

INNER CITY HEALTH

EXPERIENCES OF RACIALIZATION & HEALTH INEQUITY

THE INNER CITY HEALTH STRATEGY WORKING GROUP
HAMILTON URBAN CORE COMMUNITY HEALTH CENTRE
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INNER CITY HEALTH

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TABLE OF CONTENTS

1.0 Executive Summary	7
2.0 Partnership	9
3.0 Terms of Reference	9
4.0 Description of Partners	9
5.0 Approach	10
6.0 Detailed Research Question.....	11
Theme 1: General views and experiences of racism	12
Theme 2: Racism and barriers to accessing health services.....	12
Theme 3: Experiences of racism when using services and interacting with providers	12
7.0 Objectives and Methodology	12
8.0 Ethical Considerations.....	14
9.0 Background on Study Neighbourhoods	15
Hamilton	15
Malvern.....	15
Parkdale	16
Rexdale and Jamestown	17
10.0 Literature Review Summary	19
11.0 Project Activities	21
Socio-Demographics	22
Health-related Service Use.....	24
Racism as a Social Determinant of Health.....	25
Challenges Facing Racialized Communities in Inner City Areas.....	26
Experiences of Racism in the Health and Social Services Sector.....	28
Issues Facing Service Providers	30
Defining Racism and Discrimination	31
Experiences of Racism	32
Racism as a Social Determinant of Health.....	33
Experiences of Racism in the Health Care System.....	35
Transforming Health Care To Serve Racialized Communities	38
12.0 Conclusions	39
13.0 Dissemination Strategy	39
14.0 Future Directions.....	40
References.....	43
Appendix 1 - Literature Review.....	47
Appendix 2 - Community Survey	52
Appendix 3 - Key Informant Interview Guide	54
Appendix 4 - Focus Group Guide.....	56
Appendix 5 - Consent Forms	57

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1.0 EXECUTIVE SUMMARY

Urban issues are emerging more centre-stage within national Canadian politics and with it discussions about sustainable cities with a focus on housing, employment, education and health within inner cities. Inner city health in particular is a subject of concern for service providers and policy-makers alike who advocate reforms to the urban health care system. As this report illustrates, poverty and racism are critical factors that need to be carefully considered and incorporated into urban health strategies and policy interventions that aim to address current inner city health issues. These efforts need to acknowledge poverty and racism as social co-determinants of health which affect health in various direct and indirect ways.

This report summarizes the results from a mixed-methods study of experiences of racism in the health and social services sector in four inner city communities. Inner city refers to urban/suburban contexts in which a significant number of social, political and economic disparities converge, including but not limited to: high concentration of low-income and poverty; high proportion of persons from racialized groups, often corresponding with high rates of recent immigrant status; low concentration of health and social services; limited mixed housing, and high proportion of subsidized housing; limited access to affordable, nutritious foods; and high proportion of ‘predatory’ businesses such as pay-day lenders and fast-food chains. Overall, these factors in the inner city setting conspire as barriers to health, barriers to sustainable community economic development and barriers to development of social capital.

Over the course of several months, community members of three inner city areas in Toronto – Parkdale, Rexdale and Malvern – as well as Hamilton’s inner city took part in a survey examining their experiences of racism and its impact on their health and well-being as well as focus group discussions. Additional interviews were held with key informants in the study communities in order to reflect on the extent and influence of racism affecting racialized populations. The study focused primarily on experiences of racism within the primary health care sector, but also considered the broader impact of racism on well-being in these communities.

“Many health disparities are rooted in fundamental social structural inequalities, which are inextricably related to racism and other forms of discrimination in society.”

World Health Organization 2001

1.1 SUMMARY OF KEY FINDINGS

- *Racism and health inequities exist within the current healthcare system*
- *Racism affects the health of individuals, families and communities*
- *Racism impacts health through the social determinants of health*
- *Participants identified the need for health care providers to acknowledge racism as a reality*
- *Participants confirmed the need to have institutional policies and practices that address racism and health inequity*
- *Participants highlighted the urgency for increased access to health care services*
- *For many racialized communities quality of health care is a significant concern*

The results of the study reinforce the need for health services that confront racism within the health care system as well as within the social environment and structures that contribute to the health of racialized and marginalized communities. The experiences of the many participants in the study confirm that racism is a serious determinant of health. Racism affects the health of individuals, families and communities in a multiplicity of ways. The study suggests that one of the most important ways that racism affects health is through its impact on the socio-economic status of individuals and groups. For example, educational and employment opportunities are shaped by experiences of racism which in turn decide the income, housing and other social determinants of health that impact people's lives.

The study also documents several examples of the direct ways that racism affects health. Throughout the document there are deeply personal stories about how racism contributes to social fears and anxieties that affect how people see themselves and understand their worth. More specific to people's health-seeking behaviours, several participants expressed how their experiences of racism at the hands of health practitioners and administrators discouraged them from using health services, even questioning the benefit and value of using medical facilities to deal with serious health conditions.

The participants, when given the opportunity to offer advice to health care professionals, were eager to provide suggestions. Generally, there is a strong need for health providers to acknowledge racism as a reality in Canadian society that marginalizes racialized communities. Participants were clear in their desire for the health care system to incorporate more time for physicians and other practitioners to get to know their clients, where they are coming from and what their lives are like. A better understanding of racialized communities is needed for health services to develop culturally-appropriate and respectful services that truly improve the health and well-being of clients. Here, institutional policies and practices that address racism and health inequity and incorporate the best elements of cultural competency are needed to better inform health practitioners at the highest levels about the impact of racism and how health practices may reinforce racial inequality at the broadest levels of our society.

Further research is needed, however, to fully understand the extent and impact of racism on the social determinants of health. This research should also address the intersectionality of the experiences of racism and health inequity with other social identities and constructs such as age, gender, immigrant and refugee status, citizenship and sexual orientation.

2.0 PARTNERSHIP

Partner organizations in this research project have a rich history of community-based research and community partnership, engagement and involvement in the development of programs and services. Foremost, the importance of addressing race/racialization, inner city health and a wide variety of correlated social determinants of health, are grounded in the mission and vision of each partner organization, each of which is guided by voluntary, community boards of directors.

The research builds on these identified missions and priorities, and stems from the work of the Inner City Health Strategy Working Group to which they belong.

3.0 TERMS OF REFERENCE

For the purpose of this research project the Terms of Reference for the Partners were stated as:

- Providing input, guidance and oversight to the research project and achievement of stated outcomes
- Serve as investigators as needed
- Facilitating community engagement and involvement by assisting with community outreach and informing community members about the community surveys
- Co-organizing focus groups as needed to gather information about lived experiences from community members

4.0 DESCRIPTION OF PARTNERS

Black Health Alliance is a volunteer-led alliance whose membership includes organizations addressing health and wellness in the Black community. The mission of the Black Health Alliance (BHA) is to reduce the racial disparities in health outcomes and promote health and well-being for people from the diverse Black communities in Canada, with emphasis on the broader determinants of health. The Black Health Alliance's activities include: community based research and education on health-related issues relevant to the Black community, promotion and participation in responses addressing the health status of diverse Black communities with emphasis on the broad determinants of health, publication and distribution of materials and resources on topics such as diabetes, hypertension, sickle cell anemia, breast cancer, prostate cancer, HIV/AIDS, substance use, healthy diet and nutrition, advancement of education and knowledge on the health status of the diverse Black communities in Canada, with

emphasis on the broad determinants of health including racism, capacity building and organizational development of the Black Health Alliance.

Hamilton Urban Core Community Health Centre was founded in 1996 and provides primary health care services and health promotion programs in more than 15 languages to thousands of registered clients in the inner city of Hamilton, Ontario. The Centre is the result of extensive community collaboration and the energy of service providers, community members, prospective clients, and health practitioners who share a common vision for health services in the core. Responding to a compelling need, they work together to imagine and create a first-rate health centre to deliver quality primary health care services, health promotion, education, advocacy, and outreach services. Priority populations for Hamilton Urban Core include people who are homeless or at risk of being homeless, immigrants and refugees, individuals and families living in poverty or with low-income, street involved youth, isolated seniors and people with mental health issues or mental illness.

Community MicroSkills Development Centre is a non-profit organization that has served communities in Toronto and surrounding areas since 1984. The Centre provides settlement, employment, and self-employment services to individuals, with priority to the needs of immigrants, youth, visible minority people, and low-income women. Programs provided in their key service areas help clients achieve economic self-sufficiency, participate actively in community life, and make a productive contribution to Canadian society. Programs focus on developing clients' skills, increasing their information base, and facilitating opportunities for them to transfer their skills and knowledge to the Canadian workforce.

Parkdale Community Health Centre is located in a vibrant, multi-cultural, downtown neighbourhood. The Centre works with the community, in all its diversity, to address its health-related needs through community development and action, the delivery of primary health care, counseling, advocacy, and health promotion. They give priority to individuals and groups who traditionally encounter barriers to high quality health care services, including refugees and immigrants, gays, lesbians, bisexuals, transsexual and transgendered peoples, people who live in poverty, psychiatric survivors, women, seniors, and people who live on or near the street.

5.0 APPROACH

The purpose of the project was to explore experiences of racism and health inequity focusing on the lived experiences of racialized individuals / communities. Within this context it was clear that such an exploration would not be complete without considering poverty and an overarching understanding of the relationship between racism and poverty as cause and effect. While much has been written about the significance, importance, and effects of poverty on health outcomes very little has been produced on the role of racism, and even less on the significant inter-relationships of poverty and racism. Yet, the racialization of poverty represents a daily reality for Ontario's inner city health centres, and for the low-income clients they serve.

The connections between poverty and racism can be made on the basis of the empirical evidence (that racialized peoples experience greater rates of poverty), on the historical legacy (that racialized peoples were denied property rights or employment rights and in some cases were themselves considered property), or by comparing the similar mechanisms that contribute to poverty and racism (mechanisms such as a refusal to recognize that they exist).

In regards to empirical evidence, that racialized communities and Aboriginal communities experience significantly greater rates of poverty, the United Nations Committee on Economic, Social and Cultural Rights (May 2006) stated the following:

“The Committee is concerned that, despite Canada’s economic prosperity and the reduction of the number of people living below the Low-Income Cut-Off, 11.2 per cent of its population still lived in poverty in 2004... The Committee also notes with particular concern that poverty rates remain very high among disadvantaged and marginalized individuals and groups such as Aboriginal peoples, African Canadians, immigrants, persons with disabilities, youth, low-income women and single mothers.”

The surveys were distributed and, in most instances, completed at locations where community members have established a relationship of trust with the service provider and have access to the health services and supports they need. However, this relationship may have also influenced responses as respondents identified overall access to health exclusively with their relationship or experiences with the service provider where they do have access.

