that care recipients need to have family members or friends who are willing, available, and capable to provide care. Some families simply do not have someone like that. As one participant put it, *"I mean ...we see it all the time - you have two people just propping each other up - and that is more common when they are elderly, but it can also be if there is drug addiction, or alcoholism, or mental illness."* Importantly, families also require access to formal supports and services to stay at home, like home care nurses, home support workers and palliative physicians who will make house calls, which was deemed by participants as most critical for making palliative care at home a reality. As mentioned previously, due to recent budget cuts and resulting spatial inequities in the distribution of resources, the limited availability and provision of formal care in the home in some regions of BC has greatly affected families' choices, as another participant remarked, *"Okay, here is your choice, either go to hospice or stay at home—If you stay at home we can only put in two hours* [of support] *a day. How much of a choice is that?"*

Although favouring the home as a site of care, participants believed that private houses were not always safe and/or suitable sites for palliative care. For example, one participant explained that "*Sometimes you go in and someone's got lung cancer...and there is black mould all over the windows.*" Safety issues were also a concern with regard to social dynamics within the home:

> *I've had people who are dying and they are in a home where numerous drug addicted people share the space and so their pain control drugs become capital and so the patient doesn't get the drugs they need.*

Making houses safe as a site of palliative care sometimes requires making modifications to spaces or bringing in equipment, changes that depend on various intersecting contexts, such as socioeconomic status and access to particular material resources like vehicles: "*I sometimes have a bit of a challenge getting the right equipment in place in homes and then I have a lot of families who aren't in a position, they don't have a truck, to move the equipment and so... that can be a bit of a challenge.*" Based on the data, the most concrete barrier to providing palliative care in the home is faced by those who do not have secure housing: "*there is a lot of housing insecurity—people who have lived on their own, you know, and then they are too sick, what do they do when they are too sick but they are not quite ready for hospice?*" Additionally, taking into account the intersection of care with cultural/spiritual issues, some families do not wish to have death occur in the home. As one participant stated, "*I find the Haidas* [a First Nation] *are definitely more spiritual. They tend to believe...if they die in the house, the spirit stays in the house, that kind of thing, and they don't like that by any means.*" Because of their spiritual beliefs and lack of hospices in the area of their Aboriginal reserve territories, these families have little choice but for death to occur in a hospital setting.

(2) Distance and proximity

The physical distance between palliative care services and users, and/or between formal palliative care providers and their clients was commonly raised by participants as a major factor influencing their abilities to provide effective support. A participant from northern BC discussed some of the spatial inequities that exist in distribution of services throughout the province, claiming *"there are places out there that don't have doctors, don't have hospitals, so I doubt that those places have a hospice, and I don't even know if they have people kind of trained in that area* [palliative care] *to give the type of care that might be needed."* Importantly, participants commented that because some regions lack formal palliative services, families have no choice but to move closer to the nearest hospital or hospice (again, sometimes hundreds of kilometers from home), which can be

quite distressing for families, especially for those who do not have the finances to simply move and/or take a leave or find new paid employment in the community where the hospital/hospice is located.

While participants discussed issues of physical distance and proximity, it became clear that their concerns were also infused with social meanings and issues of belonging. As intersectionality reminds us, belonging, inclusion and exclusion are inherently linked with social justice. Some participants stated that people in remote regions feel *"lost"* and that *"some communities are just so remote and isolated, both geographically and socially"* that their needs for palliative supports are not heard or valued. However, it was also commonly noted that these remote and isolated communities are generally more 'socially' close and connected internally, which is a great strength for families experiencing death and dying: *"...the smaller places make up in personal caring and concern for the family and patient in ways that perhaps, places that may appear to have a lot more services don't."* These close connections within smaller communities were seen to be extremely valuable in terms of support for families.

Participants were careful not to make cultural generalizations and acknowledged intersectionality's claim that diversity exists within each culture; however, some general differences were raised with regard to sociocultural issues and their relevance to proximity. For example, a participant explained that *"First Nations have all sorts of family around... they usually have friends or somebody that is there for them so it is quite a close-knit community that way."* Participants from northern BC commonly remarked on the sense of community with regard to death and dying among First Nations, and particularly the Haida, including how this was often enhanced through close physical proximity. Meanwhile, another participant from northern BC explained that, *"out of all my white clients, I would say probably at least 40% of them are here all by themselves with no family. Closest family would be out-of-province."* These observations pertain to social and physical distance and proximity, which are relevant factors for intersectionality and point to experiential differences in death and dying across BC. They also expose particular needs in regard to addressing spatial inequities in palliative care supports.

(3) Location

The most dominant place-related theme raised by participants was in reference to how both the physical and social locations of care of recipients and family caregivers determine their access to palliative services and supports. In the physical sense, participants whose employment reaches beyond a health authority boundary found the bureaucracy and *"enormous variations and permutations"* in service provision extremely frustrat-

ing. As one participant commented, *"the palliative benefits program, it is supposed to be a provincial program...but what happens is that it's doled out to various regions to be administered and those regions apply their own rules around what is covered, what isn't, and how it gets covered."* Therefore, the provision of and access to palliative services is largely dependent upon where one is geographically located in BC, which intersects with overarching regional demographic, historical, cultural and socioeconomic differences among communities. During the interviews, many participants situated in rural areas compared their palliative services to those in urban locations, often emphasizing the spatial inequities that exist: *"I think in places like Victoria and Vancouver, they are doing a very good job. But when they make policies...all you have to do is come and spend three months working in a location like this* [remote] *and you will realize that we fall off the map all the time."*

Spatial inequities in palliative care services and supports across BC have a number of implications. One of these is economic, thereby connecting access and socioeconomic status. One participant remarked on the extra costs and stresses associated with accessing care in rural areas:

> *the financial burden in a rural area versus in a city is huge... you know, the cancer centre is in* [city name] *so if you live in* [smaller community] *per se, it is a four hour drive through pretty treacherous mountain passes to get to your appointment...it is just so much more stressful to have to travel for treatment.*

In recent years, there have been considerable funding cuts that have affected access to palliative care services, particularly in BC's north. One participant stated that the hospice/palliative care program there *"is essentially disintegrated,"* while another explained that *"Northern Health initiated a hospice/palliative care program and has let it wither to almost a point of non-existence.... The working conditions are impossible."* Additionally, in some locations there may not be access to a family physician due to shortages, which makes it *"a nightmare"* for families to access services, as eligibility for palliative care programs in BC is typically dependent on a physician's assessment of the prognosis and a referral.

All participants believed that one's social location shapes access to palliative services and supports in BC, along with experiences of death and dying. During the interviews, participants emphasized that each family and each death is unique; however, some patterns with regard to inequities in choices, opportunities and access to supports and services were mentioned. Issues of culture, spirituality, language, education, gender, sexuality, marital status, life course position and socioeconomic status were all mentioned by

participants as being complexly intertwined within clients' lives and affecting palliative care outcomes. Here, issues of social processes of power and subject formation results in effects of privilege and penalty for those in need of access to palliative care supports. Access was largely understood by participants to be related to issues of isolation, culture, gender, unresolved colonial injustices and ongoing experiences of poverty. There were many examples provided, however, I will present only some of the main themes that arose. Firstly, First Nation people's, but particularly those living off reserve and who are socially disconnected from their cultural communities, were said to face extreme barriers in accessing needed social and spiritual supports. Meanwhile, participants felt that the Aboriginal population as a whole lacks representation in palliative care policy and access to formal services. One participant stated that *"the First Nations are a significant part of the population... but, they are significantly, significantly underrepresented in palliative care."* Another said, *"I know for a fact that the First Nations people are falling through the cracks in terms of palliative care... there is just terrible inequality given the distribution of resources and funding."*

Unsurprisingly, participants thought that women tended to be family caregivers more often than men, while the degree of expectation for women to take on the role of caregiver varied depending upon other intersecting dimensions of language, culture and socioeconomic position. For example, one participant explained that *"in the Indo-Canadian community, often it is the daughter-in-law who is looking after the dying mother-in-law, plus her own parents, plus there is very little support, and she might be the only one that speaks English."* It was also stated that women are more likely to take on the dual responsibility of family caregiving while maintaining paid employment, which participants said creates tremendous stress on women. And while some women face these extra challenges by maintaining these 'dual responsibilities,' others experience great pressure to leave their paid employment in order to fulfill caregiving responsibilities. As one participant observed, *"either the woman is still working, or she has been forced to leave her job because women usually make less than men, so often their jobs are the ones that are given up because, you know, someone has to give up something, so take the least paying job."*

Socioeconomic status was seen by participants as greatly affecting access to palliative services. As one participant described it, *"without a doubt... accessing palliative care programs is so much harder for people who live in poverty."* Much of the time this diminished access is associated with the out-of-pocket costs families are expected to incur and the loss of wages from taking time off paid employment to provide care. One participant explained that *"we have so many people living paycheque-to-paycheque and then... it sounds funny, but there are so many expenses associated with dying and people that are not financially well resourced for that, it's really tough."* Further, and intersecting

with the issue of physical location, participants also recognized that those living in more rural areas face greater challenges in achieving job security and stable financial standing, especially rural women.

Marginalized population groups were thought to face severe challenges accessing palliative services, especially the homeless, those with stigmatized diseases and those who live in unsafe places. Elaborating on this, one participant commented that *"Street people—I mean stigma—you know, you need a referral* [to access palliative care] *and a lot of people when they are dying they don't go to doctors*." Those with particular illness and diseases also were seen as significantly underrepresented in palliative care, especially those with stigmatized diseases like HIV. Further, those suffering from mental illness face major barriers in accessing palliative services. One participant claimed that, *"mental health is a huge one... We struggle with mental health. Trying to get the mental health team involved when people are dying? Oh, it is almost impossible."* Some participants expressed concern that there is no place for those with mental illness to go when they are dying because, *"Anybody who has behavioural issues that would impact on the other clients is not somebody that would be suitable* [for hospice] *and yet we do not have anything in place - and this is especially for, I would say, people with addictions."* Participants argued that because these population groups are sometimes more difficult to house and often not trusting of people in the health field due to bad experiences in the past, they are not accessing the formal supports they may need.

Advancing New Perspectives on BC Palliative Care Policy

In 2006, the BC Ministry of Health published a framework for palliative care with the vision that end-of-life care in the province

> ...will feature high quality services that are competent, compassionate and respectful of all people who are dying and their families. Patients and families will have choices, including a range of options to support death with dignity and comfort in the setting that best meets the needs of patients and family caregivers (p. 4).

Although this is admirable, the findings of this analysis indicate that there is much to be done to actualize this vision. Great inequities exist in choices, options and access to palliative supports and services in BC. Emerging from this intersectional analysis, findings indicate that these inequities are dependent upon relational aspects of 'place' and

where people are physically and socially situated within these contexts. Site, distance and location in both the physical and social sense were found to greatly influence palliative care access and outcomes. Looking more closely at the issue then, it becomes apparent that these contexts complexly intersect in each individual's lived reality, from micro (e.g., illness or disease prognosis) to macro levels (e.g., neoliberalism).

The physical places discussed in the participant interviews (e.g., rural BC, the home, the hospital, among others) are themselves characterized by intersections of sociopolitical, economic, cultural and historical processes, as well as relations of power. Although BC policy is directed towards enabling palliative care in the home, the findings point to the home as a highly contested site for palliative care, one characterized by intersecting political, cultural, economic, social, geographic and historical dimensions. By gaining a better understanding of these intersectional aspects of the home, we are better able to uncover particular inequities, especially with regard to access and the associated relational processes of power that will simultaneously shape, and be shaped by, those who live there. By shifting the intersectional gaze to the site of the home, we gain a deeper understanding on the social fields that frame everyday life experiences. Reflecting on intersectional theory, Moss (1997), called for more research to recognize a *relational view of place*. Such an approach would not be limited to the physical boundaries of the home itself, but would emphasize how the intersecting social relations of daily lives, in turn, shape home environments and, in regard to this study's topic, access to palliative care.

The findings demonstrate that current BC palliative care policy, which is currently directed towards assisting families in the home, is based upon a number of assumptions that create major obstacles to the achievement of the Ministry of Health's vision. These assumptions include that all dying British Columbians have: 1) the willingness and desire to have a home death; 2) access to a family caregiver who is willing and has the time, capabilities and resources to provide care; and 3) families that have the physical resources and/or local medical support available to assist them through the palliative care process in the home. By unpacking the Ministry's policy directive towards enhancing supports for palliative care in the home, it also becomes apparent that the house, home and family have become conflated in the policy realm and are based on an ideologically laden perspective where families are seen as white, middleclass, heterosexual and nuclear. Mallet (2004) emphasizes that governments of capitalist countries, like Canada, tend to conflate the house, home and family as part of a broader ideological agenda aimed at increasing economic efficiency and growth, which is reflected in the shift in responsibility of palliative care from the state and its institutions to the home and nuclear family. Furthermore, this study's findings disrupt the common policy discourse, which tends to

assume that those in need of palliative care are a homogenous group of middle class, Anglo-European (white western) elderly British Columbians. The findings demonstrate that great diversity exists among dying British Columbians and their families, which in turn results in diverse needs for palliative support.

The present study also shows that some groups face higher barriers and experience greater stresses and burdens than others. For example, those who are located in rural and remote areas in BC, who are at great distances from services, who are socially isolated or stigmatized, and who may be complexly located under any of the existing arms of oppression (e.g., cultural minorities and/or First Nations, among other groups) face greater barriers to accessing palliative supports, and ultimately, achieving a death with dignity. On the other hand, this analysis also exposes characteristics of those who are situated in relatively privileged social and physical positions, for whom such policies are working, namely, those who have a relatively predictable prognosis and middle to high class status, who are located near a larger urban/town area, are home owners, and socially connected, married, and/or have an educated (preferably with a medical background) woman friend or family member who is healthy, willing, capable and available to take time to provide care in the home. Considering these findings, it is apparent that deeply embedded components are resulting in, and reinforcing, inequities in palliative care. Applying the IBPA Framework in this study has brought these components to light and generated information that can potentially be used to inform policy directions towards more equitable and inclusive palliative care policy options.

The site of the home for palliative care may be a viable and desirable option for some, yet the findings point out that this may not always be the case due to a range of complex issues (e.g., lack of access to outside formal supports, spiritual beliefs, housing security and associated costs). The social role of the home is important in reifying identities and values, desires and fears, traditions, and memories, all of which will shape opportunities, choices, access and decisions regarding palliative care. Underlying motives behind some British Columbians' preference for the home as a site for palliative care must also be considered, particularly if such preferences are based upon perceptions that hospital care is inadequate and should only be a *"last resort."* Perceptions of low-quality palliative care in hospitals may leave some British Columbians feeling as though they have no choice. Stajduhar and Davies (2005) found that some BC families choose to provide care in the home because they do not see the hospital as an *option at all* due to the paternalistic approaches to care imbued in this space, and the tendency for a biomedical environment to depersonalize and decontextualize the experiences of dying and of giving care. Exemplifying this, Pesut, Reimer-Kirkham, Sawatzky, Woodland and Peverall (2010) emphasize the significant role of spiritual care providers employed within

hospital settings and how multi-faith chaplains are able to address issues of diversity. Yet, their unique contribution to modern health care is not being recognized or valued by the dominant biomedical culture, and especially in the face of constraining budget cuts. Unfortunately, this only exacerbates the depersonalization and decontextualization of the hospital environment as a site for palliative care. Considering this, and that hospices often have long waiting lists, cost $30/night and are not available in many communities, it is not surprising that the home is often identified as the preferred site for palliative care. Links between these issues and families' preferences and decisions regarding sites of care should not be overlooked in policy creation and implementation.

Conclusion

This study has been exploratory, however, it does begin to shed light on BC's current palliative care policy landscape while uncovering inequities in access to services and supports for those in need. Using an intersectional framework and my selected IBPA questions as a guide, I have been able uncover how policy has developed and represented the 'problems' associated with palliative care in BC. I have also unpacked underlying assumptions about who is experiencing death and dying, and what are believed to be their associated palliative care needs. The study also disrupts the current policy discourse that the home is singularly the optimal and preferred site for palliative care. Further, I have uncovered the kinds of population groups that are actually affected by such policies, what inequities exist, and how issues of privilege and power are currently being reinforced.

Future efforts should be made to conduct intersectional research on palliative care in order to inform policy of more equitable ways to deliver this care (e.g., policy makers must understand who is affected by what barriers and why). More concretely, communities need to be included in the palliative care policy process and provided with committed supports and resources necessary to achieve a dependable level of quality palliative care. Also, rather than directing all policy efforts towards assisting families to stay at home, the Ministry of Health must simultaneously provide families with an option of sites for palliative care, particularly by encouraging and supporting the construction of hospices and enhancing education and improving the quality of palliative care in hospital settings. Furthermore, efforts should be made to include the knowledges of disadvantaged groups and to target these groups for services. For example, attention should be paid to cultural/spiritual diversity through the development of sensitized, inclusive programs, particularly for Aboriginal populations. Lastly, due to the complexity of death and dying, there is a need for *multiple* governmental sectors to become involved in palliative care, for example, Medicare, employment insurance and family allowance, and at *multiple levels,* such as the local, provincial and national levels, in order to adequately address the

complex needs of families experiencing death and dying. This multi-sectoral approach will require coordination, a shared vision and political commitment from local to national leaders in order to be successful.

Ultimately, this study advances the concept of place within intersectionality theory, a concept which, to date, has not received adequate attention within this theoretical domain. At the same time, I have attempted to intersectionalize the concept of place and, as such, to reveal extensive possibilities and expansive uses of intersectionality in other fields. More specifically, my study emphasizes that 'choice' at the end of life is not merely a matter of individual preference, but is related to complex issues of socioeconomic status, service provision, cultural discourses, and emotional, spiritual and relational factors, which are all infused with the physical and social aspects of place (Morris & Thomas, 2007). In light of an expanding need for palliative care services in the coming years, it is imperative that BC policy acknowledge these existing inequities in order for *all* British Columbians to have access to *"quality services"* that will support family caregivers and allow for the best possible quality of life during the transition to death.

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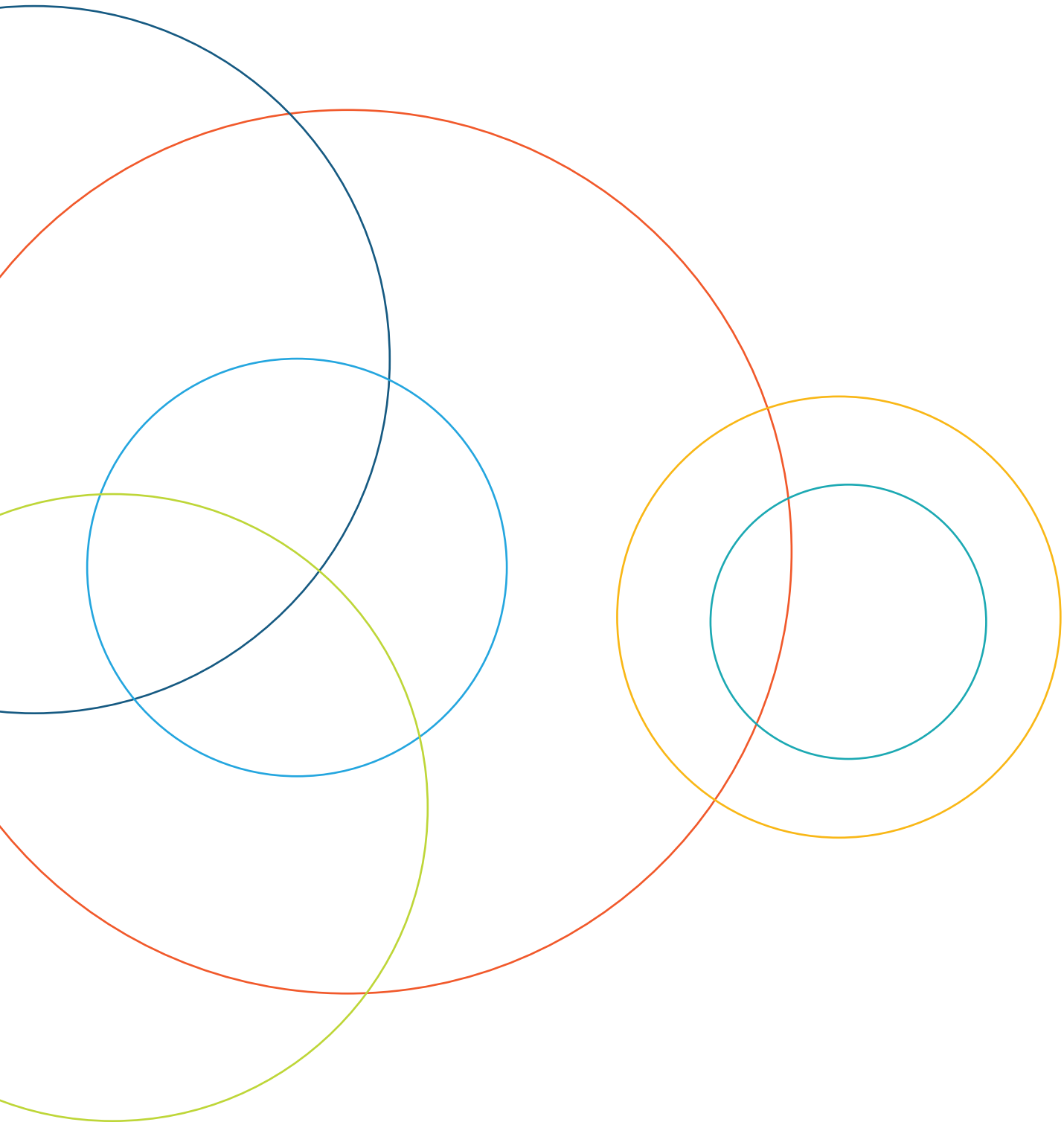

A Call for a Policy Paradigm Shift: An Intersectionality-Based Analysis of FASD Policy

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Introduction

A growing body of research indicates a close relationship between substance use and experiences of inequity and marginalization (Baumann et al., 2007; Bungay, Johnson, Varcoe, & Boyd, 2010; Corey, Godard, Abi-Jaoude, & Wallace, 2010), and recent evidence has pointed to an increase in problematic substance use among Canadian populations who experience inequity, including women who are marginalized, sexual minorities, people who experience poverty and Aboriginal people (e.g., Ahmad, Flight, Singh, Poole, & Dell, 2008; Grinman et al., 2010; Miller et al., 2011; Poon & Saewyc, 2009). Though this signals a need for substance use–related policy to better reflect and attend to the needs of groups who are often marginalized, policy processes often fail to do so. This is concerning as, in addition to lacking the capacity to influence policy, people who experience marginalization are also more likely to lack the resources that support health (Bryant, 2009). Given this disjuncture, it becomes imperative to critically examine the extent to which substance use policy and policy processes align with and impact the experiences of people who use substances.

Critical analysis of policy addressing Fetal Alcohol Spectrum Disorder[1] (FASD) in Canada is particularly pressing given increasing health and social inequities, increased evidence of substance use among certain populations and increased public attention to FASD as a "a national public health, education, economic, and social concern" (Health Canada, 2006). Recent critical analyses have highlighted the failure of FASD policy in Canada to account for the historical, structural and social contexts that situate substance use. Consequently, substance 'users' have been framed as the 'problem' requiring government intervention (Hunting & Browne, 2012; Salmon, 2004). Converging with such constructions is the prevailing assumption, permeating the media, FASD prevention campaigns and public discourse, that FASD is predominantly an 'Aboriginal problem' (Dej, 2011; Fiske & Browne, 2008; Tait, 2008b).

[1]The term Fetal Alcohol Spectrum Disorder (FASD) is used to describe a range of physical and/or developmental disabilities experienced by children born to mothers who drink alcohol while pregnant (Poole, 2003).

In contrast to the assumption that FASD is 'epidemic' among Aboriginal people, mounting evidence shows that Aboriginal people may not be any more affected by FASD than non-Aboriginal people (Pacey, 2009; Tait, 2007, 2008b). This evidence gains power when considering the fact that: a) there is a dearth of research speaking to the nature or prevalence of Aboriginal women's substance use (Gelb & Rutman, 2011; Pacey, 2010); and b) FASD research has focused almost exclusively on particular Aboriginal reserve communities where substance use rates were known to be elevated (Dell & Roberts, 2006; Pacey, 2010; Tait, 2007). Notwithstanding, dominant FASD discourses continue to construct substance users as inherently unable to make healthy 'choices,' reinforcing discriminatory assumptions about Aboriginal people and Aboriginal health (Hunting & Browne, 2012).

Discourse shapes and reflects understandings of and responses to maternal substance use and FASD. It is therefore imperative to examine how this happens, particularly in the case of the discriminatory discourses that have maintained inadequate responses to health inequity. This paper demonstrates the necessity and utility of interrogating and shifting the current FASD policy paradigm in order to strengthen the capacity of policy to promote health and social equity. It does this by applying an Intersectionality-Based Policy Analysis (IBPA) to FASD policy (*see* Hankivsky et al., 2012 for the Descriptive and Transformative Questions that guide an IBPA). As outlined in the Introduction to this volume, IBPA is an equity-oriented critical framework that highlights the macro and micro contexts and discourses shaping policy 'problems' and responses (Hankivsky, Grace, Hunting, & Ferlatte, 2012). My analysis illustrates the value of an IBPA in underscoring and resisting the legacy of FASD discourse that maintains relations of inequity. To do this, I ground my analysis within a discussion of the intersecting contexts that perpetuate health inequity for Aboriginal women, recognizing that while Aboriginal women are not a homogenous group, they are often positioned by similar intersecting processes.

As British Columbia (BC) is considered an international leader in FASD policy and program initiatives, its recent 10-year Provincial Plan (2008-2018) – *Fetal Alcohol Spectrum Disorder: Building on Strengths* (Ministry of Children & Family Development, 2008) (hereafter, the *Plan*) – can be considered a key policy document representing current FASD priorities and discourses. Though my analysis draws attention to the *Plan*'s limitations, my intention is to move beyond critique to identify issues that might be being inadvertently overlooked, as well as to point to areas of strength on which future FASD policy can be built. My paper is guided by the following lines of inquiry that derive from an IBPA:

- How have political, historical and sociostructural processes intersected with dominant approaches to and constructions of the 'problem' of FASD in Canada?
- How have these constructions positioned people that experience intersecting processes of disadvantage, and Aboriginal women in particular?
- How can an IBPA strengthen current FASD-focused policy priorities and initiatives? How might IBPA improve understandings of and responses to people (particularly mothers) who use substances?

To foreground my analysis of the *Plan*, I first provide a brief overview of intersectionality as a critical theory and policy paradigm and discuss its relevance to Aboriginal women's health. I then provide background on the intersectionality of substance use and FASD, highlighting the sociopolitical and historical underpinnings of current FASD discourses.

Intersectionality-Based Policy Analysis

The concept of intersectionality

Intersectionality has been integral to addressing the experiences of people who are subjected to multiple forms of disadvantage (McCall, 2005). Though conceived and applied in varying manners, intersectionality challenges the primacy of gender as an analytic category in understanding experiences of privilege and oppression. Developed largely from a response by black, Indigenous, third word, queer and postcolonial feminists to the inability of mainstream 'western' feminism to deal with power differentials beyond sex and gender, intersectionality considers gender as inseparable from other aspects of social identity (e.g., 'race', class, sexuality, ability). It posits that processes of structural oppression (e.g., racialization,[2] colonialism, heterosexism) intersect with peoples' social contexts and social identities to shape experiences of inequity at both micro and macro levels (Collins, 2000).

Intersectionality recognizes that discriminatory processes converge beyond the individual level to marginalize groups of people in systemic ways. For instance, socioeconomic discrimination and racialization are conceived as mutually constitutive processes, illustrated, for example, by the fact that both First Nations and recent visible minority immigrants (a demographic minority in most Canadian cities) represent up to 75% of all children in low-income households (Access Alliance, 2007). As de Finney, Dean, Loiselle

[2] Racialization is the process by which social, economic and cultural differences are attributed to 'race.' It occurs both at local and systemic levels - from personal attitudes to institutional policies and practices that marginalize individuals and groups based on presumed biological, physical or genetic differences (Browne, 2005).

and Saraceno (2011) argue, such individuals are more likely to be poor "not because of some innate characteristic, but because of the relationship between racism and economic exclusion" (p. 364). In this way, intersectionality moves beyond conceiving inequity as a sum of independent health determinants to highlight how processes of power converge in particular ways in time and place to shape health and social experiences.