In addition, responses were not directly linked to specific communities; rather data was collated in an aggregate manner.

6.0 DETAILED RESEARCH QUESTION

Health inequity, poverty and racism, to a lesser extent, have been the focus of research in recent years however, there is a significant gap in understanding the intersectionality and impact across these constructs. Identifying key research questions was an important part of the process in determining which area of a broad spectrum of realities and experiences should be the focus of the project and which group of questions would serve to solicit the desired input. The project team developed the key research questions in three broad theme areas through open discussion and reviewing current literature and related information. The overarching research question is:

“What are experiences of racialization and health inequity in the inner city for specified community areas?”

This was further delineated in three broad theme areas:

THEME 1: GENERAL VIEWS AND EXPERIENCES OF RACISM

*What does the word 'racism' mean to you?
Have you ever experienced racism?
Do you think racism affects your health?*

THEME 2: RACISM AND BARRIERS TO ACCESSING HEALTH SERVICES

Have you ever experienced racism trying to access health services? Health services may include: hospitals, doctors, community health centre, nursing homes, walk-in clinics for example.

THEME 3: EXPERIENCES OF RACISM WHEN USING SERVICES AND INTERACTING WITH PROVIDERS

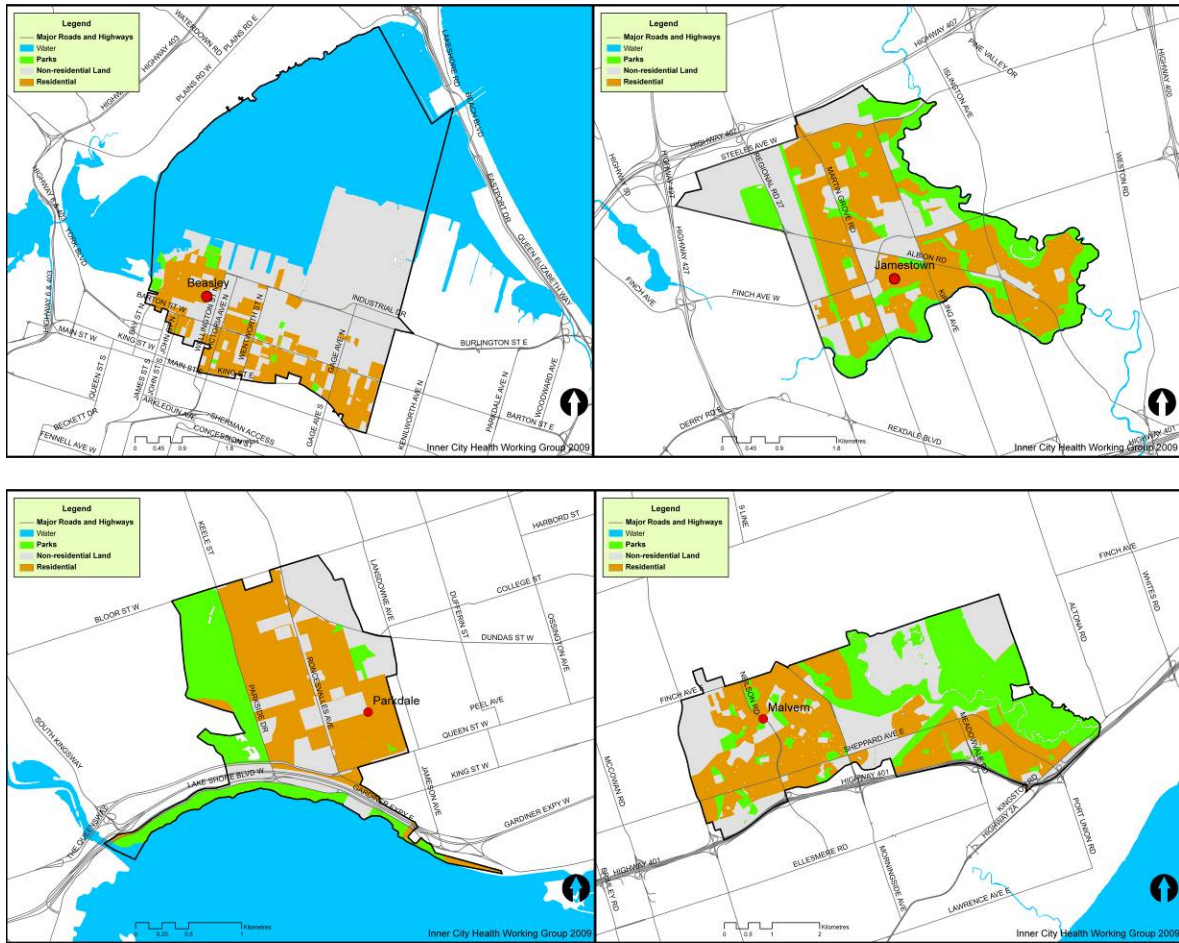
*Have you ever had an experience with a health service provider that you thought was racist?
What should health service providers do to more effectively address racism and improve access to services?*

7.0 OBJECTIVES AND METHODOLOGY

The main purpose of the study was to gather current information on the experiences of racialized groups while seeking health and social services in their communities. The main objectives of the study were to 1) examine the presence of racism in the health and social services sectors in inner city communities; 2) document community experiences of racism and racialization related to health and health services and; 3) explore the impact of racism on the health and well-being of racialized groups living in inner city communities.

A survey was conducted with approximately 200 community members of the four study communities. The survey asked community members of the four communities (see below) about their experiences of racism as well as their experiences when accessing health and social services. The four communities are noted in the following chart.

CHART 1: FOUR COMMUNITY GEOGRAPHIC AREAS



Following the completion of the survey, additional community members from the study communities were asked to participate in a series of focus group discussions. The discussions covered a broad range of issues related to experiences of racism. The participants reflected a diversity of social and cultural backgrounds including recent immigrants, refugees and Canadian-born citizens from racialized communities. In total, 40 individuals participated in four focus groups.

In addition, four key informant interviews were conducted with individuals who were identified as leaders within the community and had a high level of experience and understanding of the experiences of racialized communities.

It was also important to the project that the community surveys, focus groups and key informant interviews were all conducted by knowledgeable facilitators and/or researchers with lived experience of racism and racialization which enabled the focus of the activity to be placed on the subject area rather than requiring participants to spend time explaining or educating the facilitators and/or researchers.

8.0 ETHICAL CONSIDERATIONS

The following ethical considerations directed the process for engagement in the project activities:

1. The project activities were guided by Hamilton Urban Core Community Health Centre' s Policy on Human Research
2. All community survey questionnaires were anonymous and destroyed after data was entered and aggregated
3. All research project investigators, consultants and volunteers were required to observe confidentiality, guaranteeing that no information pertaining to individual or organizational responses or other identifying information would be disclosed during or after the conduct of the research project
4. Key informants and focus group participants were asked to sign a consent form
5. The analysis of key informant responses does not make reference to any particular names (individual, organizational or other) within the final report, and investigators reviewed this section to ensure appropriate anonymity
6. Information about the research project including the goals and intended use of the outcomes was described in writing and through verbal communication, where appropriate, to all focus groups participants, key informants and survey respondents.
7. Contact information related to the project was provided to all focus groups participants, key informants and survey respondents.
8. Focus group members were provided verbal and written assurance that their participation is anonymous, and that any reference to their responses will be described using non-specific identifiers, except where certain demographic information has a bearing upon the responses being reported (e.g., Elisa, a 24-year old Guatemalan woman identified race as a key decision in doing the following...)

9.0 BACKGROUND ON STUDY NEIGHBOURHOODS

HAMILTON

The Hamilton urban core refers to a segment of the downtown Hamilton area which is loosely acknowledged as a distinct neighbourhood within the city due to shared socio-demographic trends and patterns (see Map 1 above). Also contributing to this sense of neighbourhood is that the “core” also serves as geographical location for key targeted, health and social agency efforts including the primary health care services of Hamilton Urban Core Community Health Centre.

Hamilton’s inner city is confronted by various social and economic barriers to health, including a high poverty rate, high unemployment, high levels of precarious housing and a high proportion of racialized groups.

Due to the lack of neighbourhood-specific social and economic data configured specifically to Hamilton Urban Core and other distinct Hamilton neighbourhoods, this environmental scan focused on available 2006 Census data for 15 census tracts that closely resemble the catchment area of the “urban core”, as defined by the Hamilton Urban Core CHC. See Table 2.

Census data confirm what health and social service providers have long recognized about the core of the city: high rates of recent immigrant families, significant rates of precarious housing and poverty, largely among racialized communities. The 15 census tracts observed as the “urban core” has more than twice the percentage of ‘visible minority’ and Aboriginal residents as the City of Hamilton average; of immigrants, almost three times as many are likely to be recent immigrant than the City of Hamilton average; and, almost two-and-a-half times more families in the urban core live in low-income or poverty than the City average. These and other comparative demographics are provided in Table 2.

MALVERN

The neighbourhood of Malvern is located in the northeast corner of Toronto, in the former City of Scarborough. With a population of roughly 45,000, it is estimated that there are over 60 different cultural-linguistic groups represented in Malvern, with the most dominant ethno-racial groups being Black Canadians (predominantly Caribbean and African immigrants, and first generation African-Canadians) and Indo-Canadians (predominantly Sri Lankan Tamil, Indian, Pakistani, and Caribbean immigrants, and first generation Indo-Canadians). There are also sizeable numbers of residents of Filipino and Latin American backgrounds.¹

¹ *Malvern Social Profile #2 – Neighbourhoods, Language & Ethnicity*. City of Toronto - Social Policy Analysis & Research section in the Social Development, Finance and Administration Division. July 2008

For all foreign-born residents of the Malvern area, the percentage breakdown of immigration by periods is:

2001-2006: 22%	1971-1980: 11%;
1991-2000: 27%	1961-1970: 15%;
1981-1990: 12%	Before 1961: 13% ² .

This indicates a high proportion of recent immigration as opposed to immigrant families who have been settled for a longer period. This high rate of recent immigration, with increasing percentages being from racialized groups, is coupled in Malvern with greater than average rates of low income and poverty. Of individuals 15 years and older residing in the neighbourhood, 45.6% are identified as living with low-income or in poverty³.