The application of intersectionality to policy

It is important to note the challenges involved in applying intersectionality within the context of policy analysis. These challenges stem primarily from a lack of literature demonstrating its 'how to' application. For instance, how does one prioritize which intersections to analyze? What are appropriate ways to measure the simultaneous effects of particular intersections on experience and equity? Despite the relative newness of these lines of inquiry, it is clear that intersectionality as a 'research and policy paradigm' (Hancock, 2007) that does not subscribe to a linear method of implementation allows for flexibility in choosing how it can be applied in diverse contexts and places. For instance, Hancock (2007) emphasizes that the relationship between identity categories can be considered an open empirical question in intersectionality-informed research and practice, rather than assuming that any one particular category or intersection deserves 'a priori' status. Importantly, despite varying approaches to intersectionality-based analysis, all share a critical focus on what the intersections reveal about "techniques of power" (Dhamoon, 2011, p. 234) as well as a common purpose of transforming such techniques.

In relation to Aboriginal women's experiences of inequity, an IBPA interrogates how colonialism, neocolonialism[3] and the systems and processes with which they intersect (i.e., patriarchy, capitalism, racialization) converge with public policy. As my application of IBPA will demonstrate, gendered colonialism – that is, the intersection of gendered and colonial processes with other structures of oppression – has played a central role in how policy has both shaped and responded to Aboriginal women's experiences of inequity. An increasing body of critical policy research has shown this through analyses of how particular policy 'problems' are constructed and understood (aligning with Descriptive Question 2 of IBPA). For instance, Fiske and Browne's (2008) analysis of the implications of health policy reform for First Nations women shows that various policy 'problems' tend to be constructed as rooted within Aboriginal people themselves, demonstrating that policy itself is often a barrier to Aboriginal women's well-being.

[3] The term neocolonialism refers to ongoing and new forms of colonialism that sustain a "system of chronic poverty, social exclusion, and political and cultural disenfranchisement" and continue to subjugate and relocate Indigenous people in countries that remain actively colonial, such as Canada (de Finney et al., 2011, p. 363). My use of the term 'colonial' throughout the paper also encompasses neocolonial processes.

Relevance to Aboriginal women's health experiences

An IBPA has significant implications for adequately addressing the health of Aboriginal women, as it makes visible the intersections between institutionalized gendered colonialism and health inequity. Major discrepancies exist between the health and social status indicators of Aboriginal and non-Aboriginal women in Canada, and Aboriginal women experience higher rates of poverty, as well as a lack of access to higher education, socioeconomic opportunities and safe and affordable housing (National Association of Friendship Centres, 2007; Native Women's Association of Canada [NWAC], 2007). This glaring inequity has largely been institutionalized, typified in discriminatory policies such as the *Indian Act* (1876) and in legislative barriers to accessing appropriate health care (Browne et al., 2011a). Yet despite numerous calls to address these and other institutionalized barriers to health (e.g., BC Committee on the Elimination of all Forms of Discrimination Against Women, 2010), the Canadian government's response has been grossly inadequate.

Importantly, an IBPA can highlight how policy itself is implicated in perpetuating health inequity and obscuring the intersections of health and health behaviour. For instance, answering Descriptive Question 3 posed in the first section of the IBPA Framework – *How have representations of the policy 'problem' come about?* – can reveal policy framings of Aboriginal women's health 'problems' as inadequate. The reasons for this inadequacy may include: a) a lack of evidence speaking to the intersections within Aboriginal women's health; and/or b) a lack of meaningful involvement across the Aboriginal population in shaping policy goals and processes. Such considerations are particularly relevant in the context of policy addressing substance use and FASD.

The Intersections of Substance Use and FASD

Sociopolitical contexts of women who use substances

Compared to other developed nations, in recent years Canada has seen the most reductions in social program spending across all policy areas, a change that has contributed to inequitable living conditions that impact health (Creese & Strong-Boag, 2009; Morris et al., 2007). The effects of these neoliberal cutbacks – seen in areas such as social housing, women's shelters and mental health and addictions programs – are particularly detrimental for women, especially women situated within intersections of disadvantage (Coburn, 2010; Creese & Strong-Boag, 2009; Varcoe, Hankivsky, & Morrow, 2007). For instance, many women who use substances or experience addiction also experience racialization, poverty and violence (Rutman, Callahan, Linquist, Jackson, & Field, 2000; Schellenberg, 2005; Shannon et al., 2008). Further, the effects of gendered colonial-

ism, including intergenerational trauma, social and economic dislocation and systemic discrimination, compound experiences of health inequity for Aboriginal women and are critical factors contributing to substance use and addiction (Adelson, 2005; NWAC, 2007; Tait, 2008b).

When these intersections are absent within dominant policy discourse, homogeneous constructions of substance 'users' are perpetuated. This contributes to erroneous understandings as to the 'types of people' affected by substance use (see IBPA Descriptive Question 4) and ignores both the similarities and differences between and across populations. Intimately related to this tendency to reduce the 'problem' to particular individuals is the biomedical push in health research to investigate and frame substance use and addiction as rooted in Aboriginal 'heritage' or genetics, despite clear evidence dispelling such theories (Browne, 2005; Fiske & Stockburger, 2005; Tait, 2003). This shift in focus onto a biological or 'racial' cause of substance use behaviour contradicts the social constructivist impulse of IBPA. Specifically, an IBPA demonstrates how policy responses can maintain reductive conceptions of health and social 'problems' (see IBPA Descriptive Question 5), and in turn divert attention from the macro, meso and micro contexts situating substance use.

Fetal Alcohol Spectrum Disorder and substance using mothers

Though my intention is not to question the diagnostic validity of FASD or discount the lived realities of people affected by alcohol-related disabilities, it is important to outline the processes by which the discourse and label of 'FASD' has intersected with the lives of women who use substances. Since the diagnosis came into being, FASD-focused research and practice has, implicitly or explicitly, constructed racialized women as "the subjects of FASD research and objects of the diagnosis" (Schellenberg, 2005, p. 17). These constructions intersect with neoliberal 'health promotion' discourses that espouse taking personal responsibility for one's health and equate health issues with "self-care" (Lemke, 2001, p. 201). This ultimately perpetuates blamed-based assumptions of women who experience poor health, many of whom are located within intersections of marginalization, while the barriers that impede healthy 'choices' (i.e., the increasing lack of access to necessary resources) are ignored.

The 'blame culture' that is fostered by such discourses is largely built upon inadequate evidence, specifically due to: a) a biased focus on Aboriginal maternal substance use; and b) a lack of focus on the experiences of maternal substance use within and across Aboriginal and non-Aboriginal populations on a broad scale. The IBPA Framework's Transformative Question 6 highlights this evidence gap by interrogating what is known (i.e.,

the types of information, conceptualizations and approaches that exist) in relation to the policy 'problem.' For instance, broad-scale examinations of the association between socioeconomic status (a key health determinant shaping substance use) and FASD diagnoses have not been conducted, and such links have often been overlooked in localized studies as well. In addition, the influence of individuals' material context or health status (e.g., safe and secure housing, nutrition, comorbidities, etc.) on the "relative risk" of substances in utero (Clarren & Salmon, 2010) has often been overlooked due to a singular focus on substance use behaviour (Armstrong, 2003; Bell, McNaughton, & Salmon, 2009) Given the racialization of the FASD 'problem' and the lack of attention to the intersections of maternal substance use, it is not surprising that the FASD diagnosis itself has been deemed biased against Aboriginal people (Chrisjohn, 2002; Dej, 2011; Oldani, 2009; Tait, 2003, 2007, 2008b). For instance, Aboriginal mothers are more likely to be screened for substance use during pregnancy, and diagnosis of FASD is primarily based on facial characteristics that are often evident among Aboriginal people (Pacey, 2010). These practices perpetuate the hypervisibility of Aboriginal people in FASD-related discourse as well as exacerbate the gendered colonial surveillance of Aboriginal mothers. The extent of this surveillance is evidenced by the gross overrepresentation of Aboriginal children in out-of-home care, which has largely been influenced by colonial constructions of irresponsible parenting (Cull, 2006; Fiske & Browne, 2008). Importantly, an IBPA can bring to the fore these historical, structural and social contexts that shape and are shaped by policy, allowing for policy reform that explicitly resists the processes contributing to discrimination and inequity.

Context of Policy Analysis

British Columbia's 10-Year FASD provincial plan

British Columbia's 2008-2018 *Plan* consists of two parts: i) a summary of major goals met since the last FASD strategic provincial plan in 2003 (the first of its kind in Canada); and ii) a 10-year "framework for action" that includes goals, guiding principles and cross-government strategic priorities for addressing FASD.[4] Development of the *Plan*'s 'framework' was carried out by the BC Ministry of Children and Family Development, with cross-ministerial input,[5] followed by a review of the draft via consultation with more than 60 key stakeholders identified by each ministry, including regional health authorities, school districts, community agencies, foster and adoptive parents active in the

[4] The current *Plan* was developed independently from the federal government (the 2003 Strategy was federally funded), and was not intended to respond to the national *Framework for Action* on FASD released in 2005 (Policy Actor, personal communication, July 27, 2011).

[5] Input was obtained from the following ministries: Health, Healthy Living and Sport, Children and Family Development, Education, Public Safety and Solicitor General, Advanced Education, Employment and Income Assistance and Community Services (Policy Actor, personal communication, Sept. 8, 2011).

FASD field, clinicians, representatives from Canada's Northwest FASD Research Network and Northwest FASD Partnership, and Aboriginal stakeholders active in the FASD field. Consultative input on the framework was gathered via open-ended survey questions conducted in person and by phone, and the ministries that had provided input were involved in reviewing and accepting suggested changes.

The *Plan* was not intended to be a comprehensive mapping or evaluation of all provincial initiatives, but rather a 'visionary document' that would summarize major initiatives in the area of FASD and reflect the general FASD-related needs of British Columbians. Given the purpose of the Plan and the limited funding provided for its development and finalization, representational public input across BC (i.e., from citizens, advocates and public interest groups, including Aboriginal groups and leaders) was deemed outside of the scope of the process (Policy Actor, personal communication, July 27, 2011). However, this means that, given the intention behind the *Plan* to be a visionary document for BC, it can only be considered a 'partial vision,' as its development did not invite the input and perspectives of all citizens (particularly multiply marginalized groups).

In many ways, the *Plan* is progressive, especially when considering the longstanding framing of FASD as primarily a child health issue in Canada (to the exclusion of women's health) (Drabble et al., 2011). For instance, the document reviews the success of initiatives in BC such as Sheway (a pregnancy outreach program in Vancouver, BC) that have been able to provide pregnant women and new mothers with supportive care for both substance use and other co-occurring needs (e.g., help securing medical care, housing or counselling). The *Plan* also acknowledges the importance of maternal well-being and some of the social determinants that influence substance use, which is a crucial first step in the development of accessible and nonjudgmental care. Further, it makes collaborative care and planning an objective, reflecting recognition that FASD is a complex health issue that requires multifaceted resources and supports. This valuing of collaboration in shaping future policy priorities is reflected in the *Plan*'s interministerial and intersectoral development. Most notably, the Plan makes "improving government policy that pose barriers to women" (p. 16) an objective, indicating an acknowledgement of potential institutional barriers faced by women who seek appropriate care.

Despite these important directions, as a visionary policy document on which future FASD priorities will be modelled, a critical analysis of the *Plan* reveals specific shortcomings that must be addressed in order for it to benefit all Canadians, particularly those who experience the greatest health and social inequities. Below, I outline how critical analyses of policy discourse via IBPA can lead to more inclusive and equity-driven research and policy processes in this area.

A critical discourse analysis of FASD policy

Policy discourses can be considered intersections between language and power, as the interests and values of individuals, institutions and systems in positions of power are reflected in the language of the state (Bryant, 2009). Critical analysis of policy discourse, of which IBPA can be considered a form, moves beyond conventional linear approaches to policy analysis by focusing on the dimensions of power that are inextricable from policy in view of effecting social change (Lazar, 2007). Such analyses can highlight: a) how policy 'problems' and solutions are constructed and reproduced; and b) the differential lived effects of these processes on society. Importantly, these analyses can also support the recent push within the policy field to more effectively capture and address health inequities (e.g., Commission on Social Determinants of Health, 2008; Provincial Health Services Authority [PHSA], 2011).

Of course, FASD policy discourse does not exist in isolation. It converges with other dominant discourses to frame who and what must be targeted for action. As FASD discourse in Canada has often individualized and stigmatized substance-using mothers in discriminatory ways, it is imperative that policy researchers, actors and stakeholders acknowledge and resist this trend. Doing this requires an examination of the intersections between FASD policy and the social, structural and historical processes that influence inequity. To this end, a critical discourse analysis of FASD policy via an IBPA interrogates what is currently 'known' or taken for granted within policy and what needs to be known.

Policy Analysis

I have organized my investigation according to three discursive themes found within the *Plan,* which I take as my points of entry to explicate the strengths and limitations inherent within. These themes include: 'women-centred' discourse, 'risk' discourse, and 'culture' discourse.' These discourses converge within the *Plan* to obscure the multiple social locations, and macro- and micro-level processes that intersect to situate substance use behaviour and FASD diagnosis. The examples in my analyses are meant to highlight how IBPA makes these intersections evident, and by no means reflect the breadth of social locations and experiences across all people affected by substance use or FASD. Further, I acknowledge that some of the limitations I highlight may be due, at least in part, to the sacrifices in complexity and nuance that are inevitable when synthesizing material to produce a summary plan or framework. However, given the visibility of the *Plan* as a model for practice across multiple sectors and disciplines, it is necessary to bring these to the fore.

'Women-centred' discourse

As mentioned earlier, the shift in Canadian FASD policy towards recognizing the welfare and health needs of women who use substances is an important move from the legacy of research and policy centred on fetal protection or child health alone. This shift largely grew from a push by women's health advocates to broaden the focus of FASD research, policy and practices towards recognizing the health of both women and child as inseparable and as situated by various social and structural health determinants. These efforts, aided by the implementation of gender-based analyses (GBA), have played a pivotal role in allowing an assessment the multiple needs of women who use substances. This, in turn, has led to the creation of integrative substance use services for women that acknowledge the influence of substance use contexts, such as poverty, exposure to violence and stigmatization, and that rest on a belief in the strength and resilience of women, who are seen as being capable of caring for themselves and their children when provided with the necessary supports (BC Centre of Excellence for Women's Health [BC-CEWH], 2010; Poole, 2011).

Reflecting the prioritization of women's health is an increasing call for a 'women-centred' approach to FASD prevention and care, which is perceived as integral to the incorporation of a 'women's health determinants perspective.' This perspective entails recognition that social and structural factors, such as poverty, can affect women's overall health and well-being (Canada Northwest FASD Research Network, 2010). In the *Plan,* both a 'women-centred' approach and a 'women's health determinants perspective' are mentioned as important in prevention, yet what they involve – especially a focus on the contexts of substance use – is not discussed. Further, 'women' as a group are repeatedly referenced throughout the document, but without reference to *which* women are being discussed (beyond 'pregnant' or 'high-risk' women). This focus on 'women' as a group, combined with a failure to mention other social locations that may influence occurrences of substance use and FASD (including gender, age, sexual orientation, location, 'race,' etc.) assumes that: a) there is a common experience of substance use and FASD among all women; and b) being a 'woman,' or one's sex, is the most important factor influencing maternal substance use. An IBPA reveals how such discourse limits accurate representations of who is affected by the 'problem' (see the Descriptive Questions set, particularly Question 4). IBPA does this by highlighting that women's experiences are necessarily relational to other social locations and processes beyond their sex to different extents in varying times and places.

Thus, beginning policy analysis and development with an IBPA can help us understand how experiences of multiple identities – beyond that of 'woman' – and social locations simultaneously influence substance use and access to appropriate care. Omitting any

mention of the intersecting social locations that are significant in shaping maternal substance use reaffirms the discourse of FASD as a 'problem' of individual women who make poor choices. This discourse also perpetuates a 'one-size-fits-all' understanding of, and approach to women who use substances, which has proven ineffective in addressing many women's needs. For instance, Aboriginal women are differentially situated by factors including status, geography (i.e., rural, urban or remote locations) and their acculturation and interest in traditional healing approaches (Poole, Gelb, & Trainor, 2008). Given the diversity among Aboriginal women alone, it is necessary for policies and programming to reflect and cater to this diversity. Above all, the homogeneous construction of women 'at risk' of substance use perpetuated in the *Plan* fails to disrupt the stigmatization and oversurveillance of some women, particularly Aboriginal mothers.

'Risk' discourse

Health research and policy in Canada is often focused on what places people 'at risk' for certain health conditions. However, these initiatives have often failed to conceptualize or discuss risk as a product of the intersecting processes that shape experience. Consequently, stigmatizing constructions of individual 'risk' are promoted (Fiske & Browne, 2008). As highlighted by IBPA, examining context – both the contexts in which a policy problem is defined, and the contexts in which particular policies intervene – is vital to equity-oriented policy. Further, IBPA can capture how the legacy of FASD prevention initiatives, which have historically ignored the contexts of maternal 'risk' and focused solely on reducing fetal 'risk,' has been central in the construction of mothers who use substances as uncaring, irresponsible or dangerous to their children (Armstrong, 2003; Golden, 2005; Tait, 2007). Despite the push by women's health advocates to address the conditions that place women at risk for using substances, FASD policy often fails to make these conditions explicit, thereby furthering pathologizing constructions of mothers who use substances.

The *Plan* states that "women at high risk for substance use often face major social and health issues that limit their ability to successfully access and utilize support," including "a lack of supportive housing, unresolved trauma from violent and abusive relationships, unrecognized and untreated mental health problems, and a fear of losing custody of their children" (p. 6) as well as "poverty," "isolation" and "poor nutrition" (p. 16). Such recognition of the issues often faced by women who use substances is vital to moving towards a more holistic and collaborative approach to addressing substance use. However, the majority of issues mentioned in the document are located at the level of the individual, often separately listed rather than integrated. This further locates the 'problem' within a universal category of women. Importantly, an IBPA would contextualize the issues listed above within some of the intersecting processes of power that often situate

them, including at the systemic level (i.e., colonialism, racism and patriarchy) and at the more proximal level (i.e., stigmatization, gendered violence and the over-surveillance of substance using mothers) (see IBPA Transformative Question 6). This in turn would permit greater resistance to constructions of maternal substance use as merely an issue of individual intervention and reframe it as an issue requiring broad-scale approaches that also work to address the mutually constitutive conditions that shape inequity.

However, the need to broaden conceptualizations of risk is clearly limited by the *Plan*'s lack of acknowledgement of the processes producing risk. Individualized constructions of risk and 'risky' behaviour are particularly furthered when paralleled with the *Plan*'s numerous references to the importance of protection against this risk – e.g., ensuring the 'safety' of babies (p. 7) and of communities (p. 13), and addressing the 'dangers' of drinking (p. 6). Such discourses construct mothers who experience health or social issues – particularly Aboriginal mothers – as having inherent 'risk' characteristics (de Finney et al., 2011, p. 372). These constructions have long been used to justify institutional interventions into the lives of mothers and their children (Dej, 2011; Fiske & Stockburger, 2005; Tait, 2007). Promisingly, an IBPA can interrupt such discourses and point to their central role in maintaining ineffective and discriminatory understandings and responses to maternal substance use. This is key in strengthening policy prevention approaches, which, to date, often consist of public awareness and education about the 'risks' of alcohol use in pregnancy (reflected in the *Plan*'s first strategic objective). These prevention approaches have been critiqued for being insufficient in changing patterns of substance use for women (National Aboriginal Health Organization, 2006). IBPA can address this lacuna by specifically drawing attention to and centring the intersecting contextual factors that often set the stage for substance use.

'Culture' discourse

The importance of paying attention to the role of culture within Canadian health policy is illustrated by pervasive discourses of 'cultural competence,' 'cultural sensitivity' and, more recently, 'cultural safety,' largely in reference to 'minority' population health care (i.e., immigrant, refugee and Aboriginal populations). Aboriginal health advocates have, for several decades, emphasized the need to replace fragmented models of illness with integrated, culturally-grounded approaches to health and healing (Loppie-Reading & Wien, 2009; Tait, 2008a). Further, the increasingly multicultural population in Canada has resulted in greater pressure on health care providers and systems to offer culturally sensitive, competent and/or appropriate care to prevent barriers to health (O'Mahony & Donnelly, 2010; PHSA, 2011). Research and policy initiatives have also underscored the importance of cultural competence, appropriateness and responsivity with respect to

substance use and FASD programming across diverse populations (e.g., Centre for Addictions Research of BC, 2006; Gelb & Rutman, 2011; Institute of Health Economics [IHE], 2010; Salmon, 2007).

In line with its call to align FASD policy and practices with the needs of 'cultural' and 'ethnic' groups, the *Plan* positions culturally competent, sensitive and safe care as a key guiding principle. A description of this principle states that "Aboriginal peoples, and other individuals from BC's many cultural and ethnic communities" are involved in determining responsive FASD approaches (p. 13). This indicates recognition of the need to attend to the oft-cited gap between mainstream FASD frameworks and more holistic frameworks centred on Indigenous contexts and ways of knowing. However, what this principle entails, who these 'communities' are, and how they could be involved are not discussed. In addition, 'culture' and 'ethnicity' and 'Aboriginal' – as the only identity categories (beyond 'women') singled out as significant in the framework of the *Plan* – become hypervisible as determinants of substance use and FASD, and also isolated (namely, seen as part of a list rather than intersecting with other factors). When such discourses exist in isolation from a discussion of social contexts, homogenizing assumptions of cultural or ethnic difference are reinforced. In turn, particular groups of people, such as Aboriginal women, become stigmatized as the "main problem holders" (Lombardo & Agustin, 2009, p. 2), potentially exacerbating barriers to care. This is inconsistent with the insights of intersectionality, which critiques discourses that frame problems as located within a single group or 'cultural' location, and which argue that the problem requires a single 'cultural' solution or policy. By asking IBPA Transformative Question 9 - *How will proposed policy responses reduce inequities?* - we can conclude that intersectional understandings of Aboriginal peoples' experiences are not prioritized in such a case, which lays the ground for policy responses that fail to attend to inequity.

Promisingly, the *Plan* mentions the development of cultural safety approaches. Though these are unfortunately not described in the *Plan*, cultural safety moves beyond merely linking assumed cultural 'beliefs' or 'characteristics' with health behaviour (for which notions like 'competence' and 'sensitivity' have been criticized) to examine the structural inequities and power imbalances that affect health and health care (Fiske & Browne, 2008). Aligned with IBPA principles, cultural safety highlights the intersecting processes that shape inequitable health care and, in turn, interrupts the conflation of health and social differences between groups of people with cultural difference. Taking up cultural safety would challenge policy makers to attend to the intersecting processes of discrimination that mediate access to health and quality of care as they develop policy objectives such as decreasing barriers to care for 'cultural' groups. An IBPA recognizes that

such processes play out in varying ways and in varying contexts between and within 'cultural' or 'ethnic' groups, because it foregrounds descriptive inquiry into the genealogy of a policy while attending to transformative considerations of equity. Practically, this can show how, for example, Aboriginal women's access to substance use care is differentially mediated by status and geography (Pacey, 2010). In sum, a prioritization of both culturally safe practice and attention to intersections of power that situate such practices are integral to advancing FASD policy and practices.

Implications for Policy and Practice: Building on Strengths and Addressing Gaps

Despite the potential of the current *Plan* to promote innovative and collaborative action on the prevention of maternal substance use and care for those affected by FASD, the assumptions and constructions perpetuated within its discourses weaken the document's capacity to address the contexts influencing substance use. This can impede the efforts of research, policy and practice initiatives to appropriately attend to the processes of power that intersect with social location to shape health, health behaviour and health care. Consequently, prevention and care initiatives may not be available or meaningful to the diversity of the Canadian population and could further discriminatory assumptions and the marginalization of particular groups.

There are a few key opportunities to harness the potential of an IBPA with respect to current FASD policy initiatives in Canada. The first relates to the need to broaden the evidence base via an inclusion of perspectives from diverse groups of people affected by substance use and FASD. Much of the current evidence on FASD prevalence is based on epidemiological methods that ignore the dimensions of context that situate substance use, mostly because these contexts are not easily controlled for or measured (Pacey, 2010). To address these information gaps, an increasing movement is afoot to employ innovative research approaches that contextualize health and health care by examining multiple social locations and processes (Browne, Varcoe, & Fridkin, 2011b; Hankivsky et al., 2010). This movement requires meaningful input from stakeholders, particularly from the diversity of the Aboriginal population in Canada (Fiske & Browne, 2008; Kenny, 2004; Tait, 2008a). This is important because, despite the dominant discourse that labels FASD an 'Aboriginal problem,' there is *no* aspect of FASD for which the published evidence reflects a strong understanding of Aboriginal people in Canada (Pacey, 2010, p. 13).

Likewise, there has been increasing dialogue on the need to broaden the focus of FASD policy beyond individual substance use to incorporate a holistic, strengths-based approach to health and well-being (e.g., Cheon 2008; Gelb & Rutman, 2011; IHE, 2010),

something that is also reflected in the *Plan's* objectives. A model example of this 'strengths-based' turn is a recent community event in Skeetchesten, BC that was geared towards addressing FASD. The focus of the event was shifted by the coordinators from a prior 'problem'-based emphasis on not drinking during pregnancy (with activities such as sewing '9's into socks representing 9 months of sobriety) towards a dialogue surrounding Indigenous concepts of health and well-being and the community action required to reach well-being objectives (N. Clark, personal communication, Aug. 18, 2011).

A further recognition of the need to broaden approaches to health and health behaviour is reflected in the recent shifts from isolated policy 'silos' to more integrated policy initiatives, such as the recent BC policy framework, *Healthy Minds, Healthy People* (Government of BC, 2010), which addresses mental health and substance use as often intersecting and requiring collaborative and coordinated programming. An IBPA has the potential to inform and complement these directives, particularly those that prioritize attention to social context and diversity (e.g., BCCEWH, 2010; BC Ministry of Health Services, 2004).

Overall, however, FASD policy processes can only become equity-oriented when current evidence, assumptions and knowledge surrounding maternal substance use are interrogated and informed by the principles of intersectionality. Intersectionality theory, on which IBPA is based, is grounded in experiential and situated knowledges of people across space and time. Accordingly, fully understanding and addressing a particular policy 'problem' requires the meaningful and participatory input of those who may be directly or indirectly affected by the 'problem.' This aligns with IBPA Transformative Question 7 - *Where and how can interventions be made to improve the problem?* – to which the answer must be informed by citizen input. A key way in which people's experiences and perspectives on maternal substance use can be elicited is through consultation and dialogue grounded in and informed by an IBPA. This would allow citizens and stakeholders to reflect on and share their assumptions, understandings and needs with respect to maternal substance use and FASD. These processes can be informed by the principles of intersectionality, including encouraging reflexivity, and by paying particular attention to the voices and experiences of multiply marginalized people. Such initiatives would shift the frame for understandings of substance use towards intersectionality and social justice and, in so doing, disrupt discriminatory discourses that have impeded equitable policies and practices.

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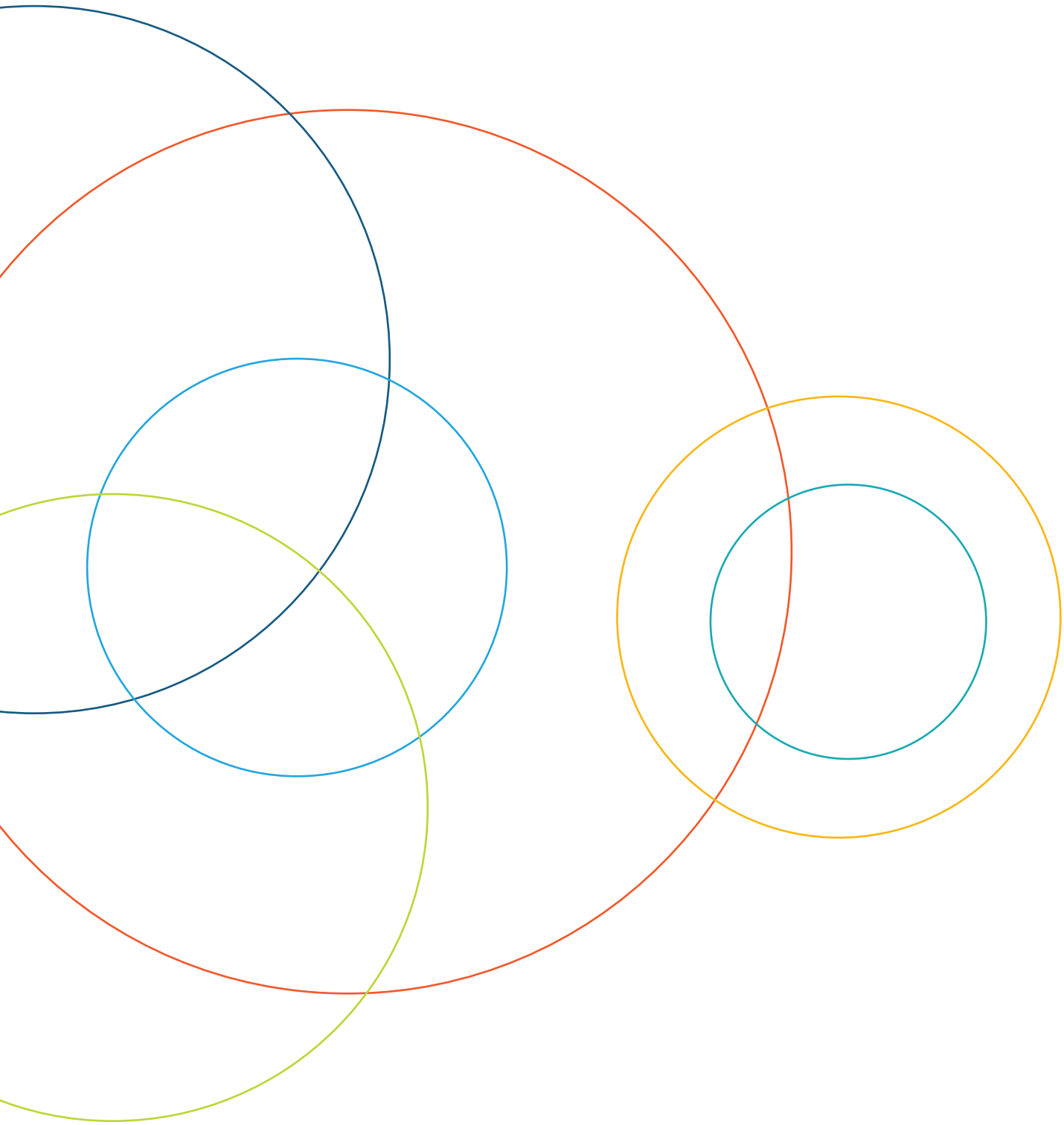

Decolonizing Policy Processes: An Intersectionality-Based Policy Analysis of Policy Processes Surrounding the Kelowna Accord

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Introduction

Health inequities affecting Indigenous peoples in Canada are persistent and increasing, as illustrated by Indigenous peoples' longstanding disproportionate burden of: infectious and chronic disease; mental health problems and suicide; addictions, trauma and violence; and inequitable access to housing, education, employment, food security and health care (Loppie-Reading & Wien, 2009). This myriad of inequities is strongly linked to the history of colonialism in Canada, with their root causes deeply embedded in the social and political structures that shape peoples' lives. As health inequities are inherently structural, new ways of analyzing Indigenous health policy issues that attend to underlying structural inequities are thus called for (Adelson, 2005).

With its attention to structural relations of power, intersectionality provides a useful theoretical lens for analyzing Indigenous health policy issues with a view to addressing inequities. In the following chapter I take an intersectional approach to policy analysis in order to illustrate how policy analysis can address issues of health inequity affecting Indigenous peoples. A central tenet to my argument is that the inclusion of Indigenous peoples in policy decision-making processes is essential for developing policies that address health inequities. Using the Kelowna Accord as a policy case study, I use Intersectionality-Based Policy Analysis (IBPA) to analyze Indigenous peoples' involvement in policy processes surrounding the Kelowna Accord. I argue that applying IBPA to Indigenous health policy can promote the inclusion of diverse Indigenous peoples and knowledges in policy and decision-making and, consequently, facilitates the decolonization of policy processes.

IBPA is a framework for policy analysis that considers the complexity of social contexts that shape policies which determine health and health inequities (Smye & Browne, 2002). If we are to address issues of inequity and social injustice, dealing with complexity in policy analysis is essential. As Hancock (2011) argues,

> [f]or those of us interested in and committed to justice, the causal complexity of our political context is not something that can be avoided in the twenty-first century. Attention to intersectionality provides a structured way to engage this complexity without being as reductionist as past approaches. (p. 55)

Intersectionality shifts the focus of policy analysis from the aim of quickly producing feasible policy solutions in a fast-paced policy-making environment to carefully consideringthe complex social and political contexts in which policies are developed, implemented and experienced. The challenge is to develop a method of policy analysis that considers this complexity while remaining comprehensible and practical to practitioners working in contemporary policy making settings. By applying an IBPA to policy processes of the Kelowna Accord, this chapter attempts to demonstrate IBPA "in action" so as to highlight the utility of this innovative approach to policy analysis.

The Kelowna Accord was groundbreaking in its extensive consultative process with Indigenous leaders and representatives from Indigenous organizations. Unfortunately, the resulting 10-year plan for Aboriginal health was ultimately not supported by the federal government, and the provinces and territories subsequently cancelled their proposed health services improvements due to the anticipated lack of federal support (Webster, 2006). To date, few studies have analyzed the Kelowna Accord experience, representing a missed opportunity to draw important lessons and insights for addressing health inequities affecting Indigenous peoples. Since the Accord involved a wide range of Indigenous stakeholders in the development of a long-term health plan, studying its unique policy development processes could provide insight into how to improve policy and decision-making in the area of Indigenous health. In this chapter, I analyze the policy *processes* involved in the Kelowna Accord, rather than analyzing the actual content of the proposed policy recommendations. Analyzing policy processes, as opposed to analyzing policy content, can deepen an understanding of how policy directions are formulated; how policies are implemented (or not);; and how to improve the link between policy formation and implementation (Matthews, Pulver, & Ring, 2008).

I begin with some background on the Kelowna Accord, followed by a discussion of IBPA as a critical framework for policy analysis. I discuss how IBPA can be used as a framework for decolonizing policy processes, before describing how I have used IBPA for this analy-

sis. I then outline the guiding analytical questions with explicit attention to how they relate to the IBPA principles, followed by a brief description of the methods of analysis (*see* Hankivsky et al., 2012 for detailed information on conducting an IBPA). The analysis and discussion section illustrates the application of IBPA and discusses three key areas: 1) Indigenous diversity and issues of representation, 2) collaboration and partnership and 3) positioning of diverse epistemologies. A concluding section makes recommendations for including Indigenous epistemologies in IBPA in order to further decolonize policy analysis and expand on the radical potential of IBPA.

Background on the Kelowna Accord

The Kelowna Accord was the culmination of a highly publicized and unprecedented national process of Aboriginal policy negotiations carried out between 2004 and 2005 under the direct authority of then Prime Minister Paul Martin. The 18-month process began with the Canada-Aboriginal Peoples Roundtable in Ottawa on April 19, 2004 and ended with the *Kelowna Accord,* which refers to the agreements that were reached at the First Ministers' Meeting in Kelowna, British Columbia (BC), on November 24 and 25, 2005. Consultations leading up to the Accord – open to approximately 1,000 selected representatives from Aboriginal organizations and provincial, territorial and federal governments – resulted in the *Blueprint on Aboriginal Health* (2005), a 10-year plan to close the inequity gap between Aboriginal peoples and non-Aboriginal people in Canada.

In 2006, Paul Martin (no longer Prime Minister) sponsored the development of Bill C-292, the Kelowna Accord Implementation Act, a Private Members' bill stating that the Government of Canada must honour its commitments by immediately implementing the terms set out in the Accord (Parliament of Canada, 2006). After its third and final reading in March 2007, Bill C-292 was passed. Although this was a significant feat, the passage of the Bill did not compel the government to fund the commitments outlined in the Accord (Turtle Island Native Network, 2009).

Previously, in November 2005, Martin's minority federal government had pledged $5.085 billion over five years to raise the standard of living of Aboriginal peoples up to that of other Canadians by 2016. The promised $5.1 billion immediately circulated in the headlines. However, later in the same month, the 38th Parliament was dissolved before the monies to implement the Kelowna Accord had been approved (Patterson, 2006). The incoming Conservative government refused to support the agreements reached under the Accord and did not approve the $5.1 billion that had been promised by the previous government, thereby effectively "cancelling" the 10-year plan for improving Aboriginal peoples' health and closing the equity gap (Webster, 2006).

Despite this failure, studying the Accord process is useful in informing future consultative processes between Indigenous leaders and governments. As well, the Kelowna Accord is a useful entry point into understanding the Indigenous policy context in British Columbia (BC), as the Accord was foundational to the development of recent Indigenous BC health initiatives, such as the Transformative Change Accord (First Nations Leadership Health Council, Government of Canada, & Province of British Columbia, 2006) and the recent establishment of a First Nations Health Authority in BC (Health Canada, 2011). Finally, studying the Kelowna Accord may shed light on why policy implementation can fail, which in turn can provide insight into how to promote implementation in the future.

Situating IBPA Within a Critical Policy Paradigm

IBPA is rooted within the critical paradigm – a paradigm based on critical theory and characterized by being value-laden, ideological and focused on achieving emancipatory aims through social activism and transformative change (O'Connor & Netting, 2011). IBPA's principle of Social Justice articulates that policy analysis from this critical approach should emphasize the transformation of social structures in equitable ways. Unlike forms of policy analysis that aim to produce non-partisan and objective findings, critical forms of policy analysis such as IBPA are overtly political (Eppley, 2009). In the critical paradigm, ideological and political transparency are essential for ensuring rigour, as scientific integrity is compromised when political ideologies are not held up to scrutiny (Reimer-Kirkham & Anderson, 2010). The IBPA Framework ensures rigour by urging the analyst to be transparent about their political motives and asking themselves, *What knowledge, values and experiences do you bring to this area of policy analysis?*

Policy analysis grounded in IBPA also exposes connections between policy contexts and processes, and unpacks how this interplay shapes the definition of policy problems and the development of policy agendas (Duncan & Reutter, 2006). Thus, IBPA acts as a framework to radically contextualize policy analysis. This contextualization can be illustrated by the IBPA Descriptive Question, *How have representations of the 'problem' come about?* The IBPA questions demonstrate attention to deep contextual investigation: the analysis begins not only with interrogation of the *a priori* definitions of policy problems, but also with analysis of the context in which the definition of the policy problem has emerged. This reflexivity and deepened contextual analysis demonstrate the extent to which IBPA is indeed critical.

IBPA as a Critical Framework for Decolonizing Policy Processes

What makes IBPA unique compared to other forms of critical policy analysis is its foundation in intersectionality, an emerging critical feminist perspective that emphasizes the fluidity between social identities (such as race, class, gender, sexuality, ability, age and religion) and the inextricable linkages of such identities to systems of power and domination (such as racism and racialization, sexism, colonialism, heterosexism, homophobia and ableism), which are also fluid and intersecting (Hankivsky & Cormier, 2009). Intersectionality draws attention to how systems of power intersect with individuals' identities to create inequities between and among various groups and individuals. Applying intersectionality to policy analysis can reveal, for example, how power operates within the Canadian policy system to determine who is and who is not, and what perspectives, knowledges and worldviews are and are not included in policy processes. I argue that an IBPA can decolonize policy processes by a) making visible how intersecting systems of power shape policy processes to differentially include and exclude people of diverse Indigenous identities (e.g., status/non-status First Nations, First Nations/Inuit/Métis, urban off-reserve/on-reserve, diversity within Nations, etc.), and b) identifying opportunities for including diverse Indigenous perspectives and epistemologies in policy processes.

A key task in IBPA is to examine the underlying assumptions that contribute to policy formation from the outset. This task is carried out when asking the Descriptive IBPA Questions presented in the Framework, such as, *What is the policy 'problem' under consideration?* and the sub-question *What assumptions underlie this representation of the problem?* Through an examination of how policy problems are defined, IBPA can expose implicit ideological norms within policy problems. For example, if we ask what assumptions underlie the central policy problem of the Kelowna Accord, we find that the problem is defined as "the gap between Aboriginal and non-Aboriginal Canadians" (Patterson, 2006). By paying attention to the IBPA principles of Power and Intersecting Categories, we see that this definition assumes that "Aboriginal and "non-Aboriginal" people are two distinct groups positioned at opposite ends of the health and social spectrum. An intersectional lens allows us to identify and problematize this assumption. We can note, for example, that Aboriginal and non-Aboriginal identities are not neatly defined, but rather exist on a continuum of multiple overlapping identities and health experiences. Paying attention to the underlying assumptions within policy problems can provide opportunities for challenging or resisting the reproduction of such assumptions. IBPA thus prompts a reframing of the policy problem in order to foreground IBPA principles, so that the "gap between Aboriginal and non-Aboriginal Canadians," might be reframed as "structural barriers to Indigenous peoples' health."

Reframing policy problems in ways that pay attention to IBPA principles may further serve as a vehicle towards decolonizing policy processes. For example, answering the first four Descriptive Questions may reveal that the policy problem definition is based on colonial assumptions, and that the policy problem could be reframed based on knowledge paradigms that are inclusive of anti-colonial/anti-racist and Indigenous epistemologies. This would foreground IBPA principles of Equity and Diverse Knowledges. Through applying the principles and questions, IBPA acts as a framework for disrupting colonial assumptions and promoting the inclusion of Indigenous knowledges and perspectives in policy problem definitions. Community control over defining policy problems is a step towards self-determination and decolonization (Fredericks, Adams, & Edwards, 2011), which is essential for the development of policies that will address health inequities at their core.

IBPA questions push the analyst towards formulating actionable policy recommendations, which is an essential part of decolonizing approaches, for as Swadener and Mutua (2008) argue, decolonizing research is "enmeshed in activism" (p. 33). The explicit action-oriented aspects of IBPA make it an approach amenable to decolonization, specifically because it is attentive to intersecting forces of power. The second list of Transformative IBPA Questions demonstrate this commitment to moving beyond theoretical analysis and arriving at policy actions. For example, the question *Where and how can interventions be made to improve the problem?* drives the analysis towards actionable recommendations. As illustrated by the Transformative Questions, IBPA is a framework for action-oriented policy methodologies. The action orientation of IBPA distinguishes it from other forms of critical policy analysis that provide in-depth analyses of complex policy issues but few insights into actionable policy recommendations that address the complexity.

It is important to note that decolonizing methodologies are often critiqued for their overemphasis on colonialism (Swadener & Mutua, 2008), which can, for example, have the effect of glossing over the gendered impact of colonialism on Indigenous women (see Bourassa, McKay-McNabb, & Hampton, 2004; Monture-Angus, 1999; Varcoe & Dick, 2008). However IBPA's principles of Intersecting Categories and Multi-Level Analysis direct the analysis towards intersections between colonialism and other systems of oppression, such as systemic racism and racialization, capitalism, classism, sexism or patriarchy. IBPA thus moves away from a singular focus on colonialism. Although IBPA can be used as a framework for decolonization, it is attuned to a multiplicity of systemic factors, not just colonization alone.

Methodology

IBPA expands what is typically defined as policy, and therefore what is typically defined as policy analysis. Policy is often interpreted to refer specifically to actions that governments take to achieve set outcomes. However there are many ways of defining policy. In this application of IBPA, policy is conceptualized as a complex process involving numerous policy actors who are engaged at various stages of the policy process and often outside a formal policy making context (Ozga, 2000; Yeatman, 1998). To illustrate this, consider public participation in a town hall debate. Although the debate is a process, not a policy document, and many of the participants are members of the public, not government policy analysts, the entire town hall debate and all its components can be constructed as "policy." Consequently, an analysis of the town hall debate can be described as policy analysis, even though it is a policy-related process that is being analyzed, and not the content of a specific policy text. Likewise, the policy analysis presented in this chapter is an analysis of the processes that were involved in the Kelowna Accord, and not an analysis of the resulting document, the *Blueprint for Aboriginal Health*.

With this goal in mind, we must consider that many of the IBPA questions outlined in the Framework assume the analysis is focused on a particular policy problem, as opposed to a process. Thus, some questions require reframing to suit an analysis of policy processes. For example, Descriptive Question 4, *How are groups differentially affected by this representation of the problem?* can be reframed as, "How are groups differentially affected by their representation in the policy process?" Likewise, I have adapted other IBPA questions for my purposes, which demonstrates the flexibility of IBPA as a framework. The three analytical questions guiding this analysis are:

a. How does the definition of the policy process shape the way diverse and intersecting social identities are constructed, and what are the implications of such constructions in relation to health inequities?
b. How do systems of power operate within the policy process in relation to shaping inclusion/exclusion and health inequities?
c. How are diverse epistemologies positioned in the policy process and how can Indigenous peoples' voices and knowledges be placed at the centre?

The first two questions fall under the Descriptive category, as they aim to deepen an understanding of how the policy process is described or defined. The third question falls within the Transformative category, as it considers how policy processes can be expanded or modified to centrally include Indigenous peoples and knowledges and to transform and decolonize policy processes.

With these questions in mind, I reviewed relevant documents, including academic papers, published reports from Indigenous-Canadian institutions, online articles from Indigenous-owned and Canadian news websites, and federal policy and legal documents. These were read in relation to each other with a view to understanding how Indigenous peoples were included in the policy processes, and the implications this has for addressing health inequitiFive policy processes related to the development of the Kelowna Accord constituted the 'unit of analysis' in this application of the IBPA Framework: 1) the Canada-Aboriginal Peoples Roundtable (CAPR), which involved 147 participants from the Federal/Provincial/Territorial governments and Aboriginal organizations, and resulted in a plan of action to enable the parties involved to work together on policy; 2) the Sectoral Tables, which involved seven two-day sessions with over 750 participants and the submission of background papers prepared by several Aboriginal organizations, all designed to inform the development of a comprehensive set of policy recommendations for addressing Aboriginal health; 3) a policy retreat with the Cabinet Committee on Aboriginal Affairs and the leaders of five national Aboriginal organizations, which resulted in the development of five agreements between the governments and each of the Aboriginal organizations; 4) the First Ministers' Meeting on Aboriginal Issues in November 2005 in Kelowna, where the parties agreed to work together to set goals for the next 10 years in improving Aboriginal health, and the Federal government pledge of $5.1 billion to support the commitment and to enhance collaboration; and 5) the decision-making processes related to funding and implementation of the agreements set out in the Kelowna Accord (Patterson, 2006).

Analysis and Discussion

Indigenous diversity and issues of representation

The IBPA principles of Power and Intersecting Categories draw attention to how multiple and intersecting systems of power operate through the policy processes of the Kelowna Accord to create categories of Indigenous identity. The principles of Equity and Social Justice prompt further analysis of how such identity constructions perpetuate or mitigate unequal power relations between Indigenous peoples and non-Indigenous peoples, as well as between and among Indigenous groups. Exploring these relationships requires analysis of the diversity of Indigenous groups involved and not involved in the policy processes. The IBPA question enabling this exploration (reframed from Descriptive Question 4) is, "How are diverse groups differentially affected by their representation in the policy process?"

The Kelowna Accord was a great success with respect to the involvement of a diversity of Indigenous peoples across gender, geographic location, as well as First Nations,

Métis and Inuit groups (Noël & Larocque, 2009). Each of the policy processes leading up to and including the Kelowna Accord involved five national Aboriginal organizations: the Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), the Métis National Council (MNC), the Native Women's Association of Canada (NWAC) and the Congress of Aboriginal Peoples (CAP), representing Aboriginal peoples in Canada living off-reserve (Patterson, 2006). The inclusion of five diverse Indigenous organizations was an attempt to move away from a "pan-Indigenous approach," where Indigenous people are represented by a singular group or leader, thus undermining Indigenous diversity and promoting the assumption that Indigenous peoples are a singular cohesive cultural group. The IBPA question, "How are diverse groups differentially affected by their representation in the policy process?" challenges the essentialization of Indigenous peoples as a monolithic entity and draws attention to the multiplicity of oppressions that affect diverse Indigenous peoples and produce layers of inequity. For example, intersections of sexism, racism and colonialism operate through policies to produce and consolidate inequities between Indigenous people of diverse genders. This was illustrated in the establishment of the *Indian Act* in 1876, which created differential privileges for Indigenous women and men by restricting Indigenous women's status and property rights (Bourassa et al., 2004). Such intersecting systems of power are also manifest in policy processes, as Indigenous women have largely been excluded from policy decisions that impact Indigenous peoples (Harvard-Lavell & Lavell, 2006), even when attempts to include Indigenous peoples "as a whole" have been made. This example demonstrates that Descriptive IBPA questions such as "How did this representation of different groups come about?" (based on Descriptive Question 3, *How have representations of the problem come about?*) are useful in historically contextualizing this representation.

By drawing attention to intersecting categories of difference, IBPA reveals how the policy processes of the Kelowna Accord were an attempt to acknowledge Indigenous diversity and the varied marginalization of different Indigenous groups. For example, the inclusion of Indigenous women through NWAC was historically significant, as it was the first time in Canadian history where Indigenous women were given a seat at the decision-making table at that level of government (Hill, Lynn, & MacFarlane, 2007).

Despite this breakthrough in accounting for some Indigenous diversity, however, issues of representation in the Accord processes still need to be examined. IBPA prompts this examination through provoking questions such as, "How are diverse groups differentially positioned by the policy processes of the Kelowna Accord?" Critiques of the Kelowna Accord point out that despite attempts at representativeness, some Indigenous groups remained excluded, such as Indigenous leaders from Quebec, who refused to participate due to "concern[s] that the Federal government may be abdicating its responsibilities

through creating tripartite agreements" thereby transferring two thirds of the responsibility to the other parties (Hill et al., 2007, p. 2). Asking the Transformative Question, "How can the policy process be redefined in ways that position Indigenous peoples in the centre?" pushes this examination further, analyzing the process to how it disrupts relations of power. The exclusion of Indigenous leaders from Quebec can be framed as a form of resistance in the light of this question, as these leaders exerted power through their autonomous decision to not participate. However despite the leaders' exertion of agency, the exclusion of Indigenous leaders from Quebec was also used by Conservative government to discredit the legitimacy of the processes of achieving national consensus (CBC News, 2006), a tactic that exemplifies the power of the government over Indigenous leaders' resistance.

IBPA's emphasis on power also draws attention to the capacity of Indigenous organizations to represent their constituent members. This can be illustrated through analysis of the inclusion of urban Indigenous peoples in the Accord processes. Although there was an attempt to include urban Indigenous peoples in the Kelowna Accord through the representation the Congress of Aboriginal Peoples (CAP), it has been noted that the Urban Native Nations (UNN), an affiliate of CAP that represented urban First Nations in British Columbia, was only representative of urban Indigenous people in a few British Columbia cities (Sookraj, Hutchinson, Evans, & Murphy, 2010). Given that the majority of First Nations people in Canada are now living off-reserve in many more urban areas (Browne, McDonald, & Elliott, 2009), the inadequate representation of urban Indigenous peoples is highly problematic. IBPA prompts this insight through provoking the question, "How do policy processes differentially include and exclude diverse groups of people and what implications does this have for inequities?"

Furthermore, IBPA allows us to problematize categories that are shaped by policy processes, particularly through the question, "What assumptions underlie the way policy processes are defined?" For example, the inclusion of five Indigenous organizations reifies the construction of five categories of Indigenous peoples: First Nations, Inuit, Métis, Indigenous women and urban Indigenous people. Based on the principles of Intersecting Identities and Power, an IBPA lens prompts policy analysts to examine how systems of power shape the construction of Indigenous identities and the implications these constructions have for inequities. The emphasis on including First Nations, Inuit and Métis peoples through their respective organizations perpetuates the notion that these are three distinct, uniform and bounded categories of Indigenous peoples. The Canadian government's role in imposing these identities on Indigenous peoples, as opposed to legitimizing Indigenous peoples' rights to define themselves, is an example of how colonialism operates within policy processes to shape Indigenous peoples' identities.

Additionally, IBPA's principle of Time and Space points to the historical construction of Indigenous identities through gendered colonial policies, reminding us that the construction of Indigenous identities cannot be understood in isolation of intersecting historical, social and political contexts. IBPA does this by asking the question, "How was the framing of the policy process historically constructed and how has this construction changed over time?"

Collaboration and partnership

Considering that Indigenous peoples are often excluded from policy decisions that impact their health, the involvement of leaders from five Indigenous organizations marked this as a historically significant policy development process. The Kelowna Accord was referred to as the start to a "renewed relationship" between Canada and Indigenous peoples, as illustrated by the Federal government's commitment to "secure a full seat at the table for Aboriginal Peoples" and "collaboration and partnership in all future policy making" (Assembly of First Nations, 2005, p. 9). In fact, the Accord exemplified a trend in Canada since the 1980's, by which Indigenous peoples' become "intergovernmental partners" when federal-provincial/territorial negotiations directly concern Indigenous issues (Papillon, 2012). While this trend has held the promise of increased involvement in policy decisions by Indigenous groups, IBPA allows us to unearth the implicit assumptions behind such notions of collaboration and partnership, which can reveal broader systems of power at play.

For example, McConaghy (2000) warns against 'collaborations' between Indigenous peoples and non-Indigenous peoples that have historically resulted in white people gaining credibility for speaking out about Indigenous issues. It can be argued that this indeed was the case with the Kelowna Accord, as white politicians were portrayed in mainstream media as central advocates for Indigenous peoples. Then Prime Minister Paul Martin was depicted as having "made Aboriginal issues a personal priority" (Berthiaume, 2012) and "speak[ing] regularly across Canada on the issue [of Aboriginal inequities]" (O'Neil, 2012). This is not to say that Martin was not genuine in his advocacy, or that his advocacy was of no value. In fact I would argue that having non-Indigenous allies in high-level positions of power is essential for pushing forward agendas of equity and decolonization. Rather, when we ask "How has collaboration been historically constructed in policy processes and what assumptions underlie these constructions?" we are prompted to think about how intersecting systems of power have operated within such 'collaborative' policy processes to differentially position certain actors in relation to power.

Although the development of the Kelowna Accord was based on a degree of collaboration between governments and Indigenous leaders, the Conservative Federal government's decision not to support the agreements illustrated that the ultimate decision-making power lay in the hands of the Federal government, thus exemplifying the continued exclusion of Indigenous people from policy decisions that impact Indigenous peoples' health. Moreover, by asking, "Which systems of power are at play in the policy process?" and "How do these systems of power intersect to privilege some groups over others?" we expose a policy system rooted in patriarchal colonialism – a system that not only positions white men as key decision-makers in Indigenous peoples' health, but further secures white men in greater positions of power than Indigenous leaders. Emphasizing collaboration and partnership without an intersectional lens may foster the notion that the process was equitable and fair. However, IBPA's principles of Multi-level Analysis and Power draw attention to how power operates at a structural level to reproduce inequities in policy processes. IBPA thus reframes the Kelowna Accord processes as, in part, inequitable and as perpetuating power inequities. This is a common outcome of policy processes between Indigenous leaders and governments where deeply entrenched power relations fail to be addressed and thus result in Indigenous peoples' continued colonization and forced dependence on the state (Irlbacher-Fox, 2009). This is not to say that the Accord did not include excellent processes that were a step in the right direction. Rather, this is to demonstrate that IBPA can reveal important lessons on how policy processes shape health inequities through the differential positioning of groups in relation to power.

Positioning of diverse epistemologies

The IBPA Transformative Questions prompt the analyst to think about how policy processes could be changed to mitigate health inequities and disrupt operations of power. IBPA prompts us to ask, "What could be done to make policy processes more truly collaborative? What interventions could transform policy processes in ways that lead towards decolonization?" Based on the principles of Diverse Knowledges and Power, IBPA draws attention to how Indigenous knowledges are positioned in policy processes and encourages us to think about how policy processes could be expanded to promote the central inclusion of Indigenous peoples. Including Indigenous epistemologies at the centre of policy processes could work to disrupt the structural relations of power that are perpetuated by the policy processes of the Kelowna Accord, including the dominance of white male decision makers.

The IBPA principle of Diverse Knowledges focuses attention on how diverse epistemologies were differentially positioned by the policy processes of the Accord. This is achieved by asking the IBPA question, "Whose knowledges are included and excluded in the policy

process?" Viewing the policy processes through an IBPA lens reveals a dominance of Eurocentric epistemologies and non-Indigenous leadership, as the Sectoral Tables and other consultative sessions were primarily led or facilitated by government departments or "professional facilitators" (Patterson, 2006). IBPA reveals that despite the inclusion of Indigenous leaders, provincial and federal governments set the terms of the policy processes. IBPA's Transformative Questions, meanwhile, prompt us to consider how policy processes could be designed with Indigenous epistemologies in the centre, thus working to disrupt power. We can ask, "Where, how and what interventions can be implemented to improve policy processes?" For example, an IBPA might suggest that policy processes based on Indigenous methodologies and moderated by Indigenous leadership would foster the central positioning of Indigenous knowledges, thus promoting inclusion of Indigenous perspectives in the outcomes of such deliberations. The Transformative Questions of IBPA are useful in pointing to how policy processes can be reoriented in ways that place Indigenous epistemologies in the centre, thereby taking steps towards decolonizing policy processes and addressing the root causes of health inequities.