PARKDALE

Parkdale is a neighbourhood west of downtown Toronto, bounded on the south by Lake Ontario and to the west by Roncesvalles Avenue. While the neighbourhood traditionally known as “Parkdale” extended to Bloor Street in the north, and to the CNR railway lines in the east, recently the neighbourhood has been commonly subdivided into two distinct geo-political sections: “Roncesvalles” to the north and “South Parkdale” to the south. This reflects a complex set of social, economic and political dynamics within the larger Parkdale neighbourhood over the past decade, including gentrification in pockets of the neighbourhood and efforts by diverse residents to shake the stigma of Parkdale as a lower-income area.

Nevertheless, Parkdale, or “Roncesvalles” and “South Parkdale” remain among the most diverse areas of the city, with many new immigrants finding their first homes in the area, largely due to lower rents. The presence of a large recent immigrant community has done much to create the vibrancy that Parkdale is known for. This may be a fact of the streetscape in Parkdale, but it remains an area rife with substandard rental apartment buildings (a large percentage of Parkdale residents are renters) run by landlords who are considered slumlords by many local residents. At the same time parts of Parkdale have seen increased gentrification in recent years, as Queen Street West’s sphere of influence extends further westward throughout the neighbourhood.

The area that extends northward along Roncesvalles Avenue has also seen a turnover to a mix of residents with a younger average age and higher proportion of families compared to the neighbourhoods to the west. A significant amount of renovation of the older homes has occurred and property values have risen accordingly resulting in a growing sense of disconnect between the southern (South Parkdale) portion of the neighbourhood and the more quickly transforming northern portion of the neighbourhood (Roncesvalles). Another social statistic that suggests an increasing divide between these two portions of the Parkdale area is in the trend of recent

² Ibid

³ *Malvern Social Profile #4 – Neighbourhoods, Income and Poverty*. City of Toronto - Social Policy Analysis & Research section in the Social Development, Finance and Administration Division. July 2008

immigrant settlement, with more recent immigrants gravitating to the South Parkdale portion of Parkdale than Roncesvalles due to cheaper rents and other factors. Trends in recent immigrant settlement between the two portions of the neighbourhood, from 2001-2006 are particularly revealing:

TABLE 1 – PERCENTAGE OF IMMIGRANTS IN RONCESVALLES AND SOUTH PARKDALE BY PERIOD OF IMMIGRATION:

Roncesvalles	South Parkdale
<u>2001-2006: 14%;</u>	<u>2001-2006: 31%;</u>
<u>1991-2000: 28%;</u>	<u>1991-2000: 27%;</u>
<u>1981-1990: 18%;</u>	<u>1981-1990: 14%;</u>
<u>1971-1980: 12%;</u>	<u>1971-1980: 12%;</u>
<u>1961-1970: 9%;</u>	<u>1961-1970: 9%;</u>
<u>Before 1961: 19%⁴</u>	<u>Before 1961: 7%⁵</u>

In addition to the greater proportion of recent immigrants settling into the southern portion of Parkdale (i.e., South Parkdale), large proportions are from racialized groups and living in low-income or poverty. The City of Toronto calculates that 56.3% of all individuals aged 15 years or older in South Parkdale are living with low-income or in poverty.

REXDALE AND JAMESTOWN

Located in the north-west corner of Toronto, Rexdale covers the northern section of Etobicoke, which was an independent city until it merged with five other municipalities to form the new City of Toronto in 1998. Rexdale evolved into a suburb of Toronto starting in the late 1950s, and has gone through significant evolution over time, from early days that saw mainly English and Scottish immigrant population, to significant waves of new, recent immigrants beginning largely in the 1980s.

The population of Rexdale, according to the 2006 Census, is 94,469 living in 30,238 households. The population grows at a rate comparable to surrounding communities; however, there are several sub-regions of Rexdale that experience significantly different social and economic realities.

Two of these in particular—identified by the City of Toronto as “Rexdale-Kipling” and “Mount Olive-Silverstone-Jamestown”—indicate significantly higher rates of low-income, poverty, racialization, precarious housing and other barriers to health than the remaining portions of Rexdale.

These two sub-regions of Rexdale were selected for examination by the Inner City Health Working Group due to these distinct social, economic and political realities. A number of these socio-demographics are presented below, in Table 2.

⁴ *Roncesvalles Social Profile #2 – Neighbourhoods Language & Ethnicity.* City of Toronto - Social Policy Analysis & Research section in the Social Development, Finance and Administration Division. July 2008

⁵ *South Parkdale Social Profile #2 – Neighbourhoods Language & Ethnicity.* City of Toronto - Social Policy Analysis & Research section in the Social Development, Finance and Administration Division. July 2008

TABLE 2: SOCIO-DEMOGRAPHICS OF FOUR INNER CITY COMMUNITY AREAS

	% Visible Minority or Aboriginal	% home language not Eng or Fre	% Recent immigrant (2001-2006)	% of all Immigrants who landed 1991-2006	Families with low-income	Low-income among indiv. 15+	% who rent dwelling (ie, don't own)	Unemployment rate
CITY OF HAMILTON AVG⁶	15.2%	12.5%	3.3%	34.4%	14%	--	31.7%	4.2%
Hamilton Urban Core	28.3%	19.7%	8.6%	49.4%	34.5%	--	71.4%	5.7%
CITY OF TORONTO AVG	43.5%	47%	11%	--	20.6%	41%	46%	7.6%
Malvern	87%	34.5%	11.3%	49%	23%	45.6%	29%	8.8%
Parkdale: Roncesvalles	32.8%	24.7%	7.6%	42%	19.4%	48.6%	55%	--
Parkdale: South Parkdale	56.7%	36.2%	18.8%	58%	40%	56.3%	91%	--
Rexdale: Rexdale-Kipling	42.4%	26.5%	8.3%	38%	19.4%	47.1%	45%	--
Rexdale: Mt Olive-S'tone-Jamestown	85.5%	47.8%	22.2%	53%	28.8%	51.5%	52%	--

⁶ Statistics Canada. 2006 Census. Calculated from: <http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92591/details/page.cfm?Lang=E&Geo1=CSD&Code1=3525005&Geo2=PR&Code2=35&Data=Count&SearchText=hamilton&SearchType=Begins&SearchPR=35&B1=All&Custom=>

10.0 LITERATURE REVIEW SUMMARY

That social and contextual elements can have a serious impact on health, including the mental health of individuals is hardly new knowledge as the abundance of international literature on social determinants of health shows. Particularly the United States and the United Kingdom contribute a large portion of related findings to the body of existing literature. There seems to be an assumption that Canada experiences fewer health inequities and inequalities that are related to poverty or socioeconomic status when compared to the United States or the United Kingdom (Wasylenki, 2001). But, as Wasylenki (2001) points out and this report supports, emerging study findings are proving contrary.

While it may have been traditionally difficult to document health problems as directly resulting from racism and poverty, recent literature and reports provide empirical support for the analytical concept of racism and poverty as co-determinants of health, particularly for racialized and disadvantaged populations in the inner city. This review makes the linkages between racism, poverty and health clear. It highlights what racism looks like in the everyday lives of racialized individuals and how it impacts their health and well-being.

Ornstein (2000) reports that apart from racial discrimination, racialized groups in Toronto experience disproportionate levels of poverty, homelessness, inadequate housing, and access barriers to health care when compared to their White counterparts. Similar disproportionate rates, such as the overrepresentation of racialized families in the child welfare system and of racialized men in the forensic system and psychiatry, suggest a strong interrelated relationship between structural disadvantage due to racism and factors associated with poverty (Fernando, 2003; Galabuzi, 2001; Kafele, 2004; Nazroo, 2003).

In terms of concrete health outcomes, disparities have been documented for various ethnic or racialized inner city communities in Canada as well as the United States and the United Kingdom. Conceptualizing racial classifications as part of the social structure and hierarchy in Canada, Wu and colleagues (2003) argue that prevailing explanations based on socioeconomic status, social resources and interaction alone cannot adequately account for such health disparities. Others echo the notion that social and economic inequalities are underpinned by racism at multiple levels, and therefore play a fundamental role in health disparities (Ahmed et al., 2007; Gee, 2002; Nazroo, 2003).

While 'race' is sometimes named a health risk factor, a number of studies clearly identify racism as a key social determinant of health (Gee, 2002; Harrell et al., 2003; Karlsen & Nazroo, 2002b; Krieger, 2003; Nazroo, 2003; Peters, 2004; The Calgary Health Region, 2007). The community health organization Women's Health in Women's Hands (2003) found that racial discrimination shapes the health of young women of colour in Toronto and identified racism as a major health risk. Their report explains that racism creates barriers to accessing quality healthcare, health education and information for racialized people. Another Canadian-based report reviewed existing health research and local initiatives in Nova Scotia, and identified that black women in Nova Scotia experience

increasing suicide rates, racism, and disproportionately high schizophrenia diagnoses rates (Enang, 2001). Examining 593 cases of breast cancer, Taylor and colleagues (2007) assessed the relationship between perceived experiences of racial discrimination and breast cancer among black women in the United States. Their findings showed that particularly among younger black women, perceived experiences of racism were associated with increased breast cancer incidences (Taylor et al., 2007).

Many other relevant studies confirm that mental health is an aspect of health which is especially affected by experiences of racism. Krieger's (2000) review of 20 American public health studies, for example, illustrates that some of the most common health outcomes from self-reported experiences of racism are depression, psychological distress, and high blood pressure. Similarly, a wide range of studies provide evidence that the material deprivation associated with low income, socio-economic status and/or poverty significantly impacts on mental health (AAMCHC, 2005).

Based on a wide-ranging review of relevant literature on various determinants of health for racialized groups, the Access Alliance Multicultural Community Health Centre (2005) in Toronto reports that low socio-economic status and poverty manifests often as depression, anxiety, and other forms of psychological distress and mental health issues. Overall, the negative effects on health caused by factors related to poverty are particularly exacerbated when poverty is experienced over a life-span rather than episodically (in AAMCHC, 2005).

Based on data from the Fourth National Survey of Ethnic Minorities, Karlsen and Nazroo (2002b) assert that experiences of racism - and not ethnic identity as traditionally assumed - are directly related to health outcomes, regardless of the health indicators that were used. Other reports highlight that racism and experiences of racial discrimination are closely tied to socio-economic status, low income, and poverty (Ahmed et al., 2007; Gee, 2002; Nazroo, 2003; Ornstein, 2000; Wu et al., 2003). Reviewing empirical evidence in available American literature, Ahmed and colleagues (2007) highlight how institutional racial discrimination shapes socio-economic status and ultimately affects the health of racialized populations, and in particular African Americans. They establish a clear relationship between the consequences of institutional racism and poverty and health. Key in their overview is residential segregation.

The reviewed reports emphasize that for analysis and action purposes around health, racism and poverty can no longer be treated as separate variables with independent outcomes for affected populations. The lived experiences of individuals who as a result of racialization often face barriers to accessing quality health care warrant further targeted research and action by way of policy development and implementation, particularly since the experiences are not limited to socio-economic status alone.

11.0 PROJECT ACTIVITIES

The project activities included:

- Community survey – *a survey disseminated to and collected from racialized individuals / groups by project partner organizations*
- Key informant interviews – *one-hour interview with racialized community “experts” using a mixture of question types (narrative response, multiple choice, scaled)*
- Focus groups – *3 or 4 focus groups comprised of no more than 10 racialized individuals (community members) led by an experienced group facilitator or researcher with lived experience of racialization*

The determination of project activities or methods was appropriate to the intended community population and was based on:

- a) the absence of systematically collected data on race and health requires the use of alternative methods to identify the impact of racialization on health
- b) The complexity of perceptions related to race/racialization, self-identification, and lived experiences that have an impact upon health require a diversity of qualitative information gathering methods.

In combination, these activities or methods (survey, focus group, and key informant interviews) increased the project’s ability to identify priority themes or findings, and to assess the impact/weight of biases and subjectivity on the findings.

The results of the project activities are summarized by category.

11.1 Results of Community Survey

One of the primary objectives of the research was to examine experiences of racism while seeking health and social services in marginalized communities within a cross-section of racialized service users. In order to meet this objective, a questionnaire survey was distributed to mainly community members accessing community health and other social services in the four inner city areas. In total, 184 community members completed the surveys. The results are summarized below.

The surveys were distributed and in most instances completed at locations where community members have established a relationship of trust with the service provider and have access to the health services and supports they need. However, this relationship may have also influenced responses as respondents identified overall access to health exclusively with their relationship or experiences with the service

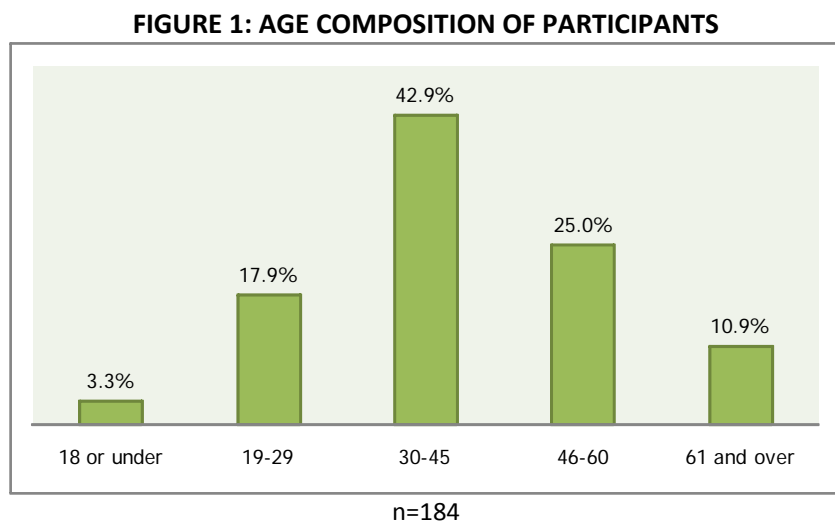
provider where they do have access. In addition, based on responses to defining racism and feedback from those assisting with the distribution and completion of the surveys, some respondents were not able to define their experiences as evidence of racism due to a number of factors including:

- being new in the country and therefore unfamiliar with the manifestation of racism in Canada
- not understanding the reason for the differential treatment
- complexity of issues
- not sure how to define racism
- not wanting to acknowledge their experience as racism

The key informant interviews and focus groups were useful mechanisms for further exploration and understanding of experiences of racialization.

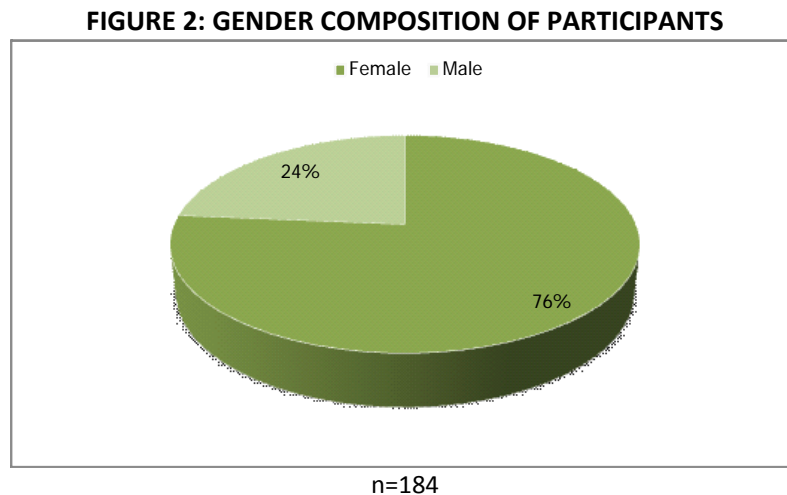
SOCIO-DEMOGRAPHICS

The surveys collected information on several social and cultural characteristics of the respondents. Overall, the largest group of respondents, over 40% of the survey sample, was between the age of 30 and 45 (Figure 1).



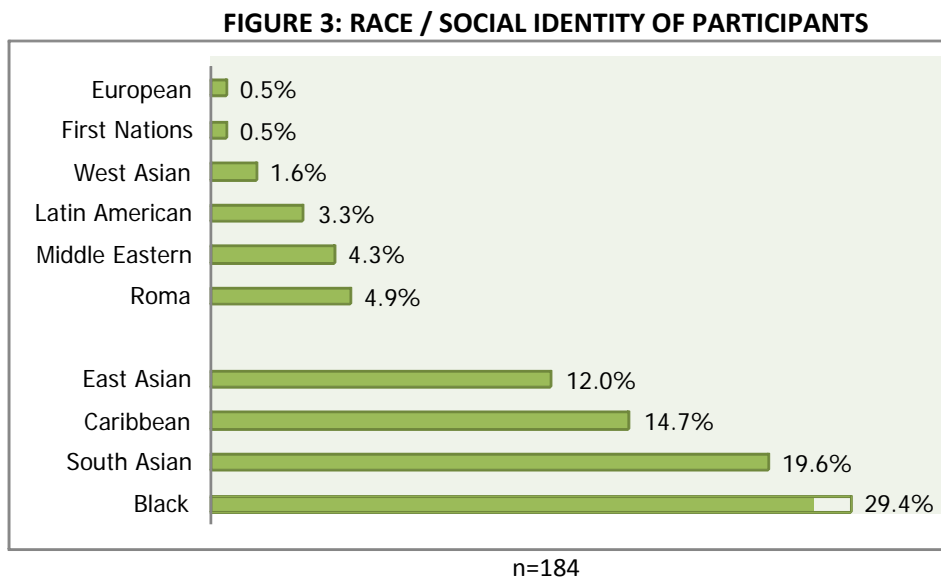
The second largest group consisted of individuals between the age of 46 and 60 years of age with over 20% of the sample coming from this age group. Respondents between the age of 19 and 29 (17.9%) and those over 60 years of age (10.9%) made up smaller although substantial numbers in the survey. Less than 5% of the survey respondents were below the age of 19.

In terms of the gender characteristics of the survey sample, more than 75% of the respondents were female (Figure 2).



Conversely, less than a quarter of the surveys were completed by male respondents. Because the sample was determined by self-selection, these numbers likely reflect the fact that more women use (community) health services than males or that a greater number of females demonstrated an interest in completing the survey than males.

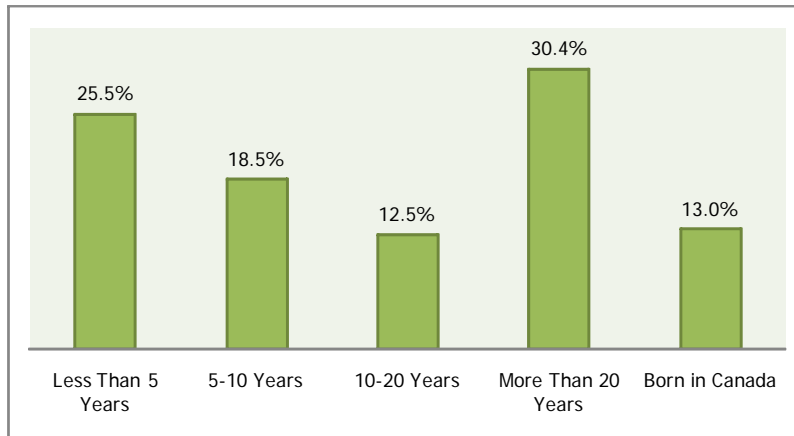
The survey participants included a diversity of ethnic and racial backgrounds (Figure 3).



The survey results indicate that the largest proportion of respondents identified their ethno-racial identity as Black (29.4%), South Asian (19.6%), Caribbean (14.7%) and East Asian (12%). It may also be assumed that many of the participants identifying as Caribbean could be categorized as Black.

There was also a diversity of immigration characteristics (Figure 4).

FIGURE 4: IMMIGRANT STATUS AND LENGTH OF TIME IN CANADA



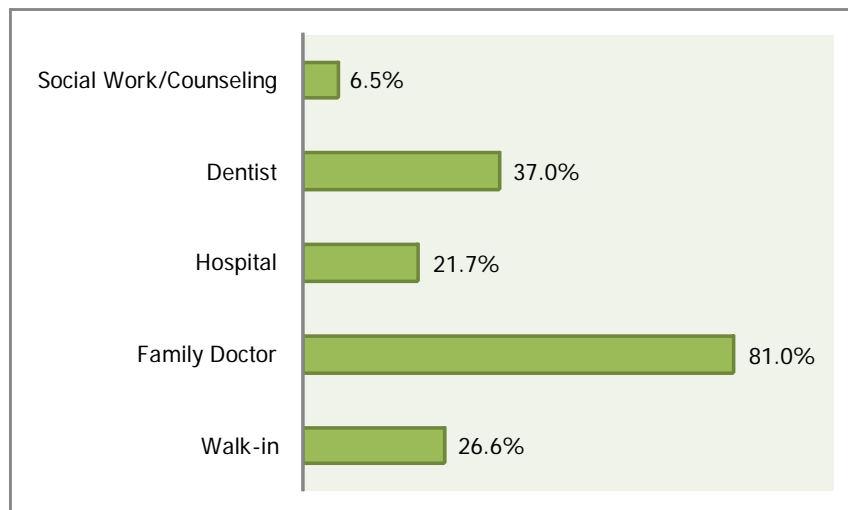
n=184

Almost 90% of the survey respondents were born outside of Canada. Slightly over 30% reported having lived in Canada for more than 20 years. The second largest group was made up of recent immigrants – over 25% indicated that they had lived in Canada for less than five years. The high number of respondents born outside of the country also contributed to the under-identification of racism as the experiences of racialization manifest differently in different countries or regions and may not be easily recognized or articulated in the same language as is generally used in Canada.