As discussed earlier, IBPA's Transformative Questions also prompt analysis that leads to action-oriented findings and actionable policy solutions. Unlike many critical policy analysis frameworks, which result in a complex critique of policy issues, IBPA encourages the analyst to focus on how policy structures can be transformed in ways that will lead towards equity. In the case of the Accord policy processes, an IBPA lens might suggest that the format for the consultative sessions be informed by Indigenous epistemologies, which could result in sessions that greatly differ from the breakout session style used in the Kelowna processes. Additionally, including diverse Indigenous peoples in decisions around funding and implementation would further shift the ultimate decision-making power from the hands of white male politicians to diverse Indigenous leaders.

Conclusion

While critical policy analysis typically focuses on deconstructing concepts (see Parken, 2010), IBPA is unique for providing an innovative framework for action-oriented policy methodologies that address health inequities. The explicit transformative focus of IBPA allows the analyst to redefine policy processes in ways that disrupt power relations thereby advancing structural change through the analysis itself. Additionally, using IBPA as a framework for analyzing policy processes can lead to the development of recommendations for improving these processes to better address issues of health equity. IBPA can serve to decolonize policy processes by paying attention to how diverse Indigenous peoples and knowledges are positioned in policy processes in relation to power, and identifying opportunities for placing Indigenous peoples at the centre of such processes.

Theoretical frameworks for policy analysis based on Indigenous worldviews are emerging in the literature as an essential step towards decolonizing policy making and ensuring that policy analysis is relevant to Indigenous peoples (Fleras & Maaka, 2010; Kenny, 2004). Just as the inclusion of Indigenous peoples at the centre of policy processes disrupts historical relations of power, future directions of IBPA should also be informed by Indigenous epistemologies in order to decolonize policy analysis itself by disrupting the reproduction of Eurocentric knowledges that are typically produced by policy analyses, and to further strengthen the capacity of IBPA to address issues of health equity for Indigenous peoples.

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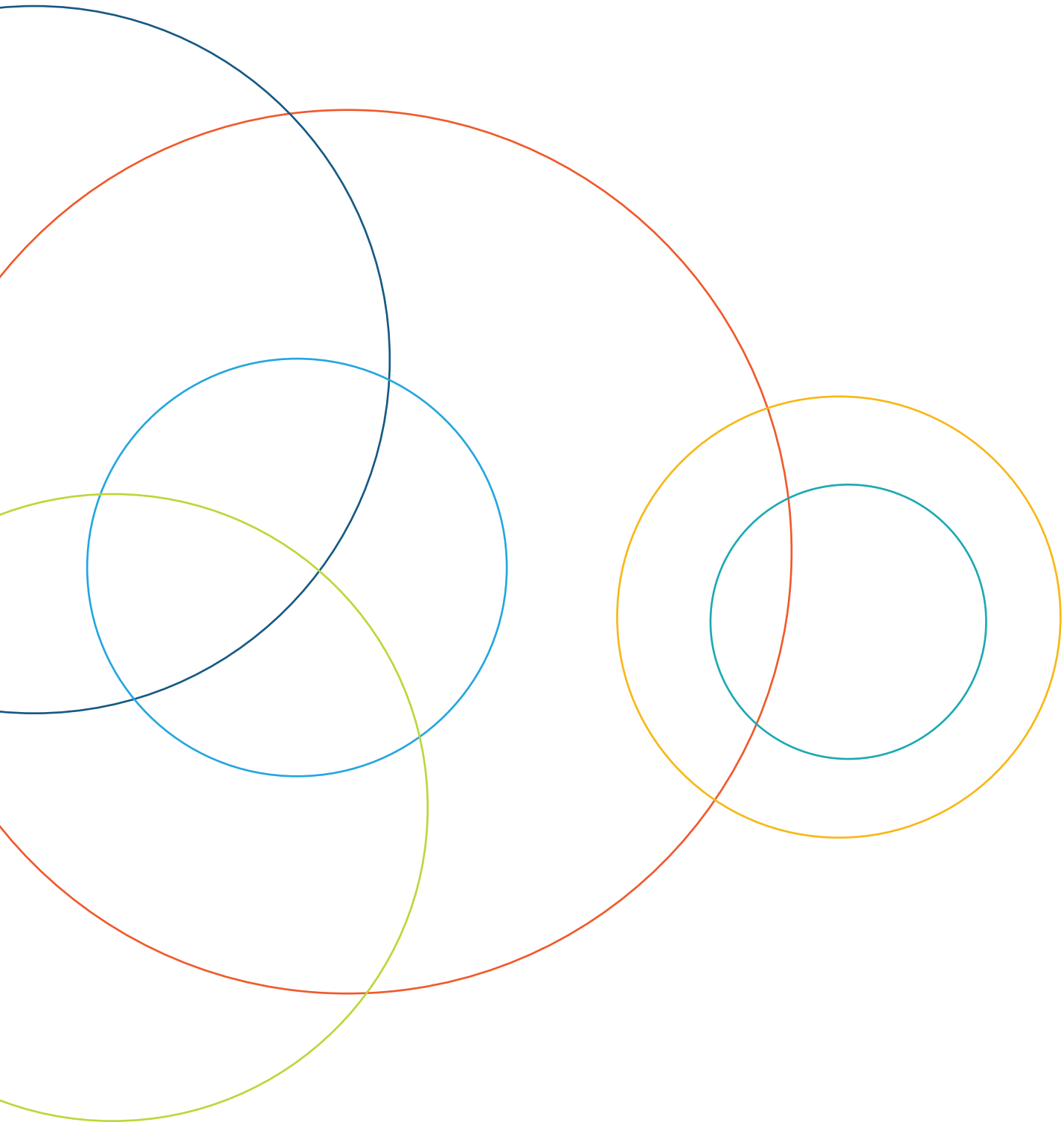

Perseverance, Determination and Resistance: An Indigenous Intersectional-Based Policy Analysis of Violence in the Lives of Indigenous Girls

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Resistance is a woman
whose land is all on fire
perseverance and determination
are her daughters...
(Connie Fife, 1998, p. 19)

Introduction

According to the report by the British Columbia (BC) Committee on the Elimination of all forms of Discrimination Against Women, *Nothing to Report* (2010), the BC government stands in violation of Articles 2 and 3 of the *Convention on the Elimination of Discrimination against Women*. The report concludes that

> conditions for Aboriginal women and girls will not change in British Columbia until strategic and co-ordinated policies are put in place to address and reverse the specific disadvantages of Aboriginal women and girls and until adequate resources are allocated, over a sustained period, to support systemic change. (p. 11)

Addressing the root causes of violence, including within policy, is key to such coordinated and systemic efforts and is the focus of this chapter. Below, I start with a story of a young Indigenous girl that demonstrates how current policies, including the *BC Child and Youth Mental Health Plan for British Columbia* (CYMH), reify colonialism, perpetuate violence against Indigenous girls, and beg for new approaches for exposing intersecting colonial discourses and practices embededded in mainstream government strategies. I follow this story by introducing what I refer to as an Indigenous Intersectional-Based

Policy Analysis (IIBPA), which draws on and extends the IBPA developed in this collection to constitute such a new approach. I believe that an Indigenous IPBA is required in order to foreground and centre Indigenous worldviews and sovereignty/nationhood, and to highlight the role of colonization, past and present, in violence against Indigenous girls.

In order to address the root causes of violence for Indigenous girls and women, it is crucial to centre the knowledge of affected Indigenous communities and to support Indigenous researchers and policy processes grounded in Indigenous epistemologies. As Grande (2004) reminds us, sovereignty, or nationhood, must be at the centre of decolonization: "If the emancipator project is built upon the spoils of conquest, how is that liberatory for Native peoples?"(243). This approach challenges conventional intersectionality scholarship by foregrounding anti-colonialism and Indigenous sovereignty/nationhood. I contend that this foregrounding is required until Canada and Canadian policy addresses the root causes of violence embedded within historic and contemporary policy and state responses. At the same time, discussions of colonialism must not grow so abstract as to overshadow individual Indigenous girls' interpersonal experiences of violence and the particular forms of gendered colonialism operating within Canadian society and within Indigenous communities. In short, while IBPA is important for attending to many intersecting factors, including gender, sexuality, geography, age, and because it advances a commitment to social change, it does not centre Indigenous sovereignty. I therefore argue for an Indigenous IBPA that is intersectional, inherently activist, responsive to local and global colonization forces, and theorized for the emergent "multifarious, polyvocal" indigenous identity within a clear goal of sovereignty (Grande, 2004, p. 2).

To develop an IIBPA, I link elements of the IBPA to literature on Indigenous worldviews. In so doing, I reveal a little -known relationship between intersectionality and Indigeneity. I then apply the IIBPA framework by returning to the case study examining how policies like the CYMH operate within ongoing dynamics of colonialism when responding to individual disclosures of abuse. I include a close examination of the material outcomes of child and youth mental health policies and of "whitestream" (Grande, 2004) settler complacency -, meaning, the ways mainstream white power is overlooked. Finally, I demonstrate how, by focusing on the agency of individual Indigenous girls and women, the implementation of an IIPBA would support the development of more ethical, anti-colonial and ultimately less violent policies for dealing with violence against Indigenous girls.

This work is grounded in my own intersecting relationships to Indigenous communities and the institutional networks in which Indigenous peoples lives are shaped. Before I offer my analysis, I am called upon to situate myself and my analysis in relation to the

land and communities to which I belong, and within a tradition developed by many Indigenous academics. In this tradition, we start from our intentions and beliefs in the work we do (Wilson, 2008). Indigenous scholar Aluli-Myer (2008), for example, echoes this when she writes of her desire "to be a woman of my intention" (p. 222). Similarly, protocol within many Indigenous communities requires individuals to situate themselves and their relationships to the people and the land. This is consistent with the IBPA principle of reflexivity, which invites researchers and policy-makers to identify how their knowledge, experience, and values informs the policy under scrutiny.

The land I am a visitor on and the community that I am part of is Secwepemc. I was born in Saskatchewan in Cree territory, but I have been on Secwepemc territory since I was five. In many ways this land and its people have shaped my worldview. Inspired by Andrea Smith, I see my identity as formed in a "radical relational way" not only through my grandmother's Indigenous roots, but also through my connection to the Secwepemc community, and through what Audra Simpson (2003) calls a "feeling citizenship." I know to whom I am accountable, and to whom I belong. These are the important questions that define my responsibility and my role within the Secwepemc nation. My work is also informed and mobilized through my interconnected identities. I am a solo parent of twin Secwepemc boys from the lands of the Secwepemc people, and a daughter who is biracial. I have spent fifteen years as a community based researcher, activist and trauma counsellor with Indigenous girls in urban and rural spaces. My heritage includes Welsh, Irish, English and Aboriginal (my maternal grandmother). This paper is rooted in my own journey and in my more than 15 years of front-line trauma work with Aboriginal girls as an ally, auntie, sister and group facilitator. In the pages that follow, I bring together my professional, academic and personal analyses, encouraged by Aluli-Myer (2008) to "see your work as a *taonga* (sacred object) for your family, your community, your people – *because it is*" (p. 219).

Policies Embodied: Case Study

Just as policies are created, monitored and implemented by individuals, their outcomes are lived by individual Indigenous girls. They must contend with their construction within child and youth mental health policies and via "whitestream" (Grande, 2004) settler complacency. Like the Association for Women's Rights in Development (AWID), I argue that case studies allow us to 'theorize up,' producing theory and understandings from the everyday lives of young Indigenous women in context. According to AWID:

> The rich descriptions produced through intersectional analyses illuminate the actors, institutions, policies and norms that intertwine to create a given situ-

> ation. Such textured analyses are critical to our ability to effect progressive change in the face of the fundamentalist forces, neoliberal economic policies, militarization, new technologies, entrenched patriarchy and colonialism. (2004, p. 7)

By viewing the stories of individual girls as extensions of larger sociocultural processes embedded within a historical context, the true impact of current policies and policy processes can be revealed. Further, the lives of Indigenous girls and their resistance to violence are poorly understood, and stories of individual women can help fill some of these knowledge gaps. Finally, centring stories is consistent with any intersectional approach that prioritizes lived experience as a necessary theoretical foundation for the pursuit of social justice (Hankivsky & Cormier, 2009, p.3).

The case study reveals how policies fail to protect Aboriginal girls from victimization and how in this particular instance, the young woman was forced into a position of resisting the very policies and relationships that were supposed to protect her. In order to understand the violence today experienced by Aboriginal girls and women, it is necessary to situate this violence within the violence of colonization, the central role of the *Indian Act* and other federal and provincial policies in this process.

In relation to the experience of the young woman presented below, I argue that the violence of state neglect, combined with the lack of belief and support on the part of individuals in the communities and networks of which she is a member, can be understood as ongoing dynamics of colonialism that compounded the sexual abuse she was speaking up against.

Case study:

A 14-year-old Aboriginal girl living on a small reserve discloses sexual abuse at the hands of a male relative. She walks into a girls group and asks if she can make an announcement. She proceeds to tell the other girls that she has been sexually abused since age seven and that she will no longer remain silent.

Weeks go by and she has not been interviewed by police. Nor has the Ministry of Children and Family Development (MCFD) removed her from the home, in spite of the fact that her family will not believe her. She is no longer attending school and has been referred to mental health services. In a meeting with MCFD and Mental Health her disclosure is questioned as potentially being a story created to help her leave her home. Instead of focusing on the abuse, her actions are seen as the result of her "being a lesbian," and it is suggested that she is "using drugs and has mental health problems." These doubts are raised in the

assessment of her credibility, her believability and her motivations. She still has not been interviewed by the police or by MCFD. Thus, established government protocols have not been followed. These events stand in stark contrast with a non-Aboriginal girl from the same small community who also disclosed abuse and was interviewed within hours of her disclosure.

The other Aboriginal girl's group facilitator and I begin making phone calls –. I become more strident with each interaction, as I encounter the labelling of this young woman. I finally speak to a senior female RCMP officer from a larger centre who agrees to interview the girl and apologizes for delays in the local response. My calls to the local RCMP are never returned. Similarly, my call to the band social worker reveals that she supports the mother and stepfather. Without an interview, she is already questioning the believability of the girl's story. It is clear that the relevant agencies, health care providers and the MCFD have developed their own narrative – that of a young woman who made up a story in order to leave her small community. Together with the other facilitator I support this young woman in calling a meeting where she, with us as supporters, presents a different "picture" of who she is. She is articulate, strong and clear about the abuse and about her right to live in a safe home and to attend school where she chooses. Unfortunately, as there are no foster homes in her community, she is forced to move to a larger city and live in a non-Indigenous foster home. She gets her day in court, and the judge marvels at her strengths and her ability to represent herself and her needs. She becomes a leader in the new girls' group she is attending, speaking up and naming her feelings. She writes a support letter about the need for Indigenous girls groups and presents the model at a School District board meeting.

In this story, policies and procedures are revealed to be largely ineffective, as individuals worked to construct the girl as untrustworthy and showed complacency and disbelief towards the violence she had experienced. If this type of response is to be avoided in the future, it is important to examine how policies that could have protected her actually served to further victimize her. One policy relevant to this case study is the aforementioned *BC Child and Youth Mental Health Plan for British Columbia* (CYMH) (Ministry of Children & Family Development, 2003). Over the last 15 years I have developed a unique understanding of this policy. As a social worker, trauma therapist and activist who has directly witnessed the ineffectiveness of CYMH in addressing the intersecting vulnerabilities of Indigenous girls I have also seen how the policy itself has in fact constructed this vulnerability, which I maintain is a form of state structural violence. Such violence occurs in the failure to act and/or in interventions of the state, via policies and systems, that lead to a culturally unsafe environment for Indigenous girls and to further violence (Native Youth Sexual Health Network, 2012).

Failure of relevant policies: Representations of Indigenous girls

In 2003, the Ministry of Children and Family Development (MCFD) instituted the CYMH for BC as part of their commitment to improving the mental health of children and youth in the province. The CYMH was the first plan of its kind in Canada and has been recognized for its leadership in this area (Berland, 2008). Key goals within the CYMH include the need to address underserved populations, in particular Aboriginal children and youth, and to provide targeted funding of $10.1 million for the development of culturally relevant services for Aboriginal children, youth and their families. In 2008 MCFD undertook a consultation and review of the CYMH plan and produced a report entitled *Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC* (Berland, 2008).

Berland (2008) found that while the investment of dollars in the Aboriginal mental health area and community-based programming were an important step forward, the key role of culture and spirituality were critical areas that had not been adequately or consistently addressed through the CYMH plan. Berland identified ongoing concerns with the labelling of Aboriginal children and youth and the medicalization of services that did not recognize the impact of colonization and ongoing trauma on the mental health needs of Aboriginal children and youth (2008, p. 51). Further, he identified a strong need for collaboration between ministries in addressing the complex needs of children and youth. Berland states:

> Although our recommendations are intended for MCFD staff, we recognize that **one Ministry of government is not solely responsible and cannot possibly address the issues alone.** Effectively tackling the myriad challenges affecting CYMH will require a whole community, cross-government approach with significant public support especially against stigma and discrimination. (bold in original, p. 5)

This need for culturally specific approaches and leadership has been echoed in a variety of recent government documents addressing mental health policy. For example, the 2007 Tripartite First Nations Health Plan called for recognition "that the mental health and substance use-related needs of BC's Aboriginal people require culturally-specific approaches" (Ministry of Health Services [MHS] & MCFD, 2010, p. 3). Similarly, on the federal level, the 2009 report by the Mental Health Commission of Canada, *Toward Recovery & Well-being: A Framework for a Mental Health Strategy for Canada*, identified the need for an understanding of health and well-being that "comes from a balance of body, mind, emotion, and spirit, is embedded in culture and tied to the land, with a

strong belief in family, community, and self-determination" (p. 17). The latter report also recognized that mainstream approaches to mental health focused on individual diseases and symptoms ignore the structural, historical and political contexts of mental health (p. 50). Still further, in the recently released BC document *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia* (MHS & MCFD, 2010), there is a similar commitment to developing a "complementary and culturally distinct plan for BC's Aboriginal populations that considers mental health, problematic substance use, as well as young adult suicide" (p. 3).[1] This report speaks briefly to the relationship between colonization, intergenerational trauma and the mental health of Aboriginal children and youth. However, the *Ten-Year Plan* does not clearly identify the link between trauma and the key mental health issues the plan addresses, and, in general, these documents fall short of their own aims. The movement towards brief interventions and solution-focused approaches is of concern, as these do not address the long-term treatment needs of trauma or the intersecting factors of age, gender, rurality or other factors that put Aboriginal populations, especially girls, at risk for violence.

According to a recent briefing paper by the Native Women's Association of Canada, the Canadian Feminist Alliance for International Action, and the University of Miami School of Law Human Rights Clinic [NWAC, CFAIA, & UMSLHRC] (2012), the intersection of gender, race, class and colonization, and an "ongoing narrative of violence, systemic racism, purposeful denial of culture, language and traditions, sex discrimination and legislatively imposed patriarchy" (10) underpin structural violence at all levels of policy in Canada. Yet, returning to the CYMH, the document about which I am most concerned, it is clear that the interaction of 'race,' ethnicity, class, sexuality and other social locations and systems of inequality is not taken into account. Significantly, the CYMH plan does not explicitly recognize that power operates within policies to continue the legacy of the *Indian Act* and other colonial structures and practices. Nor does it acknowledge the results of this continuation: structural violence that pathologizes resistance to violence and often leads to criminalization and medicalization of Indigenous girls. These failures speak to the need for alternative analytic frameworks, namely the IIBPA that I describe in the next section.

[1] While the CYMH plan and the 10-year plan both identify the need for culturally based and centred treatment of mental health, they are clearly framed within a Western and Medical understanding of illness and wellness. Further, although acknowledged briefly in each policy, the impact of past and present colonization is not adequately addressed. There is also a danger of essentialzing culture within these approaches and thus failing to realize the potential of a culturally specific approach.

Why an Indigenous and Intersectional-Based Policy Analysis

> Ideological leverage is always superior to violence... The problems of Indians have always been ideological rather than social, political or economic... (I)t is vitally important that the Indian people pick the intellectual arena as the one in which to wage war. (Deloria Jr., 1969, p. 251-252)

Intersectional-Based Policy Analysis (IBPA) provides a useful starting point for understanding Indigenous girls' experiences of violence and for gaining the ideological leverage called for by Vine Deloria Jr. Its usefulness, however, stems not only from its capacity to allow us to see complex dynamics of power operating simultaneously, but from its connection to existing Indigenous worldviews, which, it has been argued, are inherently intersectional. While it is often assumed that intersectionality originated from African-American women in the US, especially Kimberlé Crenshaw (1989), and that it is an idea that emerged in the 1980s, as Jessica Yee (2011) point out, the concept is not new to Indigenous peoples; it's the way we have always thought. Prior to colonization, Indigenous communities had multiple categories of gender, holistic understandings and approaches to health, strong matrilineal traditions, and complex systems of governance, treaty making and peacemaking. These systems of Indigenous knowledge persist in the ontologies and epistemologies of Indigenous women scholars. As Patricia Monture-Angus (1995) writes, "to artificially separate my gender (or any other part of my being) from my race and culture forces me to deny the way I experience the world. Such denial has devastating effects on Aboriginal constructions of reality" (p. 178). Mohawk scholar Audra Simpson (2003) echoes this insight, arguing that "we have to understand people within the *multiplicity* of frames that shape their lives - everyday frames of experience that they choose, that they inherit, that are imposed on them and that may be transformed, disintegrated, forgotten or ritualized" (p. 41). Among Indigenous writers and activists, there is also a strong history of resistance to colonial images (Campbell, 1973; Charnley, 1990; Maracle, 1975), which were intended to erase pre-colonization matriarchal traditions and, one can argue, intersectional ways that had existed prior to colonization of knowing. Intersectional worldviews have thus been important and, indeed, central for thousands of years in Indigenous and tribal communities.

Today, in principle, intersectionality allows theorization of current forces of colonialism, as found within reserve politics, lateral violence and identity politics (Clark & Hunt, 2011). It provides the explanatory framework called for by Indigenous critical scholar Sandy Grande (2004), "that helps us understand the complex and intersecting vectors of power shaping the historical-material conditions of indigenous communities" (p. 29).

The challenge is to "theorize the multiple and intersecting layers of indigenous identity as well as root them in the historical material realities of indigenous life" (Grande, 2004, p. 238). However, I argue that until intersectionality acknowledges its own colonial history and the erasure of Indigenous feminist scholars, it is not well situated to address the challenges that Indigenous communities experience, in particular, violence against Indigenous girls. Further, similar to other critical theories, intersectionality remains rooted in western notions of democracy and sovereignty that do not recognize the importance of tribal knowledge, spirituality and interconnectedness of past, present and future generations (Grande, 2004, p.81).

An Indigenous and anti-colonial perspective on policy-making centres Indigenous worldviews together with a strong commitment to activism and Indigenous sovereignty (that is mindful of the different meanings and experiences of sovereignty for different Indigenous peoples). This perspective also acknowledges the many intersecting factors operating through all policy work, including Indigeneity, gender, sexuality, age and geography. Overall, I contend that an IBPA analysis within an Indigenous framework, or IIBPA, offers a means of documenting first, how policies intersect and, second, how social policies, institutions and practices enable and constrict opportunities for Indigenous young girls from diverse communities and with different experiences.

Drawing on and extending IBPA to IIBPA

An IBPA starts from a set of descriptive questions about representations of the 'policy problem,' in this case, violence against Indigenous girls. These questions investigate how a problem is framed, by whom and why (questions 2 and 3); what groups are most affected (question 4); and current policy responses that maintain inequities (question 5). These sets of questions provide an important starting place for policy development because they inform the researcher/policy-maker that the violence experienced today by Indigenous girls and women originates and continues in the context of the violence of colonization.

Bringing together the IBPA Framework, literature on Indigenous intersectional knowledge, lived realities of Indigenous girls and women under neocolonialism, and intersectionality scholarship, I would like to offer five key elements of the expanded IIBPA: (1) analysis of policy and policy intersections as colonial violence; (2) anti-colonial gender analysis; (3) contextualization of individuals within community and family history; (4) positioning of agency as central, which I treat alongside of (5) acknowledgment of resistance. Through my discussion, below, of these elements, I demonstrate that, while applying the IBPA Framework allows us to consider how factors such as age, gender and Indigeneity come together to produce structural racism and barriers for Indigenous girls

the expanded Indigenous framework is essential for recognizing the multi-generational impact of colonization and trauma and points towards policy solutions that acknowledge sovereignty, build on resistance and emerge from the strengths within the community. This approach fosters a holistic understanding of policy, which encompasses mental, spiritual, physical and emotional well-being, and that builds on the strengths and resistance that exists among girls, women, and Elders within Indigenous communities.

(1) Analysis of policy and policy intersections as colonial violence

Although there is recognition in both the CYMH and in Berland's 2008 review of the plan that colonialism impacts a number of policy sectors, including education, child protection, addictions and youth justice, policy analysis and development across these sectors has not been practiced. An IBPA can attend to these connections not only in terms of describing the current policy context and approach, but also by asking transformative/normative questions about interventions (question 6) and proposed policy responses (question 8). In their analysis of Clayquot Sound and forestry policies in BC, for example, Hoberg and Morawski (1997) demonstrate that strategic alliances and "the intersection of policy sectors can be an important cause of policy change" (p. 410).

Similarly, we can consider the intersection of the related areas of child and youth mental health policy, child welfare policy and youth justice policy. The IBPA principle of multi-level analysis allows us to think about how policies have responded to the issue of violence against Indigenous girls, and how they address, maintain or create inequities between different groups (especially through questions 5 and 6 of the IBPA Framework). Such an analysis quickly unearths inequities within criminal justice and child welfare responses to Indigenous children and youth, and reveals how these systems intersect to create further harm and risk for Indigenous children and youth. A joint report by the Representative for Children and Youth and the Office of the Provincial Health Officer in BC entitled *Kids, Crime and Care: Health and Well-Being of Children in Care: Youth Justice Experiences and Outcomes* (2009) reports that Indigenous youth are overrepresented in the child protection system and within the justice system of Canada. The report was based on one of the largest studies of children and youth in Canada and included over 50,000 children and youth. It highlighted that Aboriginal children who have experienced trauma and who live outside the parental home are more likely to be involved with the justice system and to experience mental health symptoms and challenges within the education system. They are also more likely to be sexually exploited (p. 4). The report revealed intersecting vulnerabilities of age and Aboriginality, showing that nearly 1/3 of youth in custody in BC are of Aboriginal ancestry, and that Aboriginal youth are five

times more likely to be incarcerated than youth in the general population (p. 7). Aboriginal children and youth are also more likely to be in care, with 1 in 5 Aboriginal children in that situation, in contrast to 1 in 30 of the general youth population considered in the study (p. 7). Drawing similar conclusions, the organization Justice for Girls, in its 2011 report to the UN Committee on the Elimination of all forms of Discrimination Against Women, states that:

> Widespread human rights abuses against Indigenous girls are committed in the context of the criminal justice system, both in terms of over-criminalization and policing of girls, and physical and sexual abuses by police and other criminal justice authorities. These state perpetuated abuses and state failure to prevent, investigate and punish acts of violence against Indigenous girls, along with a lack of independent oversight and accountability of policing... are very serious human rights concerns.... (as cited in NWAC, CFAIA, & UMSLHRC, 2012, p. 10)

Yet, while the IBPA Framework points to the intersection of policy sectors, it does not clearly link these to colonial policies and to the process of ongoing colonization. As Mohawk scholar Patricia Monture-Angus (2006) demonstrates, criminalization is clearly a strategy of colonization, yet the criminalization of Indigenous girls and women within prisons has not been adequately examined within Canadian policy (p. 26). Current policy within the criminal justice system not only locks up girls but also fails to address the trauma, and their resistance to it, that criminalized them in the first place. As in the case study, we see how trauma is wrapped up in discourses of pathology or criminality.

In reality, policy and policy processes are central to the colonization of Indigenous peoples, locally and globally, historically and currently (Alfred, 1999; Harry, 2009; Lawrence, 2003). Policy is deeply rooted within Eurocentric value systems, and yet colonization is not often centralized or critiqued in policy analysis (Fleras & Maaka, 2010). Colonialism needs to be critiqued as a central component of any policy, including the CYMH. Meanwhile, the relationship between contemporary policies and other existing gendered and colonial structures, such as the *Indian Act,* needs to be clearly articulated.