HEALTH-RELATED SERVICE USE

In order to get a sense of the health care services utilization of respondents, they were asked to identify services they have used in the past (Figure 5).

FIGURE 5: HEALTH-RELATED SERVICE USE



n=184

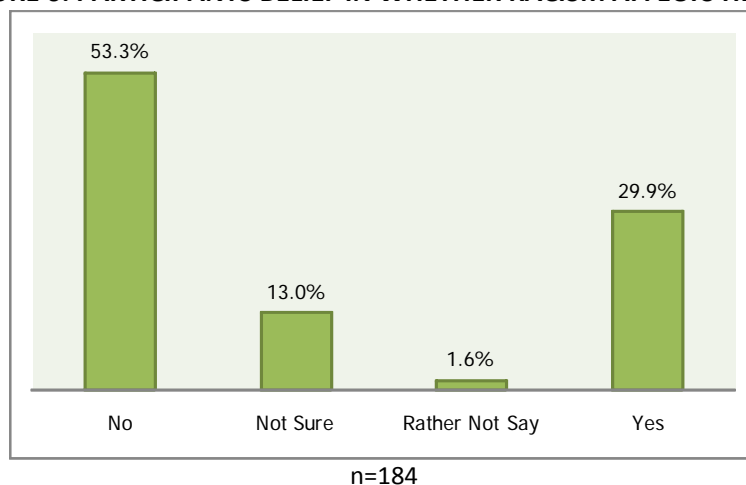
The majority of respondents, over 80%, indicated that they use a family doctor, followed by 37% who indicated using dental services. Slightly more than 25% of the

respondents indicated using a walk-in clinic for health services. About 1 in 5 reported using hospital, including emergency services. A small number of participants reported using social work or counseling services (6.5%).

RACISM AS A SOCIAL DETERMINANT OF HEALTH

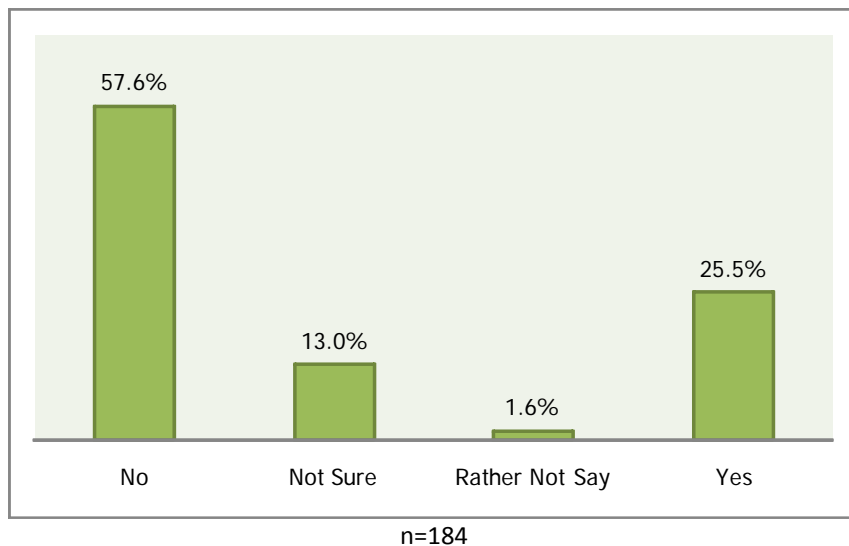
A number of respondents did not believe that experiences of racism negatively affected their health. This is likely due to the fact that there is little attention given to the impact of ongoing or “everyday racism” on racialized people in health assessments, approaches, examinations or treatment. For example, the impact of stress on one’s health is fairly well documented however risk factors such as racism are rarely considered. This may lead one to believe that there is no connection or correlation between the incidence of stress and the experience of racialization. As a consequence people often do not associate their personal experience of racialization with a health issue or concern. Interestingly, a sizable number of respondents - just over 44% - acknowledged that racism has adversely affected their health or that they are unsure or unwilling to acknowledge that racism has adversely affected their health (Figure 6).

FIGURE 6: PARTICIPANTS BELIEF IN WHETHER RACISM AFFECTS HEALTH



A significant number of surveys were distributed amongst community members who access health and health related services at community health centres. The Community Health Centre Model of Care emphasizes the importance of eliminating barriers and providing services from an equity framework that factor in the social determinants of health as a matter of routine functioning. Not surprisingly then that a number of respondents – 57% - reported that they did not experience racism when seeking health-related services. At the same time approximately 40% of the respondents reported experiencing racism, not being sure if they experienced racism or not willing to report if they experienced racism when in accessing health related services. This may be an indicator of services received in a variety of health settings and/or with different health providers. (Figure 7).

FIGURE 7: PARTICIPANTS WHO REPORTED EXPERIENCING RACISM WHEN SEEKING HEALTH-RELATED SERVICES



11.2 Results of Key Informant Interviews

CHALLENGES FACING RACIALIZED COMMUNITIES IN INNER CITY AREAS

Four key informant interviews were conducted with individuals considered to have a high degree of knowledge about issues impacting racialized communities as well as a solid understanding of racialization and the impact on the health and well being of racialized individuals, families and communities. The key informants were asked to comment on the frequent problems or barriers that are faced by the community in general and in relationship to accessing appropriate services. Highlights of their comments include the following:

“There are considerable issues for our populations regarding housing, including homelessness, those who are under-housed, those at risk of homelessness, those living on low income or with no income.

Our population is largely unemployed and for those who have a job it is casual or temporary work.

Some do not have phones and cannot be contacted even if they do get called for an interview or job. If they do get an interview they don't have the money to purchase clothes for the interview.

In general our community experiences high unemployment across all ages and our youth are certainly disenfranchised

Newcomers credentials are not recognized which affects their ability to get a job and take care of their family

Most immigrant populations want their kids to do better which is why they may have left their home country but in some cases they will not do better – they will have to leave school early

Some people may, but most do not express it as an effect of racism because they are so focused on upward mobility and may internalize their struggles as the result of personal flaws. They feel depressed, insecure, ignored. They feel stupid. They may be doing well financially when they enter the country but the funds evaporate quickly.”

Respondents spoke strongly of the relationships between racism and other experiences of oppression and adverse health outcomes. For example, one respondent remarked that:

“This is absolutely a fact that racism and discrimination affects health outcomes. Our community members are living in poverty with little or no income. Because of this, they cannot afford nutritional foods, fruits and vegetables. Their health suffers tremendously. If you have to choose between groceries and rent or hydro this stresses parents out. They find themselves in these situations regularly so it is no wonder that we are so sick all the time. They cannot afford to take children to movies or buy the right snacks for school like other children from families that have good income and from the majority group. This makes parents feel bad and embarrassed to not be able to provide for their children.”

She added that these experiences feed into social exclusion and isolation which undermines the mental and physical health of people:

“They are socially isolated because of poverty and their cultural background. No money to participate in things that people with a good income participate in such as going out for dinner, movies, shopping, taking vacations.

If you are poor and a person of colour, you are in double jeopardy – no or low income, no housing or very unsafe housing. You actually have too many disadvantages to enjoy good health and a happy contented life. People of colour suffer a lot so this will inevitably take a toll on their health and well being. I believe that mental health issues are one of the main outcomes – stress, depression, low self-esteem.”

Stress and depression were also identified by another provide who added that physical ailments were major concerns although rarely acknowledged as related to experiences of racism:

“Depression, stress or stress related mental health conditions, physical conditions that you may not readily or necessarily attribute to the impact of racism, such as heart disease, cancer and even suicide.

Stress is huge, diet changes, people are not as active. Not enough meeting places. Less activity.”

Interview respondents highlighted that experiences of racism differed according to identity. Specifically, racialized individuals experience racism in conjunction with other forms of oppression such as patriarchy and according to their age and other social markers.

“The intersection of the various forms of discrimination is observed regularly with our clients. For example, seniors, women and youth from racialized groups are more marginalized than their peers from Eurocentric communities.

Being homeless, gay, lesbian, bisexual, youth, non-Christian, woman and racialized (black, Asian, etc) and the impact of discrimination is greater.

Research for the most part is carried out using white women or white men; however the results are applied to those of other racial and ethnic backgrounds without prior testing. Most of our population lack necessary mechanisms and supports in order for them to gain access to resources.

There are no specific health promotion strategies developed for these groups by our Provincial government, and Public Health agencies. Prevention is based primarily on Eurocentric ideas so of course they do not work well on racialized populations.”

EXPERIENCES OF RACISM IN THE HEALTH AND SOCIAL SERVICES SECTOR

Interview respondents were generally in agreement that discrimination occurs at many levels within the social and health services sectors.

As one provider in Hamilton noted:

“Many of our clients face discrimination when accessing many social services and social activities. There may be multiple barriers for them in accessing any number of services such as racism and other forms of discrimination, no interpretation service, lack of cultural language services, living with poverty, no resources for transportation.

Other challenges includes discrimination based on age; too old (ageism), many have disabilities and are subjected to derogatory comments and inaccessible services (ableism), sexism, lack of communication devices, no bus tickets for transportation, no food, English is not their first language.

Some of our clients are mandated to be in school for a certain period of time and are penalized for missing school due to appointments such as medical related. Many cannot afford to pay for child-minding so that they cannot go out and look for work.”

A provider at an organization serving aboriginal and Métis communities reflected on the poor social status in her community with the following comments:

“Many Métis people are poor and do not have easy access to education – post-secondary, skilled trades or professions. This disenfranchises them from having access to good jobs, proper housing, good nutrition and social activities. Hence they continue to be poor and socially isolated. It’s difficult to get out of your predicament if you never get support to get out. There is an expectation that we will not make it out of this poverty and this has a lot to do with how you get treated.”

Nevertheless, the respondent acknowledged that the forms of racism that Aboriginal and Métis individuals experience were distinct from the experiences of other racialized communities:

“In terms of the Métis population, many of the barriers are not associated with being visible minorities unless you are Métis and Black. Most Métis people look white but are of mixed heritage and culture (Aboriginal, African or French or all). For those of us with darker skin, yes we are visible, and hence experience some levels of racism or skin colour discrimination. Much of our barriers are related to poverty, low levels of education, ostracism because of our cultural practices and beliefs, unemployment and housing (under-housed and at risk of homelessness.) We need a lot of money to be able to get out of these issues. There is a lot of despair in the community

because most of them are stuck in a cycle of poverty. How do you think of getting a job without education, or money?"

Discussing the experiences of placement students in hospitals and other health services, one respondent acknowledged that racism was not only a problem for users of services but also providers who are from racialized communities.

"In terms of my students, who are mainly people of colour they experience racism quite a lot especially in the health care system. They work in health care facilities..."

"Many of them have difficulty because their first language is not English. I see mostly the discrimination around language, their accents and sometime cultural practices. They have to be quick to understand the industry language once they are on the job or they may risk not being kept on staff or being called for work. They are made to feel inadequate and unqualified because of their accents and their command of the English language"

ISSUES FACING SERVICE PROVIDERS

Many of the conversations about discrimination in the service sector led to the challenges some community agencies face seeking support for programs for racialized and marginalized communities. According to one respondent working in an agency in Hamilton's Beasley community:

"The funding is usually not enough for the enormity of our problems. We are glad and we take it because it gives us hope.

I know that there are issues when we have organizations who are serving the same community working together – perhaps due to the competition for funding. We tend to get agitated and tense with each other.

If they (funding agencies) fund you it is project-based with a very short life and tight timelines. This leaves agencies that are working with marginalized populations with no or very little long-term ability to carry out long-term impacts.

Often we as an agency and professionals are ignored as a stakeholder and decisions are made in our absence.

There are currently no mechanisms to support and promote service user's abilities to be at the decision-making tables especially when these decisions will impact the clients."

11.3 Results of Focus Group Consultations

Four focus group sessions were held during the project across the identified communities with approximately 40 participants in total. The focus groups provided a forum for community members to share their perceptions, opinions, and experiences about racism, racialization and health inequities in an open and interactive group setting. All of the focus group participants were from racialized groups or communities.

Focus group participants were provided with information about the research project and its intended use. Ground rules for participation were established with the participants and individual consent forms were signed.

It was evident throughout the focus group discussions that participants had a clear understanding of racism and how, as racialized people, racism impacts their health. Participants identified both overt and covert manifestations of racism as experienced in their interactions with service providing organizations. General themes emerging from the focus groups discussions may be categorized as:

- *Quality of Service – feeling that racism changes the quality of service received and as a consequence impacts health*
- *Access – experiencing multiple barriers in accessing information, health and health related services*
- *Differential Treatment – strong feelings that racialized people are treated differently and receive different treatment than non-racialized people*
- *Cultural Competence – the absence of an understanding of and commitment to culturally competent care results in the lack of cultural interpreters to ensure accurate communication, poor cultural knowledge as it relates to the realities of racialized clients, health care providers who are not reflective of racialized groups and poor inter-cultural communication*
- *Impact – experiences of racialization resulting in depression, sadness, anxiety, sleeplessness, stress, physical illness such as vomiting, pain, nausea, anger, frustration*

The focus groups also provided an additional opportunity to further probe concepts of racialization noted in the community surveys and key informant interviews guided by experienced facilitators. The results are summarized as follows:

DEFINING RACISM AND DISCRIMINATION

When asked about how they thought about racism, what racism meant to them, and how they may have experienced racism, there were many different responses. These responses highlight the many forms and aspects of racism and the difficulty people

have explaining racism in its totality. For some, racism appeared a matter of interpersonal attitudes, without a historical basis that is reflected in structural inequality. For others, racism had to do with their socio-economic status and lack of opportunities in Canada.

Several participants explained how racism was a new experience for them since moving to Canada. For example, one participant from Hamilton's downtown core area remarked:

“Once I came to Canada, I started to be treated differently. I never felt out of place back home like I do here.”

Another participant identified racism based on skin colour in combination with other social identities acknowledging how racism can include bias against racialized religious minorities:

“To me, racism is related to being Black or White. It has to do with skin colour and related to my religion – being a Muslim who wears a head scarf – and if you have an accent and English as a second language.”

Most understood racism to be a phenomenon where some members of society are treated differently leading to social inequality:

“It (racism) means that I am treated like a second-class citizen and everywhere I go I feel that that – especially at work.”

Others recounted their experience of “everyday racism”:

“Racism in Canada affects me once I leave my house – I notice I am treated differently outside my home.”

From these descriptions, it was apparent that the understanding of racism extended from personal experience to experiences in society in general.

EXPERIENCES OF RACISM

For many people racism has become an everyday experience which is often far more complicated than individual acts of harassment. For the most part racism occurs as incidents against a backdrop of everyday living and can affect every aspect of a family's or individual's life.

Focus group participants shared their experience with racism and racialization through providing numerous examples. A selection of the experiences reported is noted as follows:

Comments from a survivalist approach:

“I know that racism is there, but I believe in myself and I feel that I have the power to not let it bother me. I take control of my life.”

Comments related to employment experiences:

“I have experienced racism on the job and in my career. I am an engineer and I have accepted the fact that because I am new to the job and from a different country that I need to demonstrate that I can do the job. Still, it hurts to see that employers accept other applicants who are less qualified than I am to do tasks even when the quality of the work suffered.”

“Before getting this position (as an engineer), I worked as a labourer because no one would hire me as a professional. Even as a labourer, I experienced racism because I excelled at my job and they (management) still refused to promote me. I accept that to some extent, but how long should I have to pay the price of being an immigrant? It was very discouraging to be denied over and over again to less qualified persons.”

Comments related to “everyday racism”:

*“Riding my bicycle through the neighbourhood I was called racist names.”
“My daughter and I were riding the bus and a White male had his foot against the rail causing a barrier and blocking the path. He also had a newspaper on the seat beside him. My daughter picked up the newspaper and moved it. The White male became angry and started yelling and name calling....”*

RACISM AS A SOCIAL DETERMINANT OF HEALTH

Racism, as a health risk or social determinant of health, is rarely considered in health assessment, treatment or planning. Yet, racism certainly affects peoples' lives in ways that may either directly or indirectly affect their health and well-being. For example, racial discrimination in education and employment contribute to poverty and poverty is among the most strongly associated factors in health outcomes. More directly, experiences of racism can affect how people view themselves and therefore influence their emotional and mental health. Body image, self-esteem, personal anxieties, stress, depression and physical illness may all be shaped by one's experiences of racism.

While the majority of participants had a solid understanding of how racism impacts the health and well-being of racialized groups or communities, most had never experienced their physical and mental health status being discussed as an outcome of racism with

their health provider. However, in the focus group discussions most participants were clear about the links and offered deeply personal examples.

The words of one participant summarized a common remark found throughout the four focus group sessions:

“Racism is so deeply seated in this society. It’s not open in your face like in America. I believe it (racism) affects your health in all kinds of ways. It definitely causes a lot of health problems like stress related illnesses, heart attacks and strokes, low self-esteem and depression.”

For some the links between racism as direct factor in their health was not considered a major problem, and there was not much of a sense as to how the impact of racism on other areas of their lives could relate to their health and well-being. As a respondent noted:

“Racism affects your health but not a major concern to me; I think that racism is a bigger concern for employment.”

Others observed the links between experiences of racism such as experienced while accessing services with very real health outcomes and health inequity. A parent of a young autistic child gave a very emotional account of how unequal treatment within the health care system was undermining the health of her child:

For me it is devastating...my child is autistic and I have seen firsthand how we are treated differently...

My child has been on the waiting list for therapeutic services for a long time. I met a White woman whose child is also autistic and found out that she also has a child on the same waiting list. I also met second person whose child is also on the same waiting list. Three months later I was told that both White women’s children were called for openings in the program. I called to complain and was told that I had to take proof that I was bypassed. I called these two women to ask if they would share their waiting list document with me and they did. The program manager then told me that she takes children based on need. I was so angry that I asked if it was because I am a Black woman. She then threatened to call security on me for being violent. I asked her if I am violent because I am asking a question that might be true. Shortly after this meeting she called me for an opening...

I discovered that in Hamilton only a few Black children are in therapeutic programs for autism. This situation stressed me out; I couldn’t eat and could not sleep for weeks. I was stressed waiting

for the appointment and now am stressed because I am worried that they may mistreat him because he is Black. I have gained weight because I am so stressed that I eat too much.

This account of unequal treatment by health care administrators clearly indicates the way that health care discrimination can not only put those in need of care at greater risk for poor outcomes but also affect their families. As a parent, the participant was deeply concerned with the unfair treatment of her child by health care administrators. Partly because of the lack of transparency in the way that the waiting list for services for her child was administered and partly because of her deeply-held conviction that her child was receiving unequal treatment, the participant saw her own health worsen over time. One can only imagine how the well-being of her child suffered while waiting for support from the health care system.

A participant remarked that experiences of racism led to difficulty sleeping, while others noticed that they became more isolated and less out-going because of their experiences of racism: In the words of one young woman,

“Insomnia is a problem sometimes when I think about the racist encounters that I experienced during the day.”

Another stated that they,

“Dread facing White people everyday”

This dread and apprehension was acknowledged to affect behaviours, including health seeking behaviours and experiences:

“I am happy in the house but once I have to leave home to go to some service or appointment, I get depressed”

“I feel frustrated when I have to speak with my children’s teachers because they talk down to you. They use very small, simple words and speak loudly. They give us very little information and you can hear that they are giving others more and detailed information. I know it’s because we are different than them - not White, we have an accent and English is not our first language and we are Muslim.”

EXPERIENCES OF RACISM IN THE HEALTH CARE SYSTEM

Participants were asked to discuss their personal experiences when accessing health care and related services in their communities.

“My friend has been told that in order to get her cheque she must go to a psychiatrist for help. She hates going and complains to me all the time because they make fun of her. Referring to her experiences of spousal abuse, she once said that the psychiatrist had said to her:

'is this (violence) not acceptable in your culture?' and 'why are you complaining about it' and he's referring to the violence she is experiencing in her relationship. He mocks her throughout the appointment and makes no attempt to understand her problem. She says that she is a spectacle that is observed by his student/residents and researchers – the exotic African. She is horrified to go every week. She has anxiety attacks and cries before she goes. The last time she went the doctor told her "aren't you people African and aren't Black men savage and violent anyway", "you women should be used to this by now. She asked to be moved to a Black psychiatrist who may understand and treat her with respect but OW refused."

Differential treatment by physicians was mentioned several times in different focus group discussions. One respondent described a very humiliating and racist first encounter with a family doctor whom he wanted to apply for:

"My first doctor in Canada made me take an HIV test before he took me as a patient – he said that we people of African heritage carry HIV. This made me feel so bad and unclean. I just did not know how to react and what to do. It makes me so anxious and stressed to go to this doctor who is in charge of my health because he has some kind of bias against me."