It is clear that government policies have been central to replacing Indigenous worldviews and systems of thought with those of a settler society. An Indigenous IBPA takes this a step further by connecting current policy and policy intersections as forms of ongoing colonial violence that are directly related to the early policies of the colonial government. I argue that it is essential to further examine and reveal the relationship between these policies and historical and ongoing colonial polices such as the *Indian Act*. For example. in my previous research on reporting of violence, my colleague Sarah Hunt and I found

that past colonial legacies of policing and state intervention had led many young women to resist police or state intervention even when they had experienced violence. These young women clearly situated their current experiences with the child protection, child and youth mental health and/or criminal justice system within a larger colonial legacy of policies that have created harm, and this prevented Indigenous girls from reporting violence (Justice Institute, 2002, 2006). We found that it was common for young women to have experienced violence or witnessed violence as a child; to have had a negative experience with police, the justice system or the child welfare and mental health system; and, in turn, to have developed a lack of trust in these institutions and their representatives. We noted that if young women do speak out, reserve politics and family relationships often lead to further violence. Furthermore, in a high-profile case against a well-known judge in Prince George, girls acknowledged that they did not report violence, as the police and the justice system were part of their abuse. Through an IIBPA approach to Indigenous girls and violence, then, we begin with an acknowledgment of the harm created by policy, and directly link this harm to colonial policies and both historical and current state interventions.

(2) Anti-colonial gender analysis

An IBPA calls for a radical contextualization of policy. In the case of the context for violence against Indigenous girls and women, this would involve more careful study and disruption of gendered-colonial images, and to social justice approaches for addressing societal complacency and inaction. As NWAC (2010) identified in their research on the missing and murdered Aboriginal women from across what is now Canada, "violence is perpetuated through apathy and indifference towards Aboriginal women..." (p. 7). Statistics demonstrate the outcome of this indifference: Indigenous women are five times more likely to die as the result of violence (NWAC 2010). Widespread apathy is also reflected in the media's failure to report high-profile cases. For example, the under-reporting of the 1994 Crawford trial in Saskatchewan into the murder of three Aboriginal girls and young women (ages 16, 22 and 30) can be contrasted with the Bernardo case and the media circus that followed the victimization of white women. Similarly, in northern BC, the Highway of Tears and Sisters in Spirit campaigns have been working hard to publicize the ongoing issue of missing and murdered women, yet have received little coverage. This stands in sharp contrast to the widespread media reaction when a white woman, Nicole Hoar, went missing in BC (Hunt, 2008). Winona LaDuke (2002) writes:

> we collectively, find that we are often in the role of the prey, to a predator society, whether for sexual discrimination, exploitation, sterilization, absence of con-

> trol over our bodies, or being the subjects of repressive laws and legislation in which we have no voice. This occurs on an individual level, but equally, and more significantly on a societal level. (p. 41)

However, an IBPA alone will not adequately address the context of violence against Indigenous girls and women. The Indigenous frame for the IBPA enhances the analysis by encouraging us to expand the context to include the violence of colonization and of policies, such as the *Indian Act*, that have constructed violent ideas about "Indian women." Colonization required the silencing of First Nations and other Indigenous women, as matriarchal and co-operative societies did not fit within the individualistic and patriarchal ways of the colonizer. To take the land they had to remove the women (Harry, 2009; Lawrence, 2003; Yee, 2011). Lawrence (2003) and Harry (2009) are two Indigenous scholars who have traced the key role that gender played in colonization, from the Gradual Enfranchisement Act of 1869 through to the *Indian Act* and up to today. Policy has been a tool to institute violence against Aboriginal women and girls, including via gendered and colonial policies within residential schools, and later, in the removal of children through child welfare and the 1960s "scoop," which further disconnected and displaced Aboriginal girls through adoption and foster placement (Downe, 2005; Harry, 2009).[2] Indigenous scholar Bonita Lawrence (2003) considers the *Indian Act* and the framing of Indigenous identity as a colonial production of discourse. She writes that "For Native people, individual identity is always being negotiated in *relation to* collective identity, and *in the face of* an external, colonizing society" (p. 4).

Controlling the dominant image of Indigenous girls and women and creating a discourse of "Indian women" as colonial subjects has been a tool of colonization. Indigenous scholar Fiske (1996) describes how images of Aboriginal women, constructed during times of early colonialism in Canada, included the introduction of the dichotomous images of the "squaw' and the "Indian princess," as the colonizers "reconstructed aboriginal women in the prevailing European Christian dichotomy of the Madonna-prostitute complex" (p. 663). She states that, "today Aboriginal women seek to shake off the shackles of this dichotomy and call for a new, more realistic and more empathetic understanding of the complexities and truths of their spirituality and sexuality' (p. 664).

An IIBPA thus serves to contextualize violence against Indigenous girls and women within colonialism and its intersecting forces. In this way, it complements and expands on some of the work already done to apply an Indigenous lens to policy making (Fleras & Maaka, 2010), including culturally sensitive gender based analysis of policy-making pro-

[2] For a detailed analysis and understanding of the impact of the *Indian Act* and other colonial policies on Aboriginal women, see Katrina Harry's 2009 paper *The Indian Act & Aboriginal women's empowerment: What front line workers need to know.* Battered Women's Support Services: Vancouver, BC.

cesses (NWAC, 2007). One note of caution in this regard: although the Indigenous lens and gender-based analysis both helpfully critique colonization, essentialized or fixed concepts of "Indigeneity" and "gender" within these processes are problematic. It is important to continuously come back to the questions about group representation in the IBPA Framework. Qwo-Li Driskell (2011), a Cherokee and two-spirit academic, postulates that the implementation of dual gender systems through law, policy and social norms is itself is a colonial project. Driskell points out that prior to colonization some communities had up to twelve genders, and that colonization and patriarchy needed a gender binary system in order to install colonial domination. Cherokee scholar Andrea Smith (2006) advocates for the view that activists cannot separate out colonization from gender or other factors. IIBPA facilitates the use of a gender analysis that is attuned to the particular role of gendered colonial violence in perpetuating images of Indigenous women as deserving victims, or in ignoring and normalizing their victimization.

Finally, due to early gendered colonial policies and the resulting forces of patriarchy on reserve, violence exists in Indigenous communities. As described by Indigenous activist Wilma Mankiller:

> Our tribe and others which were matriarchal have become assimilated and have adopted the cultural value of the larger society, and, in so doing, we've adopted sexism. We're going forward and backward at the same time. As we see a dilution of the original values, we see more sexism... The thinking that people come to in a patriarchal society is crazy. (as cited in Mihesuah, 2003, p. 42)

A central component of a IIBPA anti-colonial gender analysis must therefore be the development of tools that allow an examination of historical and current constructions of Indigenous girls not just externally to but within Indigenous communities.

(3) Contextualization of individuals within community and family history

IBPA foregrounds issues of power and knowledge. This type of analysis therefore points to the need for policies affecting Indigenous girls and women to include traditional and intergenerational knowledge specific to each Nation and community. To this end, Fine, Tuck and Zeller-Berkman (2008) call for:

> work that digs deep and respectfully with community to record the particulars of historically oppressed and colonized peoples/communities and their social movements of resistance, as well as work that tracks patterns across nations,

> communities, homes and bodies to theorize the arteries of oppression and colonialism. (p. 174)

Such deep work is possible with the IBPA Framework, particularly using questions 2 and 6. These questions allow us to consider the impact of multiple relational factors on the issue of violence against Indigenous girls, many of which are often under-analyzed in current policy development. However, to contextualize policies such as CYMH within individual Indigenous family and community settings requires the enhanced Indigenous IBPA. Avoiding dependence on romantic notions of community, this contextualization should occur instead through reflection upon the complex realities of Indigenous girls' lives. Carolyn Kenny (2006) calls for greater complexity in policy, deeming it "an opportunity to describe lives in context, complete with historical, personal, and cultural elements critical for meaningful and useful policies" (p. 552). Further, contextualiztion through an IIBPA seeks to recognize the importance of local and traditional tribal teachings and the intergenerational connection between the past and the present, while also accounting for, in this case, the emergent diversity of Indigenous girlhood; the geographic movement off and on reserve; and the construction of Indigenous girls through policies such as the Indian Act.

Thus, in considering the issue of violence against Indigenous girls and their mental health and well-being, an IBPA within an Indigenous framework allows us to understand the context of colonization, the racial and colonial stereotypes of Indigenous girls and women, and the material impact of these stereotypes on the lived reality of different girls at different stages of life. This is an improvement on much policy and research on violence against Indigenous women and girls, which often discusses women without reference to age (see Culhane, 2003; NWAC, 2010). Yet, of the missing and murdered women, over half (55%) have been women under the age of 30, and 17% have been under 18 (NWAC, 2010, p. 23). Similarly, although many Indigenous youth identify as two-spirit, gender and gender-expression is often essentialized in policy and considered from a non-Indigenous perspective (Driskell, 2011; Yee, 2011). Within the IBPA Framework,(question 6) binary constructs of gender and problematic constructions of Indigenous girlhood within any intervention must be challenged.

Geography is also overlooked within much policy, in particular, how place intersects with age, gender expression and Indigeneity. While an IBPA considers geography in assessments of policy, an Indigenous IBPA brings geography and Indigenous relationships to the land and to spirituality to the forefront and allows us to consider multiple relational factors, including sacred connections between land, language and spirituality, together

with gender, age and transportation. In making this kind of policy inquiry, it becomes clear that geography is a factor for the majority of missing and murdered Aboriginal women in Canada, who lived in the Western provinces, with 28% in BC (NWAC, 2010, p. 25). Although the majority of women are missing or murdered from an urban setting (over 70%), most had ties to rural and reserve communities, and the issue of mobility is not often examined (NWAC, 2010, p. 27). As well, it becomes evident that transportation is a policy factor. Indeed, transportation has been identified as a key issue by the Missing Women Inquiry, the Highway of Tears Initiative and in other research examining youth health (Smith, Peled, Leadbeater, & Clark, 2010).

An Indigenous intersectional-based policy analysis must also attend to the call from Indigenous communities to create policies that reject a pan-Indian approach and instead reflect the uniqueness of Indigenous communities throughout Canada (Kenny, 2006). Therefore, an IIBPA must facilitate the development of policies and policy processes that are rooted in dynamics specific to each community and individual's context.

Overall, then, an IIBPA approach contextualizes intersecting factors of gender, gender expression, and sexuality and how these come together with age, geography,transportation, and culture. In describing the policy problem through this kind of intersectional lens, the links between policy interventions related to these factors also become clearer. For example, it becomes evident that health policy is related to transportation policies of rural and remote communities. Examining how the interaction of interventions, or lack of interventions and these factors work together in individual communities and in the lives of individual girls, we can see how policies sometimes compound violence and work against efforts to address violence for Indigenous girls across diverse geographies.

Critics of intersectionality might argue that policy cannot be written to address the needs of individuals. However, it is important to consider how standardized policies, such as the CYMH, create the conditions for certain kinds of experiences at the individual and population levels, and to point out that the many examples showing that these experiences are often negative for Indigenous girls (including the ones I have given here) are not exceptional. Policy must be responsive to these experiences. A case-specific analysis can point to future directions for policy reforms, especially because such individual stories often reveal systemic issues. In particular, by asking a set of questions about policy interventions, an IIBPA would consider how policy frames individual Indigenous girls' coping and experiences within the current mental health, criminal justice and child welfare system policies and programs.

The case study I described in the opening of this chapter reveals a young woman caught between systems and draws attention not only to jurisdictional approaches but also to community politics. Because IIBPA is based on principles of Indigenous sovereignty, confronting power and promoting equity, it can provide possible solutions when applied to this case. Through the normative/transformative questions on types of interventions; whose knowledge informs interventions; levels of intervention; how policies promote equity; and mechanisms of accountability, IIBPA might lead to such policy changes as providing additional funding on reserves for child welfare, advocacy for access to safe housing and foster homes on reserve, and more collaboration between policy units and ministries to provide support rather than creating more stigma and harm. An IIBPA also importantly avoids individualizing the problem because the focus is on multiple levels (e.g., how the individual level links to the structural level), and instead situates mental health and trauma among Indigenous girls who have experienced violence within a broader context and acknowledges their resistance and agency at the intersection of colonialism, poverty, patriarchy, racism and discrimination, among other systems. As well, an IBPA within an Indigenous framework allows us to understand the diversity that exists within communities and cultures, and to support, through referral and advocacy, the use of local resources, capacity and strengths.

(4-5) Positioning agency as central, and acknowledgement of resistance

"Complacency is a far more dangerous attitude than outrage" (Littlebear, 1977, p. 36).

Indigenous women and girls have always resisted their colonial constructions within policy and media, and this resistance is an integral place to begin the development of an IIBPA. Such resistance takes diverse forms and is both individual and collective. For example, oral storytelling and other forms of storytelling, such as creative writing, have always been a political act and have provided an important space for Indigenous women to resist and replace colonial images with images of strength and agency (Armstrong, 1990). One example is the Memorial March that began on Valentine's day, 1991, in Vancouver's Downtown Eastside neighbourhood and has continued annually as an act of resistance by Indigenous and other marginalized women to "these acts of erasure" (Culhane, 2003, p. 593). As well, Culhane points out that staying alive is itself an act of resistance, an insight echoed by Cherokee scholar Andrea Smith (2006), who writes of the "dead Indian" and the attempt through the colonial project to erase the Indigenous body in order to clear the way for settlement.

Other acts of resistance are found in the work of Indigenous artists, such as Anishinaubae artist Rebecca Belmore. Belmore often displays and performs her art outdoors in public spaces. She states that "creating in the presence of the absent makes me a witness. I believe I am just beginning to understand my role, particularly as an artist who has inherited an Indigenous history" (Belmore, 2004, as cited in Deutsch, 2008, p. 70). One example is Belmore's piece "Vigil," which she performed on June 23, 2002 in the Downtown Eastside. As part of the performance she called out each missing or murdered woman's name while scrubbing the pavement and lighting candles. She then ate a rose and its thorns. Art and performance of this kind allow for a telling of lives lived in context, while at the same time creating new narratives of resistance where before there were only victims and statistics.

Resistance by Indigenous women does not only take aim at society's "whitestream," however. These women also hold their own communities and leadership accountable. After reading a news story about the murder of an Indigenous woman, Sarah Hunt (2011) wrote to National Chief Shawn Atleo:

> Half way through the article, I read the word "beheaded" and burst into tears, turning my face away from the screen. Apparently, I have reached a breaking point for my ability to hold these truths, as the years and generations of loss pile up on me. I wonder how is it that these ongoing losses, constant deaths, and unrelenting assaults, continue day after day without it being deemed a crisis. And why aren't First Nations leaders negotiating for a fundamental shift in approaches to ensure Indigenous girls' and women's safety, along with our economic development, resource use and treaties? Yes, National Chief Shawn A-in-chut Atleo, I am talking to you. (para. 4)

Another example of resistance is provided by Norma Peters, a Secwepemc Elder who has used local and international venues to address the issue of violence in her life and on her reserve. In 2010 she was a member of the Kamloops community group that successfully lobbied Kamloops Mayor and Council to make the city the first community in BC to name an Angel Street. The idea of Angel Streets began with Inuit Mayor Elisapee Sheutiapik, in Iqaluit, Nunavut, who sought to raise awareness of the issue of violence. Peters, together with other advocates and community members, chose to re-name the street leading from the village to the school an Angel Street "to send a strong message to the young people of their community about the importance of ending domestic violence." Their decision is both purposeful and symbolic in that it tells young people of their community and others that "we are all in this together and it is up to all of us to take action

to end domestic violence" (Secwepemc News, 2010). The Lesos (Angel) Street naming ceremony brought together Skeetchestn Elders, children, youth and community members to remember those impacted by violence in their community, as well as to honour the more than 600 missing and murdered Aboriginal women (Secwepemc News, 2010). In July 2011, Peters travelled to the International Women's World Conference in Ottawa to share her activism and her journey. Flying for the first time, she, together with this author and hundreds of women from around the world, marched on Ottawa to demand action on the issue of violence against Indigenous girls and women. Her poster proudly stated: "Marching for Skeetchesten First Nation." Stories such as this highlight how local Indigenous activists and policy makers can provide rich examples of changing norms around violence at the local level, and can impact policies at the national and international levels.

Meanwhile, the case study I have described demonstrates how Indigenous girls' resistance to their construction within the CYMH plan often leads to further labeling of the girls and/or criminalization of their resistance. For example, coping behaviours in response to trauma, such as self-harming, suicidal ideation and eating disorders are identified within both the CYMH and 10-year plan as critical areas to address; yet these issues are not connected to an understanding of trauma that is rooted in intersecting gendered, heteronormative colonial histories. Medical model approaches towards mental health issues further label and pathologize girls and also result in their criminalization and medicalization.[3] An IIBPA approach to policy would clearly situate the colonial context of violence and would not promote a medical model approach to trauma. Instead, it would require us to consider the question raised by Nadeau and Young (2006) of how "the language of deficiency and dysfunction reduces to personality traits or syndromes behaviours that have emerged as survival or resistance responses to oppressive conditions" (p. 89).

Ultimately, Indigenous girls and women continue to engage in ongoing acts of resistance to harmful policies that do not reflect their realities. Honouring this resistance is central to acknowledging Indigenous girls' agency in the development of an Indigenous intersectional-based policy analysis framework. Indigenous girls and women are the best guides for determining their own needs in this respect, as they are already engaging in daily acts of understanding, negotiating and pushing back against colonial policy.

[3] Policy and practice related to girls, trauma and violence have continued to medicalize girls and their coping, locating risk within the girls themselves. As others have noted (see Rossiter and Morrow 2011) this is consistent with research and practice in the area of adult mental health.

Building Transformative Policy Processes: Lessons from an Indigenous Intersectional-Based Policy Analysis

Returning again to the stories of individual Indigenous women, I would like to show how the work of one young Indigenous woman can illustrate the potential for building transformative policy processes using an Indigenous intersectional-based policy analysis. Jessica Yee founded the Native Youth Sexual Health Network, a national organization that addresses issues impacting Indigenous women in North America, including reproductive justice. Yee recently worked with the Native Women's Association of Canada on a project and film called the *Highway of Hope,* in response to the Highway of Tears. As Jessica Yee describes it:

two of the most powerful elements of Aboriginal culture are our youth and our traditions. Traditions strengthen and root our identity as a people. Children are revered as the most sacred of these beings. When grappling with one of the most devastating travesties in the history of violence against women in Canada, it is time to arm ourselves with enough youth and tradition to lead the way for healing, reconstruction, and hope. (Smith & Yee, 2009)

These powerful stories of resistance and hope speak to the silence in mainstream media and provide examples of both Indigenous approaches to healing and guidance to policy development. One of the principles of IBPA is inclusion of diverse knowledges, and indeed a central component of Indigenous epistemologies is local Indigenous stories and ceremonies. An IBPA informed by Indigenous frameworks would promote policy transformation that is inclusive of many forms of Indigenous knowledge, including Indigenous poetry and art, and the wisdom and knowledge of Indigenous Elders.

A recent policy statement developed by Jessica Yee (primary author) and the Native Youth Sexual Health Network provides a direct example of solidarity and coalition building across divergent interest groups, and a rich example of the transformative potential of IBPA within an Indigenous framework As well as centering sovereignty and cultural safety within policy processes, the policy states:

> Sexual and reproductive rights provide the framework within which sexual and reproductive health and well-being can be achieved. Within this framework, we take a gender-based, human rights approach to FNIM women's sexual and reproductive health, acknowledging but going beyond the Treaty rights and

constitutional obligations specific to First Nations and Inuit peoples. The sexual and reproductive health rights of FNIM women include the right to prevention, treatment, education, information, and privacy. They also include the right to:

- have timely, culturally safe, high-quality care
- decide the number and spacing of children
- rely on traditional knowledge and share in the benefits of scientific advancement
- make informed health decisions
- be free from harmful practices, including discrimination against two-spirit people, gender based and other forms of discrimination, and all forms of violence.
- (Society of Obstetricians & Gynaecologists of Canada, 2011)

This kind of policy statement offers hope because it builds policy communities composed of traditional policy stakeholders and groups who are typically marginalized in the policy process. In this case, Indigenous activist Jessica Yee worked with the Aboriginal Health Initiatives Sub-Committee and gained support from the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada, the Assembly of First Nations, the Canadian Federation for Sexual Health, Pauktuutit Inuit Women of Canada, the Native Youth Sexual Health Network, the Indigenous Physicians Association of Canada, the Canadian Association of Perinatal and Women's Health Nurses, the Canadian Association of Midwives, the National Aboriginal Council of Midwives, the College of Family Physicians of Canada, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and the Society of Rural Physicians of Canada. The potential for collaborations in policy formulation, implementation and evaluation is built into the IBPA Framework, particularly through questions about the transformative possibilities of policy. Further, in making sovereignty and cultural safety as well as Indigenous girls' and women's rights to their bodies central to policy processes, this statement points to the central importance of anti-colonial and Indigenous frameworks within IBPA processes.

Conclusion

As this chapter has demonstrated, although the CYMH plan (2003) and other policy directives, such as *Healthy Minds Healthy People* (2010), speak to the need for Aboriginal centred policy within mental health, these policy directives fail to consider and act upon such important variables as age, rurality, gender expression, experiences of trauma and

cultural difference, including the violence done through contact with multiple policy systems. What might the people who develop and implement these policies learn from Indigenous young women such as Jessica Yee, in working across various sectors to develop policies that adhere to the principles of an Indigenous IBPA?

By centring colonization, activism and sovereignty, IIBPA highlights how the intersection of policies at all levels—federal (funding), provincial (CYMH) and civic (transportation)—creates risk and contributes to violence against Indigenous girls in BC and Canada. To be consistent with IBPA principles it is crucial to centre the knowledge of affected Indigenous communities and support Indigenous researchers and policy makers whose work is grounded in Indigenous epistemologies. An IIBPA allows us to locate the source of Indigenous girls' challenges within structural and systemic problems, such as colonialism and neocolonialism that, in turn, provoke racism, poverty, sexism and the intersections of these in their lives. Finally, an IBPA within an Indigenous framework understands the diversity that exists within communities and across Indigenous cultures. It can therefore support the use of local resources, capacities and strengths, as demonstrated through the resistance stories of Angel Streets, the film *Highway of Hope,* and in individual Indigenous girls' stories, as represented in the case study.

Ultimately, there is a pressing need for an approach that recognizes how time, law, spirit and the past and current policies of colonization shape us all differently. I argue that the principles of IBPA together with the five elements of IIBPA provide a starting place for developing this theory. Until we acknowledge and reconcile the damage done through colonization, including through intersectionality theory itself, all critical theories must remain in service to Indigenous communities. This means placing nationhood and sovereignty at the centre of any IBPA, utilizing indigenous epistemologies and worldviews in their great diversity, and recognizing the relationships between humans and all of nature as equal and important sources of knowing. Indigenous activists like Jessica Yee, Sarah Hunt, Norma Peters, and my own work with Indigenous girls groups, together with Indigenous girls' stories of resistance are essential as examples of policy development and processes that resist colonial images of Indigenous women and girls and provide solutions rooted in the community and tradition while recognizing the complexity and diversity of these communities. Our work is already mindful of intersectional considerations and can be formally included in policy development by applying and drawing on IIBPA. Through examples like this we can move forward from the legacy of policies that created harm towards those that have the potential for transformation and equity.

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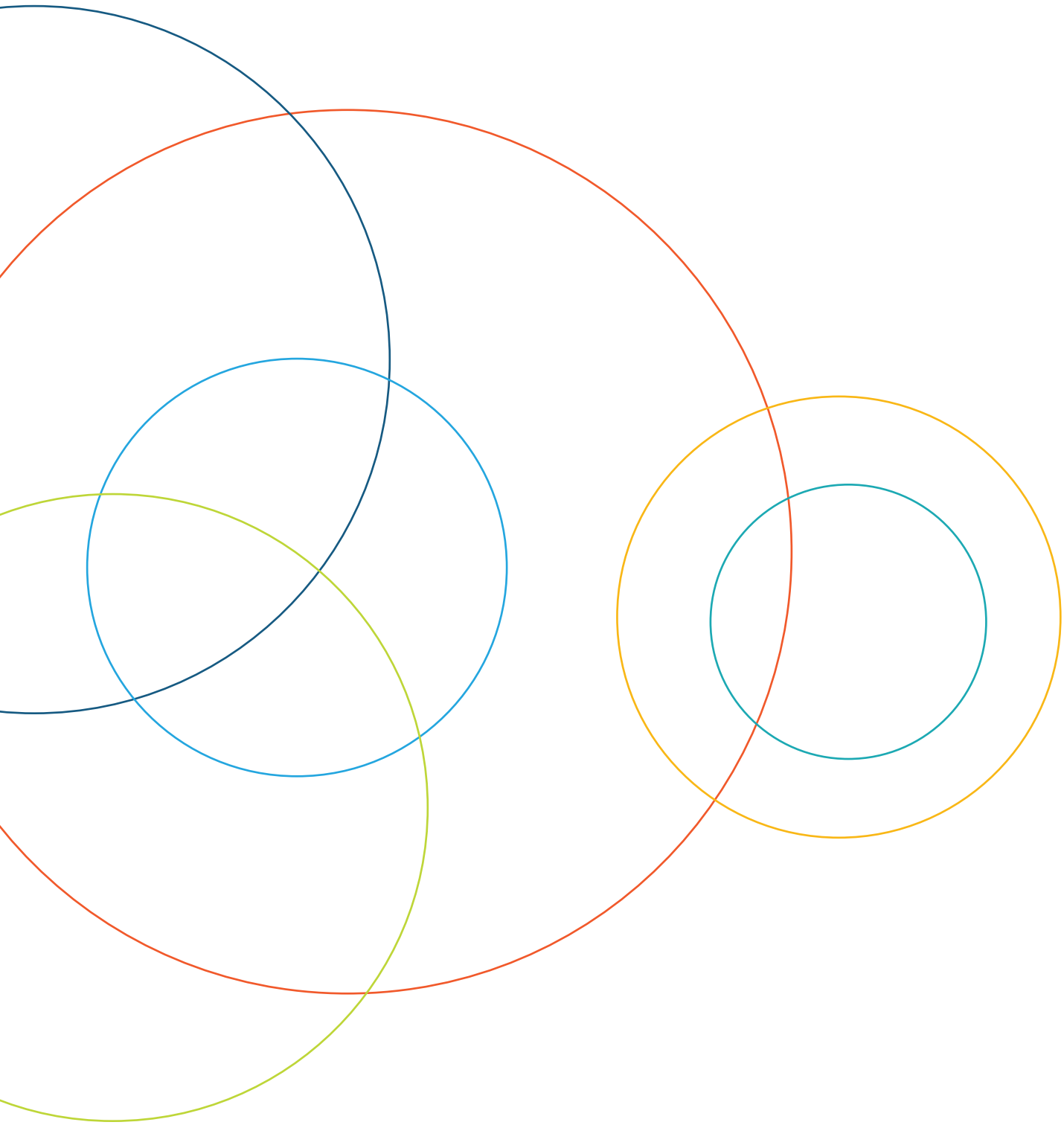

Reconceiving the 'Problem' in HIV Prevention: HIV Testing Technologies and the Criminalization of HIV Non-Disclosure

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Introduction

HIV testing technologies are evolving, and HIV-related criminal prosecutions are increasing. A new generation of HIV tests allows for much earlier detection of infection following the transmission event. HIV has an increased risk of transmission during the first eight weeks following infection due to greater infectivity in this very recent or acute phase (Brenner et al., 2007; Hayes & White, 2005; Hollingsworth, Anderson, & Fraser, 2008; Pao et al., 2005). As the Health Initiative for Men (HIM) puts it, HIV is "hottest at the start" (HIM, 2011). From a public health perspective, the importance of timely diagnosis during the acute phase is suggested from various data showing behaviour change following an HIV-positive diagnosis (Marks, Crepaz, Senterfitt, & Janssen, 2005). As such, the use of 'early' HIV tests has important public health implications for the detection of HIV and the prevention of onward transmission. This has been the rationale for using these tests in pilot programs to help address the high rates of HIV among gay, bisexual and other men who have sex with men (MSM)[1] in British Columbia (BC), Canada, as well as in other settings globally (Gilbert, Kwag, Steinberg, Grace, & Rekart, 2011). What has

[1] While I use the category of MSM in the paper due to its common application in the public health and epidemiological literature, I position it as highly problematic (Young & Meyer, 2005). My limited use of this behavioural category—used in HIV research since at least the early 1990s—is to capture men who do not identify as gay or bisexual (e.g., may identify as straight or heterosexual) but who have sex with men. It is important to consider the related conceptual challenge of non-identity categories, such as MSM, and what I call "identity-behaviour" intersections, such as Black MSM. Further, I argue that recent meta-analyses of HIV infection risk disparities among Black MSM (relative to other MSM) in Canada, the United States and the United Kingdom (Millett et al., 2012) offer much promise for understanding HIV transmission patterns but would benefit from intersectional thinking in order to more robustly account for the complex social and structural factors that produce differential vulnerability.

not been thoroughly examined, however, is the possible relationship between these innovations in laboratory technologies and related HIV testing initiatives and the increasing use of the criminal law to prosecute alleged cases of HIV non-disclosure in Canada.