Another was convinced that she was overlooked by health care staff when making and keeping appointments:

"I notice when we make a doctor's appointment and I go on time, I still have to wait a very long time and we notice that other people come after us and go in before us. More than once, I have left the office after waiting for over an hour. I have other commitments and cannot stand around waiting for them to stay on time."

In another discussion, it was added that:

"When we go to the walk in clinics, there is always a long wait time for the doctor even though we have an appointment. But, when you complain about the long wait time, they accuse us of being too touchy and complaining too much."

Another remarked that waiting made her less willing to go to her family doctor and made her question whether her experiences were due to her race and religion:

"I don't like going to this doctor and I feel anxious when I have to make an appointment. The last time when I left because of the wait, the secretary called me the next day to ask why I left. I told her that I

wait for 2 or 3 hours, no one talks to us, others go in before me and I feel that they do not respect us. She said that she left me for last because I might have more complicated problems and the others just had something quick to do. This is wrong. Is this because we are Black and Muslim??”

These experiences could potentially lead to negative attitudes about the quality of care. One even remarked that she felt that going in for surgery may put her at great risk than if she did nothing at all:

“When I had surgery I was so worried that they were not giving me good care. I was very scared that I would leave sicker than when I went in, all because I am Black. The nurse was irritated with me when she was trying to take blood and said ‘you people have such tough skin, I can’t even get the needle in’. I was scared that she would hurt me or something.”

Throughout the focus group discussions, there was a common thread of concern that the health care system did not include or respect their needs at best and, at worst, that it could worsen the health of clients.

Another participant from the Malvern area indicated that she, as a Black woman, had experienced racism at the hands of Black nurses. In her view, Black nurses do not treat other Black women well. This was an issue she saw as how racist ideas and attitudes can be directed from even racialized individuals and also underscores the importance of understanding internalized racism.

Another participant described what he thought to be clear discrimination within the emergency ward. Recently, he went to the hospital emergency department with a severe hand injury. He was in extreme pain. The emergency intake asked him to sign papers, and while doing this he noticed that a young white man came in after him with a lesser injury was given priority.

During another discussion, it was remarked how difficult it can be to even find a practitioner, especially as a newcomer. One participant described how doctors may reject newcomers because of the belief that they will be difficult patients:

“When we were looking for a doctor, we found one who said that they were taking patients but once they hear your accent you get turned down. Once we arrived at the office for our interview, the doctor came out and said that he no longer has space for us.”

In another group discussion, it was remarked that newcomers may be streamlined to practitioners who only take immigrants, although they may not be particularly expert in addressing their issues.

“I’ve experienced being passed off on the doctors that only take “immigrants” or who “understand your culture”. This doctor was not my choice but we were forced to go there.”

It was also acknowledged that finding a willing doctor located close-by was a major difficulty and therefore people were forced to travel far distances to access care:

“The doctors are far away from my home...sometimes it takes me two hours on the bus to go to appointments... I’ve missed a lot of appointments because of this and when you get these doctors who are so far away we cannot afford the transportation costs if you are on Ontario Works.”

Overall, the experiences participants had accessing health care clearly indicated that racism and discrimination were major concerns when seeking health care services. Participants were able to connect their experiences to their broader health and well-being seeing racism and racialization as a true health risk and a constant reminder of their vulnerability in Canadian society.

TRANSFORMING HEALTH CARE TO SERVE RACIALIZED COMMUNITIES

When asked for suggestions as to how to improve health care services in their communities, participants offered a lot of advice. One of the main considerations was for doctors or health providers to develop principles regarding how they treat people of colour. Most indicated the need for practitioners and health care planners and administrators to acknowledge how they may reinforce and exacerbate inequalities in the broader society and to develop ways to ameliorate these inequalities as they relate to health and well-being. The suggestions made by participants are summarized as follows:

- Develop, implement and abide by a code of conduct regarding treatment of racialized clients that includes developing trust, cultural competence, and informing, communicating and consulting with racialized clients in an appropriate and effective manner
- Spend more time with clients, be patient and listen
- Provide services that are culturally sensitive and relevant to the need of racialized people
- Consult with clients to identify their needs and to evaluate their experiences using services or receiving care
- Expand the use of professional cultural interpreters and cultural translators to ensure language appropriateness and equity in accessing information and knowledge

- Acknowledge racism and its relationship to or impact on the health and well-being of racialized clients and recognize that racialized individuals routinely experience being ignored, isolated, and patronized
- Include more racialized practitioners at all levels within health care professions. Support the training and recruitment of more doctors and health care providers from racialized communities who reflect various cultural, religious and racial backgrounds.
- Engage in education and training in terms of racism, racialization, poverty and cultural sensitivity and get an understanding on how these issues are interconnected and impact the health and well-being of individuals, families, groups and communities.

12.0 CONCLUSIONS

This research project serves to provide some insight into the complex and multiple issues of racism, racialization and health inequity. It is intended to prompt further research, discussion and exploration in order to affect public health policy and service practice regarding racialized populations. It is also intended to provide better understanding of the intersectionality of the inner city, poverty and racialization and the relationship to health and well-being. Over the course of the project many individuals from racialized groups or communities shared their experiences of racism and racialization as it relates to both health and everyday life. Their insights and responses highlight the need for further work in exploring the true human cost of racialization, improving health system performance by addressing systemic racism and enforcing accountability measures towards achieving equity in health access, experience and outcomes. The project partners hope that this document serves as a catalyst for direct and immediate action.

13.0 DISSEMINATION STRATEGY

This project report is a comprehensive account of the knowledge obtained from the activities taking place throughout the project. The report will be distributed to:

- Community organizations and agencies such as Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs), Social Planning Councils, United Way, and others
- Provincial Associations such as the Association of Ontario Health Centres, the Ontario Council of Agencies Serving Immigrants and others
- Local Health Integration Networks
- Project Participants

An electronic copy of the report will be placed on Hamilton Urban Core's website. The findings of this project will be included in a workshop presentation in June 2010 at the Association of Ontario Health Centre's annual conference titled: Health Equity: Pushing the Boundaries.

14.0 FUTURE DIRECTIONS

The Inner City Health Strategy Working Group is based on the premise that through the combined thinking, energy and efforts of a focused group a more ambitious vision of what must be done to address health disparities in the inner city will emerge. The Inner City Health Working Group will continue with this mandate and engage in further research and policy initiatives.

References and Appendices

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Appendix 1 - Literature Review

Canadian inner cities are characterized by high rates of unemployment, inadequate housing, full-time workers with low pay, single parent households, people with disabilities and chronic illnesses (Wasylenki, 2001). Inner city residents are faced with growing health risks which are associated with rising homelessness, access to illicit drugs, HIV infection and tuberculosis, and a concentration of carbon monoxide, moulds, and other pollutants (Wasylenki, 2001). What places inner city populations, and in particular 'the urban poor' at even higher health risks are public policies such as cutbacks in welfare payments and social services, and lack of proper social housing (Ahmed et al., 2007; Wasylenki, 2001).

Not surprisingly then, the Canadian International Development Agency proposes poverty reduction strategies and access to health care along with access to education, family planning, sanitation and shelter as solutions to combat the key problems of Canadian inner cities: poverty and pollution (Wasylenki, 2001).

While it may have been traditionally difficult to document health problems as directly resulting from racism and poverty, recent literature and reports provide empirical support for the analytical concept of racism and poverty as co-determinants of health, particularly for racialized and disadvantaged populations in the inner city. This review makes the linkages between racism, poverty and health clear. It highlights what racism looks like in the everyday lives of racialized individuals and how it contributes to their health. It also identifies what role racism plays in poverty and thereby contributes to the determinants of health via unemployment, low income, homelessness and social exclusion.

Life expectancy is shorter and most diseases are more common further down the social ladder in each society. Health policy must tackle the social and economic determinants of health. (WHO, 2003)

That social and contextual elements can have a serious impact on health, including the mental health of individuals is hardly new knowledge as the abundance of international literature on social determinants of health shows. Particularly the United States and the United Kingdom contribute a large portion of related findings to the body of existing literature. There seems to be an assumption that Canada experiences fewer health inequities and inequalities that are related to poverty or socio-economic status when compared to the United States or the United Kingdom (Wasylenki, 2001). But, as Wasylenki (2001) points out and this report supports, emerging study findings are proving contrary.

Poverty - often measured through the low-income cut-off (LICO) - and economic hardship tend to be the key concepts and foci among the majority of available reports. Some of these reports demonstrate that poverty can have detrimental consequences for the health and development of children from low income households (e.g. Aneshensel & Sucoff, 1996; Anisef & Kilbride, 2000; Nazroo, 2003; Samaan, 2000; Walker, 2005;

Waughfield, 2002). Particularly the American literature looks at environmental aspects of living in poverty including poor neighbourhoods, and its correlation to poorer health outcomes (Aneshensel & Sucoff, 1996; Ross & Mirowsky, 2001; Walker, 2005; Waughfield, 2002). Regardless of ethnicity, for example, a strong correlation between low income and high mortality rates has been identified (Wasylenki, 2001). Other studies have shown that income inequalities have adverse effects for good health regardless of income, such that income distribution becomes a predictor of health status (Wasylenki, 2001).

Waughfield (2002) states that being poor is a mental health risk because people who live in poverty face difficulties in relation to finances, employment, isolation and many more stressors which can in turn become barriers to health care access. Waughfield (2002) concludes that low socio-economic level results in poor nutrition, crowded living conditions, material deprivation, as well as harmful self-esteem issues. Samaan's (2000) literature review on the impact of race, ethnicity, and poverty on children's mental health in the United States, found that anxiety, depression, and anti-social behaviours are more likely to be reported by children of parents who experience poverty or extreme economic losses. Overall, Wasylenki (2001) reports that American and British literature has linked poverty to a greater likelihood of experiencing violence, producing high child abuse rates, and causing family and community breakdown in the inner cities. In 1997, the American College of Physicians referred to the social, economic, and health disadvantages of inner city populations as the 'urban health penalty' (Wasylenki, 2001). Associated with this 'urban health penalty' in the United States are higher rates of violence, teenage pregnancy, drug abuse, HIV infections, chronic illnesses such as tuberculosis, asthma and diabetes in inner cities (Wasylenki, 2001).