Exposing or transmitting HIV to another person can increasingly be subject to criminal prosecution in many areas of the world (Grace, 2012; Pearshouse, 2008). In the Canadian context, researchers have noted the intensification of HIV non-disclosure criminal cases since 2004 (Mykhalovskiy & Betteridge, 2012; Mykhalovskiy, Betteridge, & McLay, 2010). A growing body of diverse policy actors argue that criminal approaches to disease control within and beyond Canada are highly problematic because they undermine public health efforts while creating a stigmatized viral underclass (Burris & Cameron, 2008; Eba, 2008; Elliott, 2002; Grace, 2012; Grace & McCaskell, in press; International Community of Women Living with HIV/AIDS, 2009; Jürgens et al., 2009; UNAIDS Reference Group, 2009; UNDP, 2012).[2]

Medical technologies have significant implications for policy, sexuality and the law. As such, it is important to bring into conversation these different, and at times conflictual approaches to HIV prevention and governance (e.g., targeted HIV testing technologies and the application of criminal law powers), which have remained largely discrete research and policy discussions to date, in order to elucidate how populations are impacted by such approaches to public health. I argue that both targeted HIV testing initiatives and the prosecution of alleged HIV non-disclosure cases ignore the structural drivers of the epidemic and problematically frame the 'problem' being addressed. While testing is an important albeit insufficient aspect of HIV-prevention efforts, the increasing trend towards criminalizing HIV non-disclosure cases in Canada poses significant problems in scaling up an effective national and provincial HIV response. This exploratory paper, which focuses upon HIV/AIDS responses in British Columbia, is informed by the Descriptive and Transformative Questions of an Intersectionality-Based Policy Analysis (IBPA) and considers policy issues and intersectional subject positions at the "medico-legal borderland"—a field of inquiry that "suggests multiple possibilities for analysis including investigation of new forms of social control, the intersection of criminal law and health care governance and the emergence of hybrid health/crime subjects" (Mykhalovskiy, 2011, p. 674; Timmermans & Gabe, 2003).In the first section of this paper I review the concept of intersectionality and argue that this paradigm offers an important critical perspective that can help researchers and policy actors understand complex health

[2] The Oslo Declaration on HIV Criminalization, prepared by international civil society in Oslo, Norway on February 13, 2012, has compiled relevant international resources in this field as part of their transnational advocacy, retrieved from http://www.hivjustice.net/wp-content/uploads/2012/02/Oslo_declaration.pdf. Also see information on a recent Canadian documentary addressing the issue of criminalization and HIV-positive women, retrieved from http://www.positivewomenthemovie.org/.

issues for diverse populations, including gay, bisexual and other MSM. Next, I explore two discrete though conceptually related public health issues by explicating the work of researchers and civil society who are addressing *the need to consider the science of Acute HIV Infection (AHI), HIV transmission patterns and new testing technologies* and *the danger in shifting to 'law and order' approaches that criminalize HIV non-disclosure cases in Canada*. I examine three major descriptive policy factors while reviewing the research evidence and public health work being conducted in these areas: (1) *What HIV-related 'problems' are being addressed*; (2) *The factors contributing to these representations* and (3) *The effects produced by these approaches* (Hankivsky et al., 2012, IBPA Section 1). With this review presented I focus on two additional considerations with a decidedly transformative thrust: (1) *Ways to improve these approaches to the problem and/or mitigate some of the possible harms caused by these approaches,* and (2) *Different approaches to thinking about addressing HIV/AIDS in and beyond the population of gay, bisexual and other MSM* (Hankivsky et al., 2012, IBPA Section 2).

By considering complex public health issues together using an IBPA Framework, key tensions can be identified *within* and *across* different approaches to HIV/AIDS prevention and governance. This analysis supports calls for the need to expand access to new HIV testing technologies in British Columbia in order to increase awareness of HIV positive status and detect cases of AHI so as to support prevention programs and enrollment into treatment programs; adapt existing prosecutorial guidelines to help eliminate or reduce the application of the criminal law to cases of alleged HIV non-disclosure in British Columbia; and meaningfully invest in HIV prevention efforts that address the structural drivers of the epidemic.

Method

This exploratory paper uses components of an IBPA to better understand the complex interplay between medical technologies and legal problems. For detailed information on the IBPA approach used within this paper see Hankivsky et al. (2012). The IBPA Framework includes a set of twelve overarching questions which may be adapted as needed to suit the specific policy field being addressed (Hankivsky et al. 2012). My use and modification of a subset of these sensitizing questions within this paper represents a first step in applying intersectionality to this complex issue which I locate at the "medico-legal borderland" (Mykhalovskiy, 2011; Timmermans & Gabe, 2003).

Throughout this analysis I make use of diverse data sources including various awareness campaign activities committed to supporting the health and human rights of people infected with and affected by HIV and AIDS in Canada in order to articulate the work ac-

tivities and arguments of this group of heterogeneous social actors. In doing so, I seek to make explicit the space from which this intersectionality-based inquiry begins: the commitment of this paradigm to supporting a social justice agenda (Dhamoon & Hankivsky, 2011; Hankivsky et al., 2012). In this paper I also draw upon qualitative research and policy analysis in this field with focused attention on the work of two Canadian studies: 1. Mykhalovskiy et al. (2010), who interviewed key informants in Ontario (n=53)[3]; and 2. Grace and MacIntosh (2010; MacIntosh & Grace, 2010), whose preliminary analysis begins to bring the science and law of HIV transmission into conversation vis-à-vis insights from HIV positive and negative gay men in British Columbia (n=55).[4]

This analysis is informed by my collaborative research experience with the Canadian Institutes of Health Research (CIHR) team in the study of acute HIV infection in gay men (2009-present). The research team is investigating the use of new HIV testing technologies, including nucleic-acid amplification testing (NAAT), for early HIV detection and response.[5] As part of a much larger research study, work with this interdisciplinary team has uncovered some of the ways in which the criminalization of HIV non-disclosure poses many challenges for people living with HIV/AIDS, public health practitioners and HIV researchers in British Columbia. For example, the experience of our team working with community partners reveals the ways in which conducting HIV research under the specter of criminalization poses many challenges and ethical concerns for researchers and community-based organizations (CBOs). Previous work and ongoing transnational research has also informed my thinking in this field and allowed access to key texts and empirical data used in this analysis (Grace 2012; Grace & Hankivsky, 2011; Grace & MacIntosh, 2010; MacIntosh & Grace, 2010).

Intersectionality and Sexuality

To begin, I define intersectionality as a theoretical approach and mode of inquiry that can help to illuminate and interpret complex systems of power, penalty and privilege (Crenshaw, 1991, 1997; Grace, 2010; Hankivsky & Christoffersen, 2008; McCall, 2005; Weber, 2001). Theories of intersectionality offer important challenges for HIV/AIDS researchers, social theorists, activists and policy actors when they seek to conceptualize categories and examine systems of inequity. In short, categories must not be reified and intersectionality is a sensitizing paradigm that allows one to make sense of complexity and difference in the everyday world. Researchers of intersectionality work to critically

[3] This included lawyers, medical health professionals, medical and mental health professionals and AIDS Service Organization (ASO) staff (n=25) and people living with HIV/AIDS in Ontario (n=28).
[4] n = the number of study participants interviewed in each cited study.
[5] The website for the CIHR Team in the Study of Acute HIV Infection in Gay Men, which includes published research and background information on AHI, is: http://www.acutehivstudy.com/.

explore the intersections of multiple axes and levels of oppression and privilege so as to elucidate aspects of identity, social difference and structural inequity (Winker & Degele, 2011). The simultaneous, interdependent interactions of factors such as gender (expression), sex, sexuality, 'race,' ethnicity, class, indigeneity, HIV-status, age and (dis)ability must be considered within the context of broader structures and systems of oppression, including, but not limited to, racism, sexism, colonialism and heterosexism.

This approach can critically expand upon social determinants of health research paradigms by paying focused attention to questions of power, history, complexity and relationality (Grace & Hankivsky, 2011). While subjective lived experiences of inequity must be accounted for, one must not lose sight of the complex structural conditions and power asymmetries that help to produce health disparities. The pathways to health inequity are not always straightforward, and a lens of intersectionality helps to foreground the urgency of attending to the messiness and complexity of the social world in order to provide richer and more accurate accounts that can inform evidence-based policy responses.

Intersectionality can help make visible the kinds of mutually constituting intersections that must be considered in complex policy fields. Theoretically expanding upon the oppression-focused "matrix of domination" (Collins, 2000), an IBPA demands that policy actors consider the complex, dialectical nature between systems of penalty and privilege and the individuals and groups who have intersectional standpoints along various social identities and lived actualities (e.g., racialized gay men). The concept of an "intersectional standpoint" (or intersectional subject positions) that I advance here builds upon the heritage of standpoint feminism and critical race theory in the work of Collins (Collins, 1998, 2000; Smith, 2004). I argue that rather than focus on the centrality of one unitary category to understand lived experience (e.g., women's standpoint; *see* Smith, 2004) intersectional standpoint brings into focus that multiple systems and social identities (e.g., gay men who are differentially raced and classed) simultaneously inform the place from which subjects view and experience the world—including their experiences of health policy.

Thinking about how we use categories of most-at-risk population (MARPs) in policy strategies—e.g., what groups like 'gay,' 'MSM' or 'Black MSM' may reveal and/or erase—is important in this field of inquiry. The policy effects of so-called 'behaviour' or 'epidemiological' categories, such as MSM and WSW (women who have sex with women), must also be considered. Young and Meyer (2005) discuss how the use of categories can lead to the erasure of sexual minorities, arguing that the "purportedly neutral terms" of MSM and women who have sex with women (WSW) are highly problematic insofar as "they

obscure social dimensions of sexuality; undermine the self-labeling of lesbian, gay, and bisexual people; and do not sufficiently describe variations in sexual behavior" (p. 1144). Furthermore, I agree with Hindman (2011), who argues that we must not fractionalize social groups by "treating formerly broad descriptive categories such as 'woman' or 'African-American' as smaller, internally-coherent empirical units" (p. 190). This is consistent with an IBPA approach, as IBPAs emphasize heterogeneity and context-specific analysis.

A limited amount of scholarship in this interdisciplinary field of intersectionality has explicitly addressed issues of sexuality and HIV status among gay and bisexual men (Meyer, Ouellette, Haile, & McFarlane, 2011; Taylor, Hines, & Casey, 2011). For example, in a recent critical review of intersectional theorizing, Hindman (2011) notes the conceptual complexity of dealing with questions of intersectionality:

> ...within LGBTQ political mobilization, in-group marginalization does not fall neatly along lines of race, ethnicity, or gender, though intersectionality has undertaken the important and significant task of shedding light on these imbalances. Beyond descriptive traits lie complex issues of desire, self-affirmation, in-group contestation, and individual and collective expectations, all of which coalesce to determine not only which people, but also which practices and which political interests comprise the group. The tortuous history of signification offers a powerful testament to the agonism, compromise, and complexity that characterize the discourse on LGBTQ sexuality. (p. 205)

IBPA has the potential to take intersectionality work on sexuality and HIV further because it requires that the discourse of policy 'problems' be critically analyzed; that groups who are adversely affected by dominant policy frameworks be identified; and that policy interventions that come from affected stakeholders be meaningfully integrated.

IBPA Part 1 (Descriptive): The 'Problem' Being Addressed, the Reason for this and the Effects of this Approach

I will now offer a discussion of two approaches to HIV prevention and governance. First, I review the use of new HIV testing technologies in British Columbia to detect AHI. This approach to HIV constructs the HIV-related 'problem' to be both high viral loads during early stage of infection (which leads to a significant proportion of new HIV infections), and high rates of HIV among MSM, with many being unaware of HIV-positive status.

Second, I discuss the context in which these tests are taking place: a climate of increased criminalization of alleged HIV non-disclosure. I argue that this criminalization approach to public health constructs the HIV-related 'problem' to be people living with HIV (PHAs) who do not disclose their HIV status to sexual partners, which puts these partners at risk of HIV infection. Table 1 acts as a summary of some of the key Descriptive Questions adapted from the IBPA sensitizing Framework: (1) *What is the 'problem' being addressed?; (2) How has this representation of the 'problem' come about?;* and *(3) What effects are produced by this approach to the 'problem'?*

Table 1: Descriptive IBPA Questions

Modified IBPA Questions, Section 1	*Targeted Testing for Acute HIV Infection*	*Criminalization of HIV non-disclosure*
What is the 'problem' being addressed?	*High viral loads during early stage of infection leads to significant proportion of new HIV infections* *High rates of HIV among MSM (with many being unaware of HIV-positive status)*	*People living with HIV (PHAs) who do not disclose their HIV status to sexual partners and put them at significant risk of HIV infection*
How has this representation of the 'problem' come about?	*Scientific advances in testing technologies that shorten the 'window period' between HIV transmission and being able to detect the infection* *Body of research on the significance of AHI to HIV transmission rates* *Provincial, national and international focus on biomedical solutions to HIV prevention*	*Sensational media stories construct ideas of many "evil," and "reckless" perpetrators who intend to transmit HIV* *NO research demonstrating efficacy of criminalizing non-disclosure in preventing HIV transmission* *Provincial, national and international trends demonstrate increasing criminalization of HIV non-disclosure*

Modified IBPA Questions, Section 1	*Targeted Testing for Acute HIV Infection*	*Criminalization of HIV non-disclosure*
What effects are produced by this approach to the 'problem'?	*Many positive effects from the viewpoint of detecting HIV infections earlier: demonstrated efficacy in detecting cases of HIV that would have been missed by other testing technologies1* *Limited access to new tests along lines of geography (only available in urban settings in Vancouver) and sexual behaviour (to gay, bisexual and other MSM)* *Need to secure funding to ensure continued access to tests at the end of the CIHR research project* *Increased community-based awareness campaigns of AHI and testing options for some key populations (must assess if knowledge is lower among some groups than others)* *Supports a biomedical-focused approach to HIV prevention in a climate of 'treatment as prevention' logic*	*NO positive effects from a equity and public health perspective* *Stigmatizes PHAs and leads to the social construction of criminals and victims along intersecting categories of 'race,' immigration status, gender and HIV status* *High rates of prosecution among racialized heterosexual men; trend indicating an increase in the prosecutions of gay men* *Creates a barrier for researchers and health service providers* *Confusion among PHAs of legal obligations to disclose HIV status and about the meaning of 'significant risk'*
	Criminalization of HIV non-disclosure stigmatizes PHAs and may serve as a deterrent to getting tested for HIV *Increased HIV testing and AHI detection could lead to increased HIV non-disclosure cases among specific populations, including gay, bisexual and other MSM* *Both of these approaches to HIV prevention and governance ignore the structural drivers of the epidemic*	

Acute HIV infection and HIV testing: "Hottest at the start"

Growing evidence strongly suggests that a significant proportion of all new HIV infections arise from individuals with acute HIV infection (AHI) who have very recently acquired the virus. During this stage of infection, persons with AHI may be up to 26 times more infectious compared to those in later stages of infection (Hollingsworth et al., 2008). Research explicates that depending on the stage of the epidemic, partner concurrency and the rate of partner change, between 11-49% of new HIV infections may occur during this approximately 8-week period of "hyper-infection" (Brenner et al., 2007; Hayes & White, 2005; Pao et al., 2005). This knowledge, coupled with an awareness of the high concentration of HIV among gay, bisexual and other MSM in British Columbia has led for calls to raise awareness of AHI among this heterogeneous group of men.

The Health Initiative for Men (HIM) has developed a useful summary of salient health information that gay, bisexual and other MSM in British Columbia should know about AHI and HIV testing. The key points they highlight help to elucidate the work of community organizations trying to translate complex health messages to publics in accessible ways.[6] The accompanying public health campaign—featuring advertisements on free condom packs, magazines, bathroom stalls, bus shelters and online—explains that HIV is "hottest at the start" and a "powerhouse in the sack" in the early stages of infection.

This campaign has been partially informed by qualitative research conducted with gay men in Vancouver and Victoria (Grace & MacIntosh, 2010; MacIntosh & Grace, 2010). Among other factors, the intersections of age, geography (living in urban or rural parts of the province) and HIV status were important categories for MacIntosh and Grace. For example, their analysis points to different knowledge levels of HIV prevention and testing access according to these intersectional factors. This qualitative research has also highlights the confusion for many gay men in the meaning of different HIV testing terminology (e.g., 'rapid' HIV tests versus 'early' HIV tests) and window periods (e.g., how long one has to wait after a risk event to get tested for HIV) (Grace & MacIntosh, 2010; MacIntosh & Grace, 2010). MacIntosh and Grace (2010) argue that many gay men appear to be "waiting out the window": waiting 3-6 months after a risk event based on outdated information about HIV testing windows.[7] Knowledge translation and exchange (KTE), along with a commitment to developing feasible short, medium and long-term solutions, is central to the transformative commitments of an IBPA. This is a small example of the collective efforts of researchers to work in ways consistent with the paradigm of

[6] For more information on this campaign, including HIM's key messages on AHI, visit: http://checkhimout.ca/hottest/.

[7] This research has also informed other public health outreach activities, including working with AIDS Vancouver Island (AVI) and HIM in 2010 to conduct awareness campaigns in gay bars in Victoria, British Columbia.

intersectionality through ongoing collaborations with CBOs to help have best available evidence inform HIV testing and prevention activities in the region.

It is important to recognize the many positive effects of new testing campaigns from the viewpoint of detecting HIV infections earlier. For example, researchers have demonstrated efficacy in detecting cases of HIV that would have been missed by other testing technologies (Gilbert et al., 2011). However, limited access to new tests along lines of geography (only being available in urban settings in Vancouver) and sexual behaviour (only to gay, bisexual and other MSM) must be further considered through the lens of intersectionality. Securing funding to ensure the continued availability of tests is also required. Finally, as already discussed, it is important to acknowledge the extent to which this testing initiative supports a biomedical-focused approach to HIV prevention in a climate of 'treatment as prevention' logic in and beyond British Columbia.

The criminalization of HIV non-disclosure: "The creep of criminalization"

In 1998 the Supreme Court of Canada found that a man from British Columbia was guilty of assault (including sexual assault or aggravated sexual assault) for not disclosing his HIV-positive status before having sex where a significant risk of transmission existed. The *Cuerrier* decision created precedence for other HIV non-disclosure cases across Canada, as the Criminal Code is federal law (Betteridge, 2009; Canadian HIV/AIDS Legal Network, 2011). In Canada one does not need to transmit HIV to be charged; only the "significant risk" of transmission through exposure to the virus must be determined. Much has been written about the confusion in the current legal landscape in Canada, including under which circumstances a person must disclose one's HIV-positive status (Betteridge, 2009; Symington, 2009). For example, while vaginal and anal intercourse without a condom seems to meet the "significant risk" of transmission test set out in *Cuerrier,* many ambiguities exist regarding disclosure obligations when condoms are used, viral loads are low, and/or the sexual behaviour has a low risk for transmission (e.g., oral sex).[8] At present, British Columbia's attorney general has a four-page policy manual related to HIV transmission with its section on aggravated sexual assault citing the *Cuerrier* decision.[9]

[8] Betteridge (2009) explains that people may even have a duty, under existing interpretations of *Cuerrier,* to disclose their possible HIV-positive status if "the person knows there is a real possibility that he or she has HIV (but has not received an actual HIV-positive test result" (para. 4).

[9] A recent article in the gay and lesbian newspaper *Xtra!* reviews why key policy actors believe new HIV guidelines are needed for BC prosecutors (Christopher, 2011). See Grace and McCaskell (in press) for further information on HIV activism in this field.

A significant intensification of HIV non-disclosure criminal cases in Canada has been observed since 2004 (Mykhalovskiy & Betteridge, 2012; Mykhalovskiy et al., 2010). From 1989-2009, 98 individuals in Canada were charged with criminal offenses (resulting in 104 charges) related to HIV non-disclosure (Mykhalovskiy et al., 2010; *see* Grace & Macintosh, 2010). By September 2011 this number had risen to more than 120 PHAs being charged.[10] An escalation in the severity of charges laid, media attention to criminal HIV cases and overall anxiety and debate within the "HIV community" has also been observed in Canada (Larcher & Symington, 2010, p. 3; Grace & McCaskell, in press). British Columbia has the third highest number of people being charged in HIV non-disclosure cases after Ontario and Quebec (Mykhalovskiy et al., 2010, p. 10; Mykhalovskiy & Betteridge, 2012). The figures presented below provide some descriptive statistics of British Columbia cases of HIV non-disclosure by sex (Figure 1) and by the intersecting categories of sex and ethnicity (Figure 2). While some of the data on ethnicity is missing or unavailable, this previously unpublished information on British Columbia charges may point to a disproportionally high number of Black men being charged in non-disclosure cases, echoing trends in the rest of the country. For example, Mykhalovskiy et al. (2010) discuss the large number of charges against Black heterosexual defendants in Ontario and argue:

> Understanding the large number of recent cases involving Black male defendants requires careful consideration of the sexual cultures in which they participate and the organization of HIV non-disclosure therein. It also requires a deeper understanding of how police and Crown prosecutors respond to Black male defendants. (p. 13; *see* Larcher & Symington, 2010)

Current advocacy work related to HIV non-disclosure is focusing on how racialized men are being constructed as 'criminals' in Canada (Larcher & Symington, 2010; *see* Davis, 2007) and why the criminalization of HIV non-disclosure may be particularly dangerous for women in the context of Sub-Saharan Africa (Armien, 2008; Open Society Institute, 2008; Grace, 2012).[11]

[10] For updated information on Canadian non-disclosure charges and material on HIV/AIDS and the law, see www.aidslaw.ca.

[11] For more information on the 10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women, visit: www.athenanetwork.org/assets/files/10%20Reasons%20Why%20Criminalisation%20Harms%20Women.pdf

Figure 1: HIV non-disclosure cases in British Columbia disaggregated by sex.[12]

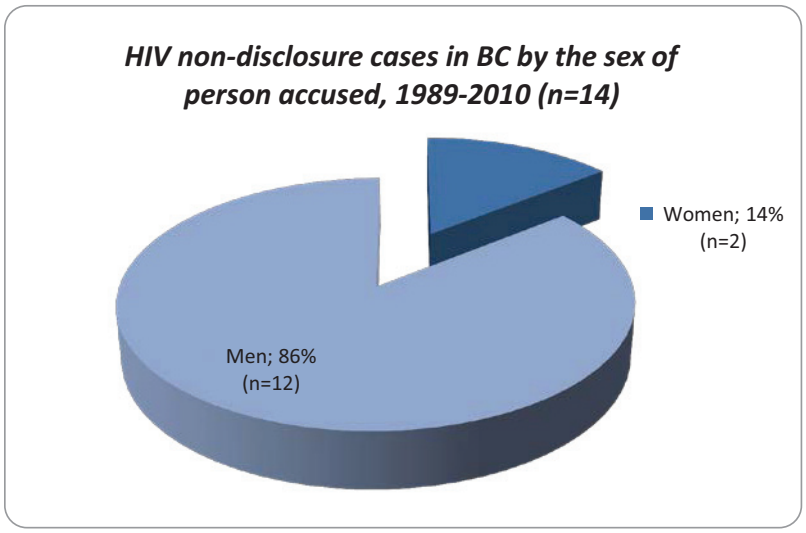
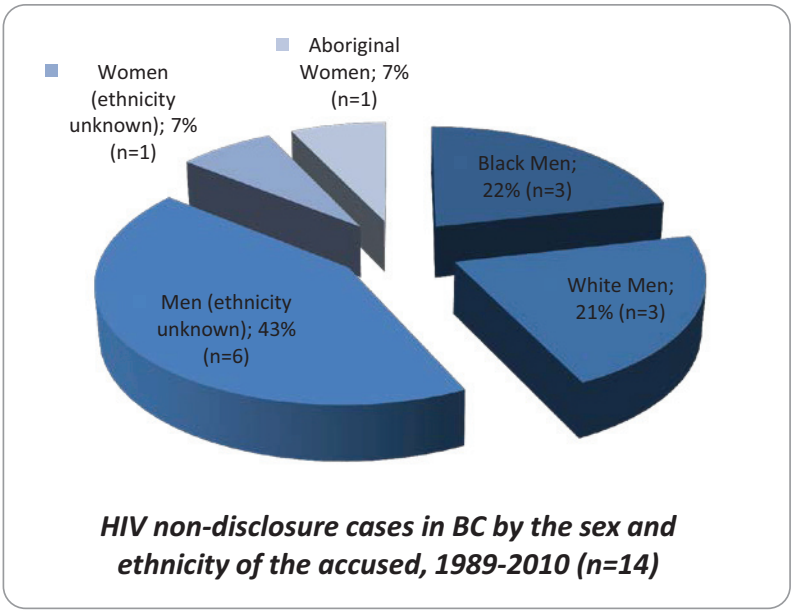


Figure 2: HIV non-disclosure cases in British Columbia disaggregated by sex and ethnicity[13]



[12] Data provided by Betteridge & Mykhalovskiy (2011).
[13] Data provided by Betteridge & Mykhalovskiy (2011).

The majority of defendants in British Columbia have been cases where men have been charged with not disclosing their status to women (n=11). To date there has only been one known case of a man not disclosing his status to a same-sex sexual partner (n=1; 2 cases unknown) (Betteridge & Mykhalovskiy, 2011). However, analysis of recent demographic patterns reveals an overall increase in Canada with respects to the number of criminal cases involving gay or bisexual men being accused of HIV non-disclosure (Mykhalovskiy et al., 2010, p. 13).

Drawing on research with PHAs and service providers in Ontario, Mykhalovskiy (2011) has contributed to the scant empirical data in this field finding:

> (1) the concept of significant risk poses serious problems to risk communication in HIV counseling and contributes to contradictory advice about disclosure obligations;
> (2) criminalization discourages PHAs' openness about HIV non-disclosure in counseling relationships; and
> (3) the recontextualization of public health interpretations of significant risk in criminal proceedings can intensify criminalization. (p. 668)

This research makes explicit the unintended consequences of discursive vagueness and relates to proceedings currently before the Supreme Court of Canada (cases from Manitoba and Quebec) where the issue of "significant risk" is central.[14] Further, the above points build upon the descriptive statistics presented earlier (Betteridge & Mykhalovskiy, 2011) and the work calling for a review of policy options in Ontario (Mykhalovskiy et al., 2010; Grace & McCaskell, in press).

Research by Grace & MacIntosh (2010) has focused on the knowledge and concerns of HIV-positive and HIV-negative gay men related to AHI and the criminalization of HIV non-disclosure. The qualitative component of this research project involved 55 face-to-face interviews conducted during the spring and summer of 2009 in British Columbia. A portion of these informants (n=23) specifically discussed concerns about the criminalization of HIV exposure and/or transmission in the Canadian context. Few men were aware of the increased risk of HIV transmission during the early phase following infection, or of innovations in HIV testing technology that can shorten the 'window' between HIV infection and detection. As respondents discussed issues related to the criminalization of HIV non-disclosure in Canada, themes of responsibility and intersectional stigmas, and questions regarding the meaning of "significant risk" and legal repercussions of

[14] Supreme Court of Canada. Court File Nos. 33976/34094. Her Majesty the Queen and Clato Lual Mabior, and Her Majesty the Queen and D.C.

non-disclosure to sexual partners dominated the men's narratives. Men articulated both why disclosure of one's HIV status is important and how it can be highly problematic to disclose. Just as men sought to have the science of AHI explained, many men discussed knowledge gaps and ambiguities related to HIV legal issues and AHI.

When specifically discussing legal issues and practices of HIV disclosure, three main themes emerged from the qualitative interviews regarding why the disclosure of one's HIV-positive status to (potential) sexual partners is problematic. First, many men do not know their HIV status, or they may be in denial of their HIV-positive status. Second, practices of disclosure—such as the language used between men when discussing their HIV-status, or the meaning of using or not using condoms—can be unclear or misunderstood. For example, men highlighted how the language used between potential sexual partners can be confusing. One man explained that a lot of men say—online or in person—that "I'm safe" or "I'm clean." This man questioned what such utterances may camouflage: "'I'm clean'—what does that mean?....and a lot of guys will go with that word" [47 year old, HIV negative]. Work by the HIV/AIDS Legal Clinic Ontario (HALCO) supports how disclosure of HIV status may be confusing or misread by sexual partners (2008, p. 22). Betteridge (2009) puts it this way: "If you are going to disclose your HIV status to your sex partner, make it count. Avoid code words or hints like 'poz' and 'positive'" (para. 5). Third, the appropriate method by which to record how and when someone discloses their status to sexual partners was seen as unclear or unrealistic by many men (Betteridge, 2009; HALCO, 2008).[15] An IBPA demands that this kind of knowledge is included within the policy process in order to better understand how that which may be conceived of as simple in a policy (e.g., disclosure of HIV status) is rendered complicated by the contingencies of everyday life.

Finally, the extent to which "intersectional stigmas" may be produced due to mutually informing epidemics—*or syndemics*—of HIV, criminalization and heterosexism is worth interrogating. I argue that the concept of "intersectional stigmas" can allow researchers and policy actors to understand unintended policy effects and unpack the ways in which HIV stigma intersects and co-constitutes other kinds of socially constructed (criminalization-related) stigmas and related structural opportunities for political participation. For example, Berger (2004) explicates how stigmas intersect within social structure among HIV positive and negative female sex workers and drug users: "Their experience of stigma that incorporates sexuality, race, class, and gender helps us to ascertain their unique responses to their struggle en route to political participation" (p. 30). Early HIV research also noted the relative privilege of white, middle-class gay men, who had more

[15] HALCO goes as far as suggesting a disclosure declaration or contact be signed prior to sex—a text-mediated disclosure practice that will unlikely have much uptake in or beyond the gay community (HALCO, 2008, p. 24).

economic and cultural capital than other infected groups, including those within other gay and lesbian, bisexual and transgendered networks (Epstein, 1991). Current intersectionality research addressing funding regimes of gay men's health calls into question the extent to which researchers, CBOs and ASOs have been able to gain the material and economic resources to effectively mobilize a proportional response to the state of the HIV epidemic in British Columbia for gay, bisexual and other MSM (Ferlatte, 2012; *see* Aguinaldo, 2008). Policy actors must consider the extent to which policy approaches can meaningfully address intersectional stigmas and inequities, promote social justice and not reinforce stereotypes, biases, or produce further inequities.

IBPA Part 2 (Transformative): Possible Improvements to Current Approaches and Other Ways of Addressing the Public Health Issue

Emerging research, primarily based in the United States, the United Kingdom and Canada, is making clear the many problems with trying to prevent the spread of HIV within a culture of increased criminalization (Adam, Elliot, Husbands, Murray, & Maxwell, 2008; Burris, Beletsky, Burleson, Case, & Lazzarini, 2007; Dodds, Bourne, & Weait, 2009; Galletly, DiFranceisco, & Pinkerton, 2009; National Aids Trust, 2011). Building on the analysis already provided, and through the lens of IBPA, I now offer an overview of some possible ways to improve these existing approaches to the 'problem', as well as potential ways to think about this public health issue differently, including the need to address structural drivers of the epidemic and understand the relationships across medical and legal state apparatuses. Table 2 addresses two additional IBPA questions in order to synthesize some of the key transformative tensions within and across the two public health approaches reviewed: (1) *What needs to be done to improve this approach to the 'problem'?* and (2) *Can the 'problem' be thought about differently and what are the structural and political challenges in doing so?* I build upon material presented in Table 2 in the discussion that follows by paying focused attention to calls for prosecutorial guidelines that would reduce or eliminate the use of the criminal law in alleged cases of HIV non-disclosure.

Table 2: Transformative IBPA Questions

Modified IBPA Questions, Section 2	*Targeted Testing for Acute HIV Infection*	*Criminalization of HIV non-disclosure*
What needs to be done to improve this approach to the problem?	*Wider and continued availability of tests to detect AHI (ensure all people who could benefit have access to the test by removing barriers such as geographic availability)* *Continued partnerships and support of CBOs and ASOs* *Continued medical and psychosocial support of newly infected persons (this includes giving clear information about the state of the science and the law, including the disclosure responsibilities of PHAs)*	*Greatly reduce the application of the criminal law to cases of HIV non-disclosure, recognizing that only in exceptional cases does the law have a role to play (e.g., where intentional and successful HIV transmission actually occurs); follow key international policy guidelines (UNAIDS/UNDP, 2008; UNDP, 2012)* *Support calls to develop prosecutorial guidelines (Crown Council Policy Manual) at the provincial level to define the scope of the law and clarify the meaning of 'significant risk' based on best available scientific evidence; engage with civil society groups and PHAs in this process* *Responsible reporting by police and media outlets that does not stigmatize people in alleged HIV non-disclosure cases*

Can the problem be thought about differently?	*Understanding HIV transmission requires attending to the broader social and structural conditions which produce differential vulnerabilities for infection* *This way of approaching the problem is compatible with a critical social determinants of health perspective and places emphasis on equity, social justice, complex power relations and the context-specific nature of HIV risk and resilience*
What are the structural and political challenges of doing so?	*Canadian and international public health funding largely focused on biomedical approaches to HIV prevention* *Narrow policy focus on the risk behaviours of individuals and groups* *Stigma around HIV and other intersections of vulnerability (e.g., sexual orientation, gender expression, sex work, drug use)* *Financial constraints and competition for limited resources* *The need to both fund and make use of research in policy making (including qualitative, mixed-methods and community-based research) to better understand the unique needs of populations along diverse intersections of vulnerability*

Intersectionality adds necessary complexity when considering issues of sexuality, science, HIV/AIDS, public health and the law. Policy actors must address questions of relationality and complexity so as to account for the broader conditions in which health differences are organized. The IBPA Framework used in this preliminary analysis may help to spark such critical policy thinking. We must find ways to safeguard all people from the potential social and legal ramifications of an acute HIV diagnosis, including those with heightened vulnerability due to their intersectional subject positions. On a related front, we can also see the use of intersections and the social determinants of health language becoming mainstreamed in global HIV/AIDS texts such as a recent UNAIDS report in which the authors emphasize the need to address a confluence of intersecting factors related to HIV vulnerability:

> The intersection between social exclusion, inequality and HIV risk underscores the need to address the epidemic's social dimensions. Without courageous action to alleviate the social roots of HIV risk and vulnerability, it will be impossible to reach global HIV goals. (UNAIDS, 2011, p. 38)

More research is needed to examine the relationship between new HIV testing technologies and the criminalization of HIV non-disclosure and intersectionality-informed analysis may be helpful in this work. For example, while the gay men interviewed in Grace & MacIntosh's (2010) analysis had much expert knowledge to share, many expressed a lack of knowledge regarding AHI, new HIV testing technologies and the specifics of how criminal law is being applied to cases of HIV non-disclosure in Canada. These knowledge gaps point to areas were increasing the health and legal literacy of gay, bisexual and other MSM could support community and public health goals. The relationship between criminalization and access to treatment, care and support must also be further examined. As Mykhalovskiy (2011) has argued:

> In a perverse fashion, rather than promoting openness, criminalization has made it more difficult to provide meaningful HIV prevention counseling and support about HIV non-disclosure. While the use of the criminal law may be warranted in some circumstances, the expansive use of a vague legal concept of significant risk does little good either for preventing HIV transmission or for the credibility of the criminal justice system. (p. 675)

Further research is also required to explore other related issues of criminalization and HIV testing technologies, including the complex field of phylogenetic analysis, which considers how two or more HIV strains are related (NAT, 2011).

The work of organizations such as HIM, among others, must continue to be supported, as they are working to raise awareness of HIV and AHI in British Columbia alongside efforts to support sex-positive messaging that targets determinants of health, such as heterosexism. For example, HIM has spearheaded campaigns that address broader determinants of gay men's health and recognize the role of the law as one distal determinant. HIM launched the "Vancouver/*Fabulous since 1969*" campaign during the 2010 Olympics, which included posters reading: *"Gay love has been legal in Canada since 1969, protected by the Constitution since 1992 and celebrated with marriage since 2005"*.[16] Focusing only on biomedical solutions to HIV can risk framing the 'problem' of HIV trans-

[16] For more information about this and other HIM campaigns, visit: http://checkhimout.ca/. It is also worth noting that employees and volunteers of HIM have been a part of discussions about intersectionality (e.g., reading group meetings, special guest lectures) hosted by the Institute for Intersectionality Research and Policy (IIRP) at Simon Fraser University.

mission as one that exists only at the individual level of risk, rather than focusing on the structural conditions that produce differential risks along complex intersections of social identity and location. While the law can support health equity, it can also play a highly problematic role in criminalizing PHAs, creating stigma and negatively impacting population health (*see* Aguinaldo, 2008; Burris, 2011; UNDP, 2012).

In the context of large-scale efforts to increase HIV testing in Canada, a growing number of groups have worked to articulate why the criminalization of HIV non-disclosure is a problem in Canada. For example, *AIDS ACTION NOW!* along with more than a dozen ASOs has supported the call of the *Ontario Working Group on Criminal Law and HIV Exposure* (CLHE) to ask for prosecutorial guidelines for cases of HIV non-disclosure, believing that:

> Guidelines are needed to ensure that HIV-related criminal complaints are handled in a fair and non-discriminatory manner. The guidelines must ensure that decisions to investigate and prosecute such cases are informed by a complete and accurate understanding of current medical and scientific research about HIV and take into account the social contexts of living with HIV. (CLHE, 2011, p. 1)

Like HIM's aforementioned work on AHI, this campaign has endeavoured to translate key issues in accessible and actionable ways while making use of the best available, albeit limited, criminalization-related scientific evidence in the Canadian context (Grace & McCaskell, in press).[17] This awareness campaign is part of the work of a growing community of transnational actors focusing on issues of justice and equity in order to raise attention to why the criminalization of HIV non-disclosure is problematic (Larcher & Symington, 2010; Grace, 2012).

ASOs and advocacy groups are working to consider how the blunt force of the criminal law is both ineffective and may be increasingly dangerous for some subsets of the population, within and beyond the Canada context. I argue that applying the lens of intersectionality is a natural extension of the kind of thinking and advocacy that many ASOs and community groups are conducting as part of their efforts to problematize the application of the criminal law to cases of alleged HIV non-disclosure. To date, the initiatives I cite have not explicitly invoked the language or paradigm of intersectionality, and more research is required in this field to better understand how systems of penalty and privilege may result in differential impacts and applications of the criminal law and experiences of intersectional stigma.

17 For more information on this campaign, visit: http://www.aidsactionnow.org/?p=349.

Echoing calls in Ontario for prosecutorial guidelines, Positive Living BC chair Glyn Townson recently explained the need for such a text in British Columbia: "The bottom line is we want everyone to have an enjoyable, full sex life, and making criminals out of people for natural human behaviour is a little bit problematic" (*quoted in* Christopher, 2011, para. 2). Thinking about this issue from an intersectional perspective, policy actors must also question the extent to which some intersectional subjects may be more likely to be criminalized and stigmatized by increasing targeted testing practices, prosecutions and media spectacle. The shortened window period between a risk event and positive test result also makes it increasingly likely that people have a better idea of how they were infected with HIV and who may have infected them. The extent to which this may lead to increased charges within the gay community is unknown. While biomedical solutions to HIV prevention and treatment are important, the current (dominant) logic of *treatment as prevention* does little (if anything) to address the social and structural determinants of heath for sexual minorities, including gay, bisexual and other MSM. In fact, structural factors, including the criminalization of HIV non-disclosure, support systems of oppression, marginalization and health disparity. Rather than simply posit gay, bisexual and other MSM as homogeneous MARPs, policy actors must consider both the heterogeneity of this population and the role of distal systems of privilege and penalty in Canada. Such work requires that complex, historically situated factors, including, but not limited to, colonialism, heterosexism, capitalism and patriarchy be meaningfully considered as part of the HIV response, and IBPA promises a rich resource to address these specificities and complexities.

Conclusion

Policy analysis, argues Fischer (1987), "lies squarely (if uncomfortably) between science and ethics" (*cited in* Kenny & Giacomini, 2005, p. 257). It is at these co-constituting, sometimes uncomfortable intersections that an IBPA is conducted: analyzing the social constructions of policy problems and the empirical actualities of inequity through a critical paradigm that remains committed to a set of ethics of equity, social justice and rigorous empirical inquiry. These normative ethics—"what ought to be done in specific circumstances" (Kenny & Giacomini, 2005, p. 253)—demand that policy actors foreground their commitments and values in order to realize the transformative potential of an IBPA. Currently in its nascent stages of application to this complex health field, more work is needed to consider the extent to which the research paradigm of intersectionality, and an IBPA Framework specifically, can be used effectively to address the specific health needs of heterogeneous groups who have disproportionally high rates of HIV infection, including gay, bisexual and other MSM. For example, recent conference and meeting presentations in British Columbia have worked to begin a dialogue with civil

society, researchers and policy actors about the limits and possibilities of intersectionality in the field of gay men's health (Hankivsky, 2010; Grace & Hankivsky, 2011). However, it is important to acknowledge that this paradigm of analysis is but one way to understand the complex policy field under investigation and should be complemented by other critical social science literature including that which attends to the public health implications of shifting sexual landscapes and 'technologies of risk' for gay men (Race, 2001). For example, Kane Race's scholarship in this field is consistent with the focus within an IBPA on questions of power, politics and problem definition:

> If, as Foucault argued, political technologies advance by reframing what is essentially a political problem in the neutral language of science (Dreyfus and Rabinow, 1982: 196), then we must attend to the power effects of the seemingly neutral – but undeniably useful – technologies of medicine, if we are to respond effectively to HIV/AIDS (2001, pp. 168-169).

Calls have also been made to recognize the value and urgency of integrating intersectionality, along with other theories, such as the minority stress model, life course perspective and social ecology perspective, into research and policy approaches that address the needs of LGBTQ communities (Institute of Medicine, 2011). While this attention to questions of intersectionality and sexuality represents an exciting development reflective of critical thinking within this field, I caution that the operationalization of intersectionality by the Institute of Medicine as a perspective that examines "an individual's multiple identities and the ways in which they interact" risks obfuscating important discussions of power, history and social structure central to this mode of inquiry and recasting the discussion of LGBTQ health as one of identity politics removed from sustained considerations of structural disadvantage (Institute of Medicine, 2011, p. 2). The mainstreaming of intersectionality in policy and research discussions is exciting, but principles of equity, power, social justice and the multi-leveled nature of the issues being addressed must not be lost along the way (Hankivsky et al., 2012). As Dhamoon (2011) urges, "in the process of mainstreaming intersectionality, it is crucial to frame it as a form of social critique so as to foreground its radical capacity to attend to and disrupt oppressive vehicles of power" (p. 230).

Rather than predetermine all of the social determinants of HIV transmission, intersectionality demands that researchers remain open to the process of discovery when considering complex, intersecting proximal and distal factors. The same is true for policy actors as they critically engage in the process of an IBPA and work to consider equity-focused solutions to the problem of HIV transmission. While much focus has been placed on the public health implications of low viral load in a so-called 'post-AIDS' era

(Dowsett & McInnes, 1996), this analysis signals the need for further reflection on the implications of utilizing new testing technologies that detect HIV infection when viral loads are at their highest. The wide availability of new HIV testing technologies that can detect AHI must be welcomed alongside an increased focus on the structural drivers of the epidemic that produce differential vulnerabilities depending on one's intersectional standpoint and a sustained consideration of the social context in which technologies are being implemented including the state's legal climate. No evidence exists that the use of the criminal law will prevent HIV transmission in Canada. Instead, the criminalization of HIV non-disclosure poses a range of public health challenges and may even serve as a deterrent to people coming forward for HIV testing, including for new testing technologies capable of detecting AHI. Current efforts to support the creation of prosecutorial guidelines as a harm reduction strategy to limit the application of the criminal law in Ontario underscore the need for such guidelines to be revised in British Columbia in order to clarify disclosure obligations for PHAs and mitigate the stigmatizing, dangerous and overly broad use of existing criminal law powers.

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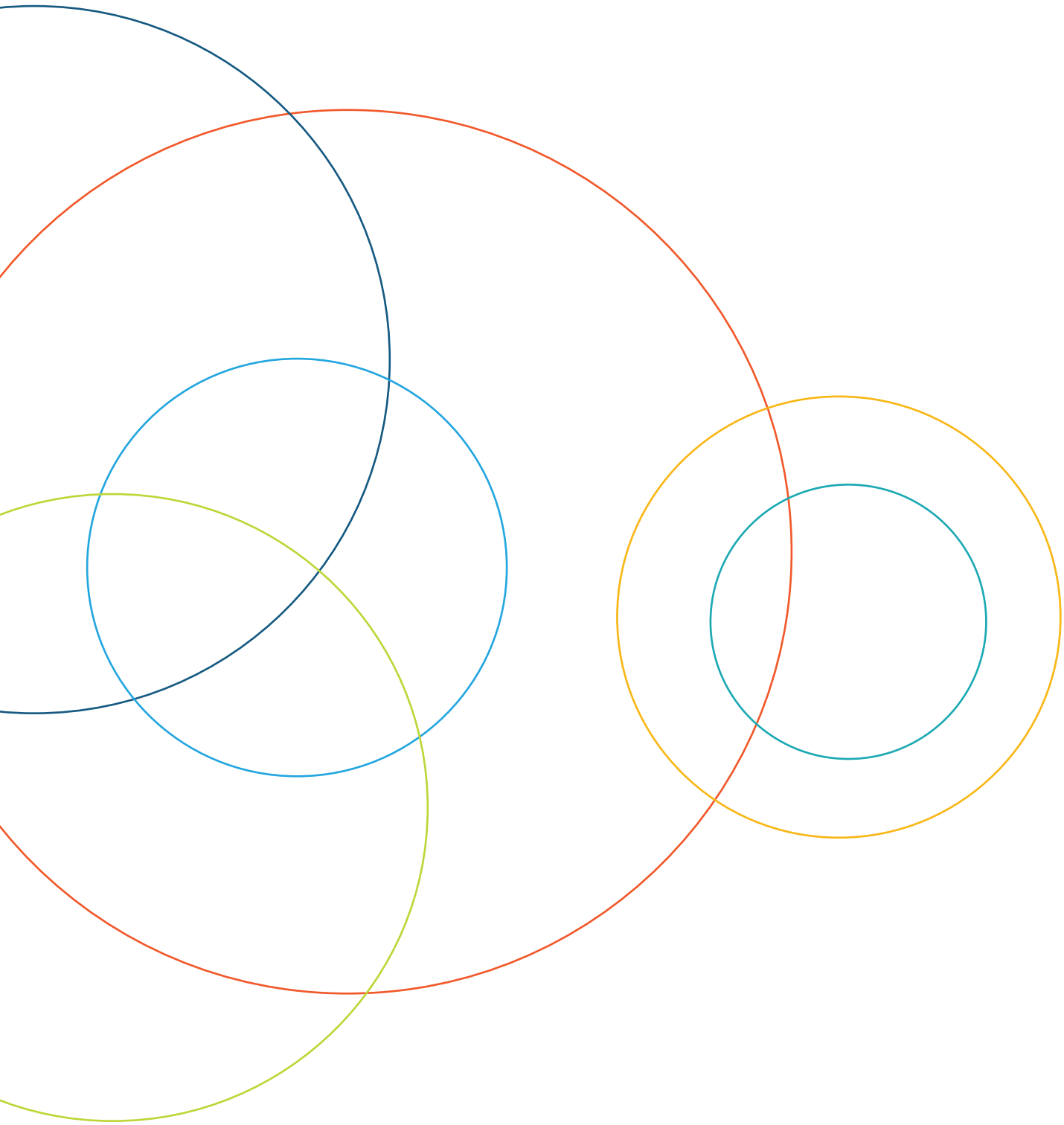

Are There Enough Gay Dollars? An Intersectionality-Based Policy Analysis of HIV Prevention Funding for Gay Men in British Columbia, Canada

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Introduction

For three decades, British Columbia's (BC's) gay men and other men who have sex with men (MSM) have remained a key population that continues to be dramatically impacted by HIV. While the prevalence of HIV is estimated to be 0.09% (1 in 1,000) in the general population (McInnes et al., 2009), among gay men in the city of Vancouver it is 18.1% (1 in 5) (Trussler et al., 2010). And while BC's gay population is estimated to be roughly 2% of males (Statistics Canada, 2004), it has accounted for at least 40% of new HIV cases each year for the last decade (BC Centre for Disease Control [BCCDC], 2009). Despite this disease burden, policies that might have supported interventions to prevent infections in gay men and MSM have fallen short, and health investments have failed to reflect the epidemiology of HIV in the region.

Indeed, an environmental scan conducted for the BCCDC in 2001 showed that, of the $7.5 million invested by the province in community action on HIV, only $104,000 (1.4%) went directly to HIV prevention targeted to gay men (Marchand, 2001). In 2005 a Vancouver senior public health administrator noted that, "Gay men are a priority population. However we have disproportionate resource allocation: the highest number of new infections, but the lowest number of dollars and resources" (Community-Based Research Centre, 2006). Such weak support eventually led two years later to the closure of AIDS Vancouver's gay men's program, the main prevention service in the City of Vancouver. The gay men's community was left with barely any prevention services at a time when the HIV incidence rate among gay men was at its highest in 15 years.

A gay men's program reopened a year later under a new organization, the Health Initiative for Men (HIM). However the lack of commensurate, long-term investment remains a concern among gay men's advocates and health professionals alike, who feel they haven't been given a fair shot at reversing the epidemic, which would require sufficient funds that reflect the true extent of the issue in their population (CATIE, 2010; Trussler & Ferlatte, 2010). While the community has relentlessly pointed out the lack of resources, the reasons why this state of neglect is allowed to continue remains unexplored.

One observer has suggested that insufficient evidence of disparities is to blame: "What gets counted, gets done" (Harrop, 2009). However if the evidence provided by three decades of surveillance data and epidemiological research is insufficient to prioritize resources for HIV prevention for gay men something else must be needed. It therefore seems essential to investigate the processes and flows of power that are thwarting the force of evidence from resulting in tangible action. In this chapter, I examine the current state of HIV prevention funding for gay men in British Columbia by applying an Intersectionality-Based Policy Analysis (IBPA) Framework (*see* Hankivsky et al., 2012). I use this Framework to demonstrate the set of complex intersecting factors that contributes to sustaining inequities in the distribution of resources for HIV prevention.

First, I review the concept of intersectionality and its use in this inquiry. Next, I present an audit of HIV prevention funding for gay men. This is contextualized through a critical analysis of the current discourse on HIV, funding allocation processes and the prevention approaches that are funded. Finally, I conclude by using an intersectional perspective to point out some promising avenues that may contribute to the advancement of gay men's health and, more particularly, to the fight against the HIV epidemic.

Intersectionality-Based Approach

The concept of intersectionality

Coined by Kimberley Creenshaw in 1989, the term "intersectionality" has a long history in the social sciences. It refers to an approach that assists in documenting how multiple forms of oppression affect identities and opportunities of specific groups or individuals (Hankivsky & Christoffersen, 2008; McCall, 2005). But it is mainly within the last decade that this approach has emerged as a useful paradigm among health scholars to explain health disparities among populations and within groups. It has helped illuminate how ill health is sustained among marginalized groups in many areas such as violence, mental health, diabetes, obesity and HIV (Crenshaw, 1991; Doyal, 2009; Hulko, 2011; Sokoloff & Dupont, 2005; Vissandjee & Hyman, 2011). Many intersectionality scholars have also been interested in sexuality and sexual orientation and its related forms of power and

oppression (Anderson & McComack, 2010; Bowleg, 2008; Cronin & King, 2010; Doan & Haider-Makel, 2010; Meyer, Ouellette, Haile, & McFarlane, 2011; Rahman, 2010; Taylor, 2011; Thing, 2010). However the relationships between sexuality, sexual identity and health have yet to be fully interrogated within an intersectionality paradigm, particularly as they apply to gay men. Nonetheless, the potential of applying intersectionality to these policy areas is significant.

One underlying assumption of intersectionality is that there is no singular identity or system of oppression that can account for all disparities within a certain group or population. On the contrary, inequities are produced by simultaneous and interlocking factors that need to be uncovered. Intersectionality also strives to challenge favoured categories of analysis (i.e., analysis by gender, race, sexual orientation, etc.), arguing that specific identities and categories are more or less salient depending on the historical context, situation or issue under scrutiny (Hankivsky & Cormier, 2011). Therefore, with every inquiry a new constellation of social identities and dynamics may present, as there are no prescriptive categories. The intersectionality perspective also challenges the static understanding of social categories or locations prevalent in the public health field. Intersectional analysis seeks to demonstrate the constructedness of social categories and divisions and how they are experienced, reproduced and resisted in everyday life (Taylor, 2011).

The appeal of applying this approach to a case analysis of gay men's HIV prevention funding is that it helps to contextualize the distribution of resources from a social justice perspective by examining how power and privilege are reinforced in the process of allocation. Intersectionality has already demonstrated its potential to produce new hypotheses and potential policy solutions within the field of HIV, solutions that would not have been revealed by an analysis that failed to consider how identity and oppression interact (Collins, von Unger, & Armbrister, 2008; Doyal, 2009). For example, in a study of black African migrants in London, England, Doyal (2009) used an intersectionality lens to reveal their experiences of HIV stigma. She found that HIV stigma alone could not explain the discrimination these migrants were subject to given their HIV positive status. Rather, their marginalization takes place at the intersection of multiple factors such as HIV stigma but also gender expectations, racism, culture and homophobia. These factors must then be considered in support programs and policies for this population.

Intersectionality is thus a promising approach for addressing existing limitations in the understanding of gay men's social and health disparities. Gay activists have tended to highlight homophobia as the dominant system of oppression shaping gay men's ill health, with generally little consideration given to other identities of gay men (those

that depend on race, class, Aboriginal status, etc.). Additionally, research on gay men and homophobia has largely sought to explore micro-level experiences, that is, examining interpersonal experiences of discrimination. The emphasis has been on describing internalized feelings of oppression among gay men (i.e., internalized homophobia), without acknowledging the social processes that lead to the development of these feelings (Aguinaldo, 2008). Few examples exist of gay men's health studies that have investigated structural forms of oppression, the role of institutions in producing health inequalities at the meso and macro levels and, in particular, interlocking forms of power and oppression relevant to gay men.

Intersectionality moves beyond the interpersonal experience of homophobia to consider how gay oppression is enacted at structural levels and through multiple interrelated oppressions (class-based, racialized, etc.). This is particularly relevant for this case study, which attempts to uncover how institutional funding is distributed. Previous reviews of funding distribution have not located their analyses within discourses of power. The potential of intersectionality is for it to provoke a shift in this focus towards addressing power dynamics and examining those who benefit and who are thus responsible for maintaining the status quo of inequity. This is crucial, as social and health inequities are unlikely to be reversed if we do not address power and the structural disadvantages that contribute to the vulnerabilities of diverse groups of gay men.

Additionally, as mentioned earlier, intersectionality helps disrupt the current thinking, particularly in public health, about MSM or gay men as homogenous groups and strives to challenge the construction of static categories, such as MSM, and to demonstrate their inadequacy. By focusing on MSM and, therefore, on a sexual behaviour, the field of public health fails to recognize the greater social context that shapes the everyday experience of those self-identified or labeled as gay (Prestage, 2011; Young & Meyer, 2005). This is important, as there appears to be a large discrepancy between the social and health experiences of gay men, and non-gay identifying MSM who are partnered with women. A Canada-wide survey showed that MSM partnered with women were less likely to be victims of bullying and career discrimination than single or male-partnered men (Trussler et al., 2010). They were also less likely to have had mental health problems requiring care, such as depression, and less likely to engage in risky sexual behaviours. HIV prevalence among female-partnered MSM in the survey was 1.2%, while among single and male-partnered men it was 9.2%. Even so, intersectionality reminds us that homogeneity does not exist even among those who self-identify as gay, as all men hold various social locations and have different lived experiences. Indeed, research suggests that variation in categories like age, ethnicity, sexual identity and life-course develop-

ment may impact health outcomes among gay men (Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Friedman, Marshal, Stall, Cheong, & Wright, 2007; Ramirez-Valles, 2007).

Finally, as an inductive approach that does not intrinsically favour any particular category of analysis, like homophobia or heterosexism, intersectionality may help reveal how multiple systems and forces contribute to the issue under scrutiny. Focusing solely on homophobia risks obscuring other operating forms of power and, as a result, could lead to only partial solutions for helping reverse the inequality. For example, some scholars have noted that progressive and creative approaches to gay men's HIV prevention have been marginalized not only by homophobia, but also by a form of moral panic, which I discuss in detail later in this paper, related to the predominance of conservative and negative views on sexuality within public health and society (Dowsett, 2009; Halperin, 2009; Numer, 2009). Similarly, gendering practices and hegemonic masculinities have been shown to be relevant in the experience of gay men, including their experience of marginalization and HIV risk behaviours (Dean, 2011; Numer, 2009). Failing to address or to take into account these intersecting factors may contribute to widening health inequities of and among gay men.

Applying intersectionality: IBPA and inquiry method

As pointed out by Hankivsky and Cormier (2011), intersectionality has only recently become a lens for health policy analysis. The case I present here is informed by the IBPA Framework developed by Hankivsky and colleagues (2012 – as published in the present volume), which consider typically unasked questions in traditional policy analysis in order to reveal issues of power in the formulation and results of policies. For this case study, I utilized Descriptive Questions 2 to 6 of the IBPA Framework, which I have adapted to fit the specificities of the inquiry using a reflective process of engaging with the first question of the IBPA: *What knowledge, values and experiences do you bring to this area of policy?* My policy interest in this particular area comes from a decade of engagement in the gay community through activism, health promotion and research. As a gay man who has worked in prevention, I have witnessed and directly experienced the consequences of the scarce resources attributed to gay men. This experience and my commitment to social justice and health equity for gay men have informed this project. I hope to engage with the intersectional analysis to produce knowledge that will contribute to the ongoing advocacy efforts to see proper funding for the fight against the HIV epidemic.

Additionally, the first Framework question guided me to consider my own positionality within the gay men's movement and communities; as a Caucasian, middle-class urban

gay men, it helped me to reflect on my own privileges. These types of reflections are particularly important in intersectionality in order to address issues of diversity and ensure that researchers consider the experiences of those differently situated from themselves. In this case, Question 1 served as a reminder throughout the analysis that there are multiple gay men's realities that are shaped by multiple intersections, such as class, geography, ethnicity, age, etc.

The following questions guided my analysis:

- What is the policy "problem" under consideration? What assumptions underlie this representation of the 'problem'? (Question 2)
- How have representations of the 'problem' come about? How is prevention represented and defined? How do various actors define HIV prevention? What are the consequences of these representations? Whose definition of prevention is accounted for? (Adapted from Question 3)
- How is the HIV epidemic represented? Who is involved in defining the epidemic? How are gay men (and other groups) affected by this representation? And how do these representations affect funding allocations? How has the representation of the epidemic changed over time? (Adapted from Questions 3 and 4)
- What are the current policy responses to the "problem"? How do existing policies – in this case, funding distribution – address, maintain or create inequities? Do policies and responses target specific groups? Are targeted groups seen as homogenous or heterogeneous? Are groups including gay men stigmatized by the processes of funding distribution? Do the current processes of funding allocation create competition among differently situated groups? (Adapted from Question 5)
- What inequities exist in relation to funding distribution? What are the systems of inequality or forces that interact in relation to the problem? (Question 6)

I explored these questions through semi-structured interviews with six informants, including two individuals working in health administration and four community advocates working with gay communities. The number and diversity of participants were appropriate considering the size of the field, and suited the purpose of this small exploratory study, of which the aim was to gather in-depth insights into the processes and power at play in funding attributions for HIV prevention in the Province of British Columbia.

Informants were chosen using purposive sampling techniques on the basis of their experience and involvement in either the distribution of funding or their attempts to

obtain or retain funding. Interviews lasted between 45 and 110 minutes, depending on how much participants had to say on the topic. The interviews were audio-recorded and transcribed with the informants' consent.

In addition to the interviews, relevant health policy documents and other text (media coverage, conference presentations and websites) were reviewed to complement the qualitative data and to provide insights into how gay men are described in policies and other HIV discourses. While some texts were identified prior to the interviews and helped shape discussions with the informants, others were pointed out by the informants.

Counting "Gay Dollars"

It has been suggested that gay men face inequities in the distribution of HIV prevention resources. To investigate these inequities, I applied Descriptive Question 2 of the IBPA Framework, asking participants how, in their opinion, gay men were positioned within the distribution of dollars for HIV prevention. Most informants believed that gay men are at a disadvantage in this respect. They pointed to an issue in how HIV funding policies are developed and executed. They described how gay men have historically been and remain inadequately funded for the breadth and scope of the health problem – "the most affected group with the least prevention funding."

With this as a backdrop, I sought to provide hard evidence of the suggested inequity through a process of counting how many dollars were currently invested in gay men's HIV prevention. However I was confronted with the issue of defining "prevention." To address this methodological challenge I adapted Descriptive Question 3 of the Framework and tried to illuminate the following: "How is prevention represented and defined?"; "Who is defining prevention and how?"; and "Whose definition of prevention is accounted for?".

In this case study the representations of what constitutes HIV prevention differed among interview respondents. Interestingly community informants described prevention mostly in terms of "low-road" approaches, that is, promotion of health and wellness among communities from a holistic and rights-based perspective, in contrast to the public health perspective, which tends to emphasize "high-road," clinically-based interventions. High-road perspectives are dominant within HIV prevention strategy documents available from the province and its health authorities. High-road perspectives focus on mass testing and early treatment and view vulnerable populations as patients rather than citizens. The high-road approach often obscures social inequities among those af-

fected by HIV, which may further contribute to the problem and frustrate intervention (Vanwesenbeeck, 2011).

Because IBPA foregrounds marginalized ways of knowing, this analysis focused primarily on low-road funding initiatives. High-road approaches tend to be population non-specific and located within primary care. The high-road issue is not how many dollars are being spent to support vulnerable groups, but mainly how accessible services are to the various affected groups. On the other hand, institutional funding for low-road approaches tends to be allocated to community groups to address the needs of specific populations. Therefore, one group can rarely benefit from a low-road intervention designed for another population, which may reinforce health inequities and ignore the overlap among groups that IBPA often reveals.

Including high-road approaches in an audit of prevention dollars was also problematic because these approaches are rarely designed as prevention strategies first and foremost. In fact, because they are treatment focused, the impact of high-road approaches on the epidemic is often an afterthought. Defining HIV prevention in high-road terms may also be used as a way to deny that some groups are neglected. Indeed, one participant in the interviews argued that there are a lot of "gay dollars" (funds specifically allocated for prevention among gay men) invested in HIV prevention through primary care, as many gay men have a family physician. However there is no evidence to support this assertion, particularly since gay men have been shown to be more likely to have unmet primary health care needs (Tjekema, 2008), and surveys have also shown that gay men are largely dissatisfied with current prevention efforts (Trussler & Ferlatte, 2010). Furthermore, as IBPA reminds us, access to health services is bound to vary among gay men due to intersecting factors that IBPA attempts to bring forward, such as age, income and geography. Finally, low-road approaches usually serve a wider set of health outcomes and are more likely to provide long-term achievement if sustained (Vanwesenbeeck, 2011). Hence, a continued investment in these types of approaches in certain populations versus others is likely to widen the gaps in health equity.

I next conducted an audit focused on low-road initiatives. This work was informed by Descriptive Question 5 of the IBPA Framework: *What are the current policy responses to the problem?* and by an attempt to address the sub-question: *How do existing policies* – in this case funding distribution - *address, maintain or create inequities between different groups?* Most HIV prevention dollars in British Columbia come from two sources: regional health authorities and the Public Health Agency of Canada through the regional AIDS Community Action Plan (ACAP) program. These two funders allocate moneys through different processes. Health authorities mostly contract community services for HIV pre-

vention or, in some cases, deliver the programming themselves, while the ACAP program allocates funds through a competitive process based on requests for proposals. In both cases, allocation is not informed by equity, and little attention is given to intersecting factors and diversity among affected populations.

As part of the audit, I analyzed a list of projects funded by the ACAP program in BC. ACAP provides operating funding for projects five years in length and for time-limited projects of up to two years. Since 2007, ACAP has funded 8 operational projects in BC, only one of which has been for gay men – i.e., to provide services on Vancouver Island for the amount of $95,000 a year. ACAP has also funded and continues to fund some time-limited initiatives in the region that target gay men. Between 2007-2008 and 2008-2009 ACAP invested $249,870 and $301,699 a year for time-limited projects targeted to gay men. For the fiscal years 2010-2011 and 2011-2012, two time-limited projects were funded for a total of $120,000, making the overall contribution of ACAP to gay men's HIV prevention $215,000 in 2010-2011 and 2011-2012. This represents at most 10% of the over two million dollars invested in the region. Among ACAP's eight priority populations, gay men are among the groups receiving the least amount of resources.

A list of the regional health authority contractors was not readily available for review, making inequities within prevention services and its related co-factors impossible to measure. With the help of informants, I was able to identify that among the health authorities only Vancouver Coastal Health (VCH) provides support for HIV prevention initiatives directly targeted to gay men. This is done mainly through an investment in the Health Initiative for Men (HIM), a non-profit community organization dedicated to gay men's health. The annual budget for HIM was confirmed to be around $500,000. This includes funding for prevention activities and a sexual health clinic offering testing for HIV and other sexually transmitted infections.

Additionally, at the time of writing, investments were made through the STOP HIV/AIDS (Seek and Treat for Optimal Prevention of HIV/AIDS) program. This program is a provincial policy that includes $48 million dollars for HIV prevention. This policy is a four-year pilot project launched in 2010 to increase testing and treatment in the province in an attempt to stop the spread of HIV. STOP HIV/AIDS invests in services related to testing and treatment delivered by HIM, which has doubled the organization's budget for a limited term of three years. Additionally, the STOP HIV/AIDS initiative has made other investments (for which numbers were unavailable) to increase clinical services for gay men. However, these additional investments fail to come into line with the community's non-clinical definition of prevention, outlined earlier in the paper, and as revealed by this IBPA.

This IBPA of HIV prevention funding for gay men shows that over $1.2 million dollars was invested in gay men's HIV prevention in the fiscal year in 2011-2012, which is approximately a 12-fold increase over the investment made in 2001. Over half of the dollars were spent on short-term initiatives that will end upon loss of funding unless the gay community is able to secure more permanent funding.

Discourses on an Epidemic

Beyond the actual dollars spent, the IBPA Framework has allowed me to consider how the problem of the HIV epidemic is represented (Question 3), how groups, particularly gay men, are affected by this representation (Question 4), and how these representations affect funding. Intersectionality scholar Weber (2010) reminds us that those with privilege generally frame issues and can easily dismiss or overlook the situation of subordinate groups. This process was reflected in the experiences of community informants who took part in the qualitative interviews, and who felt that the current framing of the HIV epidemic by lead researchers and public health institutions erases gay men's experiences. This erasure was believed to be the main barrier in securing appropriate funding. For example, one informant pointed out that during the last International AIDS Conference in 2010 a series of newspaper headlines in British Columbia showcased claims by the president of the International AIDS Society and director of the BC Centre for Excellence in HIV/AIDS of a reduction of HIV incidence in the province.[1] The headlines and articles failed to mention that the same reduction did not occur in the gay men's population; in fact, the articles did not mention gay men at all.

Canadian HIV researchers, who usually play an important role in providing evidence for policy makers, also appear to be neglecting gay men. A recent content analysis of the Canadian Association for HIV research (CAHR) conference revealed that only 12% of all abstracts over the last five annual conferences focused on or mentioned gay men or MSM (Tooley, 2011). And when research does target gay men, it does so by focusing solely on risk and deficit-based perspectives that highlight the failures of gay communities to halt the spread of HIV, providing little insight into prevention opportunities and obscuring the various social and structural factors that promote HIV infection within this population.

This trend of neglect is also apparent in the actions of the Federal and BC provincial governments. There has never been an explicit strategy for gay men's HIV prevention, either

[1] On July 19th 2010, the *Province* and *The Vancouver Sun* ran a similar story claiming a 52% decline in HIV incidence since the introduction of HIV treatment (Chai, 2010; Ivens, 2010). The articles failed to mentioned that infections among gay men had dramatically increased during the same period.

in British Columbia[2] or federally. Gay men have also been invisible within the new policy STOP HIV/AIDS. As pointed out by one informant: "The first two reports of the STOP HIV/AIDS program did not mention the word gay even though gay men represent 62% of new infections in Vancouver." With the exception of rare references to the epidemiology, initial documents produced by the program did not mention gay men. Only after lobbying and advocacy efforts from gay activists were gay men included in the strategy.

However when the problem of HIV is being described to the public, gay men remain invisible. For example, on a recently launched website for STOP HIV/AIDS, there is only a passing mention of gay men. The website states: "Concern is growing about increasing numbers of new cases among all sexually active people." Yet data collected by the British Columbia Centre for Disease Control demonstrate that new HIV diagnosis among heterosexuals has not increased in the last decade (BCCDC, 2010). A second website launched in November 2011 reads: "Forget what you heard about high-risk groups. HIV does not discriminate." Although the campaign may have intended to remove stigma around the practice of HIV testing, one of the unintended outcomes is that it renders invisible the disparities faced by gay men and other groups who are in fact discriminated against by HIV due to complex and interacting factors that increase their risks of becoming infected.

When considering "how the framing of the problem has changed over time" (Question 3), we can see that HIV, which was once considered a gay disease, is now being framed as a health concern that does not discriminate on social grounds, including sexual orientation. Those involved in HIV policy and in developing public health strategies are contributing to this reframing by providing explanations and interpretations for the epidemic that exclude gay men and make invisible the interlocking social vulnerabilities that perpetuate HIV disparities. Policy makers tend to see their work as mainly managing public outcry (Varcoe, Pauly, & 2011). But there is little incentive to fund prevention among gay men if the public, including gay men, is unaware of how HIV is concentrated within marginalized groups that suffer various forms of inequities and disadvantages. Additionally, as gay men are currently made to believe that HIV is no longer a concern to them, they may relax their risk reduction strategies, which could potentially contribute to the epidemic itself.

[2] I found barely any mention of the gay men's HIV epidemic in most governmental documents and websites reviewed. However gay men were cited as a priority population for prevention in Vancouver Coastal Health Authority's strategic plan for 2007-2012.

Uncovering the Allocation Process

The IBPA Framework seeks to illuminate how existing policy responses create inequities. Guided by Question 5 of the IBPA and its sub-questions, I wanted to consider the processes through which agencies have responded to the needs of communities with resources to fight the epidemic, and which inequities have occurred as a result of these responses. As mentioned above, VCH and the STOP HIV/AIDS programs distribute their resources by contracting services with community agencies, while the ACAP program allocates resources through a competitive process where community agencies whose principal mandate is HIV are invited to submit proposals.

When investigating with the informants how these processes "addressed, maintained or created inequities," respondents felt strongly that they were unfavorable to gay men. For example, they described how the lack of infrastructure for gay men has allowed VCH to ignore this population throughout much of the epidemic. Indeed, it was more than 20 years into the epidemic that HIM, the first gay health and HIV organization, was established and received funding from VCH. Until then, gay men's HIV prevention initiatives were largely inconsistent in the Vancouver area among VCH-funded programs, despite gay men carrying a large burden of the infections. The funding gained by HIM offered more stability to gay men's HIV prevention, but community informants remain critical of VCH. Informants felt it was their advocacy efforts that led VCH to fund HIM and that, without "political pressures," VCH would have probably remained unresponsive to the ongoing epidemic in gay men. Additionally, community informants felt that the amount of funds allocated is still inequitable, considering the scope of the gay HIV epidemic.

Similarly, informants described how it was their advocacy efforts that led to the release of funds from STOP HIV/AIDS. Despite its ambitious goal of reducing HIV infections in the province, it appears that this initiative did not consider all impacted communities at the outset, including gay communities. Informants claimed that it was only after their advocacy efforts that gay men became part of the strategy and that initiatives were funded.

Community informants also discussed how the processes through which funds are allocated from the ACAP program "invites prejudices" and contributes to inequities. The ACAP program invites proposals for one of the eight priority populations they have identified, which includes gay men but also women at risk, Aboriginal peoples, youth at risk, the prison population, injection drug users, individuals from countries where HIV is endemic and people living with HIV. Although prevalence and incidence vary greatly among these groups, there are no processes in place to ensure equity or even minimum funding for each population. Additionally, the IBPA Framework, by its focus on inter-

secting identities/locations, highlights how members of gay communities may belong to multiples priority groups due to their intersecting identities. However, the current breakdown of priority populations obscures this, and we see a lack of prevention activities among gay men who belong to multiple priority groups, such as Aboriginal gay men, gay men in prison, gay men who inject drugs and gay men from countries where HIV is endemic, who are potentially much more at risk of infections.

The IBPA Framework also prompted me to consider the underlying issues that allow this neglect from funding agencies. First, informants described how gay communities have limited capacities to advocate for funding or put forward competitive applications. There are only two organizations in the province that have a sole mandate to do work with gay men, one of which was only established in 2007. However, this issue goes unrecognized by policy makers, who, according to community informants, make assumptions with regards to the capacity, size and resources of community organizations to put forward competitive proposals.

Second, the IBPA Framework guided me to question informants about potential competition created among differently situated groups in funding allocation processes. Informants felt strongly that other populations may have better access to resources because of their capacity to demonstrate to funders they are "true" victims of HIV, and because they hold social locations that may provoke fewer biases at review panels than gay men do. The distribution of funding, which tends to be administered according to populations rather than need, appears to be contributing to this competition by reinforcing the idea that vulnerable populations are distinct, that they have separate needs and that interventions targeted to one group cannot benefit another.

Although informants did not acknowledge other groups' penalties, they were deeply aware of other groups' and agencies' blindness to gay men's marginalization. Informants explained how gay men (or MSM) tend to be seen by outsiders as homogenous, often with a stereotypical assumption that all "gay men are privileged," which is used as the basis to deny gay groups funding. This is perhaps due to what Purdie-Vaughns and Eibach (2008) describe as "intersectional invisibility," defined as the lack of recognition within a group of members who belong to two or more subordinate groups (i.e., gay men from ethnic minorities, those of a lower social class, etc.). Due to ethnocentrism, the tendency is to define the standard as membership in the dominant ethnic group. Thus, assumptions are made that all or most members of the gay community are Caucasian. Additionally, marketers targeting gay communities and Christian right-wing organizations attempting to argue that gay men are not oppressed have fuelled the myth that gay men are economically advantaged (Ryan & Chervin, 2000). These assumed privi-

leges, combined with being of the "dominant" gender (i.e. men), were described by the informants as being sufficient to deny that gay men are oppressed and suffering health inequities despite a greater burden of HIV infections.

Respondents explained how gay groups are similarly constructed as an advantaged group within the HIV movement. One described this situation as follows: "There was always a perception somehow, that gay men were over-resourced at the expense of other populations." This was the case, the respondent pointed out, even when minimal resources were actually going to gay men. Another informant described how the recent increases in funding for gay men have "helped reinforce the belief within the wider HIV community that gay men were getting too much. It inflamed the situation because it fed the existing mindset." Hence, community informants felt that gay organizations are perceived as taking away resources from those who are truly vulnerable to HIV and who, unlike gay men, do not bring the disease upon themselves. Community informants felt that these erroneous social constructions of gay organizations are imprinted so strongly in the minds of those involved in the field and within the HIV discourse that informants felt it is a great barrier to receiving funding.

This IBPA-informed review of the funding allocation processes suggests that the structural barriers faced by gay communities are so strong that funders can easily overlook these communities despite the epidemiology, which clearly highlights gay men's social vulnerability as a group in society. Almost every dollar that has been allocated to the gay community has been the result of pressure and activism. Gay men themselves have had to ensure that resources are available to counter the HIV epidemic. The time and resources invested by community groups to demonstrate the negligence of funding institutions and subsequently make the case for allocation of funds detracts from their ability to focus on the priority of prevention initiatives.

Approaches: Towards a Re-medicalization of Gay Men's HIV Prevention

Lack of resources has often been cited as the reason the community has failed to reverse the epidemic. And this analysis suggests that sustained investments are indeed lacking. However, one informant felt that financial investment might only be part of the problem. He explained: "The issue is not only about getting resources. Because even in other parts of the country where there are more resources, prevention is failing." In line with this observation, IBPA Framework Descriptive Question 5 directed me to consider not only how resources have been distributed, as described earlier in the paper, but also

what kind of interventions are receiving funds, what gaps remain and how current interventions may contribute to inequities of gay men.

The current distribution of resources in British Columbia is largely informed by the philosophy of the STOP HIV/AIDS pilot project, which is to increase HIV testing and treatment as the solution to curb the epidemic for all populations. This is currently being promoted with no consideration of specific group vulnerabilities or epidemiological trends. Within this context, much of the recent gains seen in funding have been made in interventions directed at increasing testing and the uptake of treatment, to the detriment of other health initiatives that address the social and emotional vulnerabilities of differently positioned gay men.

The IBPA Framework asks that we challenge assumptions of homogeneity by considering the impacts of policies on different groups. When considering the impacts of scaling up testing and treatment as a prevention strategy, we can see that this approach is unlikely to stop the epidemic among gay men. Such medicalized interventions offer only partial effectiveness (Nguyen, Bajos, Dubois-Arber, O'Malley, & Pirkle, 2011), given the existing high uptake of testing and treatment among gay men (Trussler et al., 2010) suggests that the prevention impacts of these programs have probably peaked. Therefore, other strategies must be promoted. In fact, the narrow focus on testing and treatment may increase inequities for gay men, as suggested by the increase in new infections among this population since the introduction of antiretroviral drugs. In gay communities, the high prevalence of HIV in conjunction with treatment optimism may outweigh the potential benefits that treatment has on prevention. Therefore, treatment is not prevention for gay communities, and gay men require even more prevention efforts in the era of treatment.

A review of projects funded by ACAP did not indicate the same trend towards medicalization as is seen in the provincially-funded projects. However, a close review of ACAP's funded projects since 2007 shows that roughly half of funding for gay men is for direct interventions with this population, and only one limited-term project addressed the vulnerabilities of gay men in Vancouver, where most HIV infections occur. The other funded projects have been for professional development and need assessments, which may have indirect impacts on HIV prevention but no agenda to directly target those most at risk. Although these types of initiatives may make important contributions to the gay men's movement overall, their funding raises questions as to whether ACAP avoids providing resources for approaches that may be perceived as promoting a "homosexual lifestyle."

A list of the projects submitted to, but not funded by ACAP was not available for review. However community informants discussed their concerns that the program may indeed only fund certain types of approaches. This was demonstrated by the recent funding proposal rejection of one of the informants. The proposed project targeted gay men who seek sex, companionship or information online, which is in line with recent research evidence that indicates that gay men are withdrawing from physical community spaces to engage in virtual communities where they can more easily meet sexual partners (Trussler, Ferlatte, Marchand, Banks, & Moulton, 2009). The project aimed to provide information to gay men in those sexualized online environments. The project was approved and recommended for funding by the public health agency. However it remained with the office of the federal Health Canada minister for months, until the organizations involved received a notice that the project had not been funded. Although no "official" explanation was offered, it was suggested that the sexual nature of the project was deemed inappropriate for receiving taxpayers' dollars.

Since the beginning of the ACAP program it was unheard of that a project recommended for funding by public servants would not receive approval at the minister's office. This highlights the vulnerability of gay communities to the political climate. There was a growing concern among informants that a socially conservative government such as the current federal administration will continue to block resources that could prevent the epidemic, particularly if the evidence prescribes interventions that challenge society's values and norms surrounding sexuality and homosexuality.

The case above may well be an example of the sex panic that informants feel is tainting the field. One informant explained that, "Funders and public health professionals are afraid of sexuality, there's a moral panic and they are worried about not being politically correct." In short, informants felt that funders support gay men's HIV prevention as long as it is not sexualized. Among the projects identified in the province, those that are explicit about addressing sexuality, particularly sexuality that may be seen as "deviant," such as unprotected sex, high numbers of sexual partners and anonymous sex are rare. The trend towards professionals development, conducting need assessments and supporting medical approaches as favored prevention strategies may be directly linked to the discomfort of our governments and public health institutions at being perceived as supporting homosexuality or sexualities they see as perverted.

Discussion

The application of the IBPA Framework to the allocation of HIV prevention funding for gay men has exposed a number of issues that were not revealed by previous analysis. While this review, like previous ones, demonstrates a lack of investment, particularly for long-term initiatives, in the reduction of HIV infections among gay men, the application of the IBPA shows that commonplace public health descriptions of the epidemic and proposed solutions to it are themselves problematic and are actually contributing to maintaining inequity.

The continued invisibility and the recent exclusion of gay men within discourses and policies such as STOP HIV/AIDS represent neglect and abuse that is more likely to perpetuate the epidemic than resolve it. Additionally, the social construction of gay men's communities as privileged, homogenous units blinds public health professionals and policy makers to the ongoing injustice faced by differently positioned gay men. Intersectionality, with its focus on troubling assumed categories, such as gay men or MSM, highlights the health inequity faced by gay communities, which cannot be ignored or erased by leaning on assumed or constructed privileges. Additionally, this IBPA shows that further attention to the intersecting factors shaping gay men's vulnerabilities must be considered and integrated into policies that govern the distribution of funding.

Much of the discourse on the gay men's HIV epidemic has been concerned with explaining the difficulties gay communities have faced in securing resources due to homophobia/heterosexism. However, this IBPA reveals a pattern of systemic discrimination against gay men that is defined at the intersection of heterosexism, medicalization and sex panic. For example, the application of the IBPA questions shows a troubling focus on medical interventions at the expense of community-led initiatives. This is problematic, as community efforts have generally been much more successful at reducing HIV transmission than public health and medical interventions (Dowsett, Bollen, McInnes, Couch, & Edwards, 2001). Medicalized interventions may be more in line with the sanitary version of sex promoted in public health and HIV policies, which view unprotected sex and high numbers of partners as "bad behaviours" (Numer, 2008; Halperin, 2009). Additionally, the IBPA highlights the fact that, beyond just being of limited use, medicalized interventions may in fact increase the gap of health inequities between gay men who do conform to public health versions of safer sex, and those with alternative sexualities, as the sexual rights of the latter are not promoted. These gay men are therefore left without interventions that address their vulnerabilities.

The application of the IBPA Framework to this case has focused on use of the Descriptive Questions to demonstrate the tensions within the current policy context. However IBPA also seeks to be transformative. Perhaps the first step towards social justice and change for gay men will be achieved by bringing new nuances into how the epidemic is understood, and by locating the issues faced by gay communities within an analysis of power, privileges and penalties. For example, the revelation that homophobia alone is insufficient in explaining how the epidemic goes unaddressed may offer new avenues for the advancement of gay men's health.

Gay men advocates have traditionally been alone to challenge homophobia within public health and health policies. However, there is perhaps new potential for collaboration by locating the oppression experienced by various groups of gay men within a moral/sex panic discourse. By inquiring into similarities among vulnerable groups, the IBPA Framework can illuminate less obvious similarities that may lead to coalition building. Gay men's isolation within the HIV movement may shift if the focus is diverted away from the subordination associated with a gay identity and towards a focus on sexual rights that intersect with gay health, but also with Indigenous health, women's health and the health of other affected populations. While gay men have been mostly alone to cope with the impacts of homophobia within AIDS infrastructures, others have suffered as a result of narrow and moralistic views on sexuality and have seen their ability to access resources diminish as a result.

Among these groups suffering as a result of moral panic are sex workers, who are also disproportionately impacted by the HIV epidemic. On the occasion when the Health Canada ministerial office denied funding to the project of one of my interview informants, another project was also rejected. The other project was aimed at promoting safer sex negotiation skills among sex workers. Meanwhile, other projects for sex workers were approved, but these were aimed at removing sex workers from the sex trade. As with gay men's HIV prevention, it appears that there is little support for promoting the empowerment and sexual rights of sex workers. On the contrary, favoured approaches attempt to reduce prostitution. IBPA helps us consider how this similarity could foster an alliance between gay men and sex workers around a shared interest to see their sexual rights promoted.

Conclusion

Applications of intersectionality to the field of gay men's health are only beginning to emerge, but frameworks like IBPA may facilitate their development. As demonstrated in this chapter, IBPA's potential is significant for identifying policy problems and highlighting new solutions. This case analysis shows that gay men's HIV inequity is sustained by a complex system of oppression, defined as the intersection of heterosexism, sex panic and medicalization. IBPA also helps identify new avenues for activism and coalitions with other underfunded groups around sexual rights. Further, intersectionality analyses of gay men's health are likely to highlight other factors and help the development of gay men's health theorizing. Since little has been written about the relationship between gay men's health and intersectionality, this case reported on here highlights not only the potential for intersectionality to bring further positive developments to gay men's health, but also the potential of gay men's health to contribute to the further development of the intersectionality conceptual frameworks.

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