But as several significant reports and research findings point out: poverty is not the only critical determinant of health (Gee, 2002; Galabuzi, 2001; Ornstein, 2000). In 2002, the National Anti-Racism Council of Canada reported that experiences of discrimination based on 'race' or skin colour are a common reality in Canada. The Council asserts that Canada is stratified and experiences a growing racialized divide (NARCC, 2002). 'Race' indeed matters in people's lives, particularly in terms of structural barriers, access issues, and socioeconomic status (Ahmed et al., 2007; AAMCHC, 2005; Galabuzi, 2001; Gee, 2002; Harrell et al., 2003; Nazroo, 2003). 'Race' or the experiences of racialized individuals due to the consequences of institutional and structural racism often go hand-in-hand with experiences of economic hardship and low socio-economic status (Galabuzi, 2001; Ornstein, 2000). Galabuzi (2001) calls this the racialization of poverty, and with it cements the notion that a discussion of poverty can no longer exclude its racialized subjects. Galabuzi (2001) highlights the growing gap between the rich and poor in Canada is increasingly characterized by an ethno-racial divide.

In fact, statistical data provide supporting evidence. According to Statistics Canada's data of 2001, the low income rate of racialized minorities as a group in Toronto is nearly twice as high as that of the Canadian-born, white population (in AAMCHC, 2005). More recent numbers for Toronto, illustrate that both unemployment and poverty rates are

three times higher for racialized populations than for White groups (Lovell & Shahsiah, 2006). Overall, racialized groups as well as new immigrants are earning less in the Canadian labour market today than previous immigrants (Aydemir & Skuterud, 2005; Schellenberg & Hou, 2005). The lack of recognition for their 'foreign' credentials and local work experience, and a scarcity of affordable housing have placed many immigrant households in Canada at the margins, despite being on average more skilled and educated than their Canadian-born counterparts (AAMCHC, 2005; Preston & Murnaghan, 2005). While there are many differences among groups, those who are racialized and recent immigrants are statistically more likely to fall into the lowest income levels in Canada and are disproportionately represented at these levels (Galabuzi, 2001; Ornstein, 2000).

Ornstein (2000) reports that apart from racial discrimination, racialized groups in Toronto experience disproportionate levels of poverty, homelessness, inadequate housing, and access barriers to health care when compared to their White counterparts. Similar disproportionate rates, such as the overrepresentation of racialized families in the child welfare system and of racialized men in the forensic system and psychiatry, suggest a strong interrelated relationship between structural disadvantage due to racism and factors associated with poverty (Fernando, 2003; Galabuzi, 2001; Kafele, 2004; Nazroo, 2003).

In terms of concrete health outcomes, disparities have been documented for various ethnic or racialized inner city communities in Canada as well as the United States and the United Kingdom. Conceptualizing racial classifications as part of the social structure and hierarchy in Canada, Wu and colleagues (2003) argue that prevailing explanations based on socioeconomic status, social resources and interaction alone cannot adequately account for such health disparities. Others echo the notion that social and economic inequalities are underpinned by racism at multiple levels, and therefore play a fundamental role in health disparities (Ahmed et al., 2007; Gee, 2002; Nazroo, 2003).

While 'race' is sometimes named a health risk factor, a number of studies clearly identify racism as a key social determinant of health (Gee, 2002; Harrell et al., 2003; Karlsen & Nazroo, 2002b; Krieger, 2003; Nazroo, 2003; Peters, 2004; The Calgary Health Region, 2007). The community organization Women's Health in Women's Hands (2003) found that racial discrimination shapes the health of young women of colour in Toronto and identified racism as a major health risk. Their report explains that racism creates barriers to access to quality healthcare, health education and information for racialized people. Another Canadian-based report reviewed existing health research and local initiatives in Nova Scotia, and identified that black women in Nova Scotia experience increasing suicide rates, racism, and disproportionately high schizophrenia diagnoses rates (Enang, 2001). Examining 593 cases of breast cancer, Taylor and colleagues (2007) assessed the relationship between perceived experiences of racial discrimination and breast cancer among black women in the United States. Their findings showed that particularly among younger black women, perceived experiences of racism were associated with increased breast cancer incidences (Taylor et al., 2007).

Many other relevant studies confirm that mental health is an aspect of health which is especially affected by experiences of racism. Krieger's (2000) review of 20 American public health studies, for example, illustrates that some of the most common health outcomes from self-reported experiences of racism are depression, psychological distress, and high blood pressure. Similarly, a wide range of studies provide evidence that the material deprivation associated with low income, socioeconomic status and/or poverty significantly impacts on mental health (AAMCHC, 2005). Based on a wide-ranging review of relevant literature on various determinants of health for racialized groups, the Access Alliance Multicultural Community Health Centre (2005) in Toronto reports that low socioeconomic status and poverty manifests often as depression, anxiety, and other forms of psychological distress and mental health issues. Overall, the negative effects on health caused by factors related to poverty are particularly exacerbated when poverty is experienced over a life-span rather than episodically (in AAMCHC, 2005).

Based on data from the Fourth National Survey of Ethnic Minorities, Karlsen and Nazroo (2002b) assert that experiences of racism - and not ethnic identity as traditionally assumed - are directly related to health outcomes, regardless of the health indicators that were used. Other reports highlight that racism and experiences of racial discrimination are closely tied to socioeconomic status, low income, and poverty (Ahmed et al., 2007; Gee, 2002; Nazroo, 2003; Ornstein, 2000; Wu et al., 2003). Reviewing empirical evidence in available American literature, Ahmed and colleagues (2007) highlight how institutional racial discrimination shapes socio-economic status and ultimately affects the health of racialized populations, and in particular African Americans. They establish a clear relationship between the consequences of institutional racism and poverty and health. Key in their overview is residential segregation.

Residential segregation has historically shaped the residential distribution of whites and blacks in the United States and can today be witnessed in predominantly poor black urban neighbourhoods (Ahmed et al., 2007). American Census data from 2000 not only shows that residential segregation of African Americans continues to exist today in the United States, but also that these neighbourhoods are characterized by high levels of economic hardship and lower socio-economic levels (Ahmed et al., 2007).

Unfortunately, there are few Canadian studies that examine the implications of housing and neighbourhood segregation. But it is known that income segregation is rampant in Canadian cities and that this segregation is highly racialized in many urban areas (Dunn, 2002; Galabuzi, 2001; Ornstein, 2000). Galabuzi (2001) points out that racialized groups experience residential segregation even when they experience an improvement in their economic status. Indeed, a significantly high proportion of racialized people in Canada live in poor neighbourhoods with poor quality, over priced and marginal housing conditions (AAMCHC, 2005; Dunn, 2000; Novac, 1999). Poor housing in Canada is related to low income, which is in turn related to poor health outcomes. On average, households pay around thirty percent of their income on rent, leaving very little for food, clothing, transportation and other necessary expenses (AAMCHC, 2005). The resulting

material deprivation can lead to poor health outcomes through poor nutrition and financial barriers to accessing necessary services.

Level of income, however, is not the only determining factor in quality of housing and residential segregation. The source of income such as from social assistance as well as the tenant's ethnic and cultural background, 'race' or skin colour, citizenship status, language and accent, gender, and religion play also important roles (Dion, 2001; Murdie, 2003; Novac, 1999; Novac et al., 2002). Prejudices against people on social assistance and racist views about people of colour in general prevent many individuals and families from accessing quality housing in good neighbourhoods. In other words, differential access to decent and affordable housing exists due to discrimination based on these factors, in addition to affordability for racialized groups.

The reviewed reports emphasize that for analysis and action purposes around health, racism and poverty can no longer be treated as separate variables with independent outcomes for affected populations. Poverty and racism are co-determinants of health.

APPENDIX 2 - Community Survey

INNER CITY HEALTH: Experiences of Racialization and Health Inequity

Community Members Survey

We are gathering information from racialized groups about their experiences accessing health services and health care. This information will help us to paint a picture of what is taking place now as well as possible ways to make improvements. Please take a few minutes to complete this survey. Thank you!

BACKGROUND INFORMATION

AGE:

18 & under 19 – 29 30 – 45 46 – 60 61 & older

GENDER:

male female transgendered other

ETHNICITY: _____

NUMBER OF YEARS IN CANADA: (Non-Canadian born only)

less than 5 years 5 – 10 years 10 – 20 years more than 20 years

FIRST LANGUAGE SPOKEN: _____

1. What is your understanding of racism?

2. Give us an example of a situation where you experienced racism?

3. Have you experienced racism in a way that has affected your health?

Yes No Not sure Rather not say

4. What approaches have you used to address these health issues?

5. Have you experienced racism or other barriers (problems or challenges) when trying to access health care or social services?

Yes No Not sure Rather not say

6. Which types of health care or social services do you use most frequently?

- | | |
|--|--|
| <input type="checkbox"/> family doctor | <input type="checkbox"/> social assistance (OW, ODSP) |
| <input type="checkbox"/> hospital | <input type="checkbox"/> family counseling centres |
| <input type="checkbox"/> walk-in clinics | <input type="checkbox"/> public health / community nurse |
| <input type="checkbox"/> dentist | <input type="checkbox"/> social / public housing |
| <input type="checkbox"/> Children's AID Societies | <input type="checkbox"/> Long-Term Care / CCAC |
| <input type="checkbox"/> Specialists (Physio, Psych) | <input type="checkbox"/> Other, please identify _____ |

7. What do you need in order to be more comfortable when accessing health or social services?

- | | |
|----------|----------|
| a) _____ | c) _____ |
| b) _____ | d) _____ |

8. How comfortable are you with your current health care service or provider?

- Very comfortable Somewhat comfortable Not at all comfortable

9. Have you ever used a service (gone to an agency) where the service provider did something or said something about you (your race, ethnicity, language skills, etc.) that you thought was inappropriate or offensive?

- Yes No Not sure Rather not say

10. What does a health care provider need to know about your experiences of racism or other barriers to more effectively meet your needs?

11. Is there anything else about your experiences accessing health care or social services that you think is important for us to know?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY.

Appendix 3 - Key Informant Interview Guide

INNER CITY HEALTH: Experiences of Racialization and Health Inequity



Key Informant Interview

1. Who do you serve?
(probe for organization's mandate, diverse populations, priority groups, geographical catchment areas)
2. Please tell me a little bit about some of the more frequent problems or barriers that are faced by the community that you serve:
 - a) In general (housing, employment, immigration, transportation, low-income & poverty, etc).
 - b) Accessing appropriate services, including health care

NOTE: Provide the key informant the following sheet, and allow them a few minutes to complete.

3. To the best of your knowledge and experience, please indicate to what extent you agree or disagree with the following statements.

Among members of our community, racialization and racism act as a significant barrier to:

a) Employment among adults

1	2	3	4	5	6	7
Strongly disagree			Neither agree nor disagree			Strongly agree

b) Employment among youth

1	2	3	4	5	6	7
Strongly disagree			Neither agree nor disagree			Strongly agree

c) Career/workplace advancement

1	2	3	4	5	6	7
Strongly disagree			Neither agree nor disagree			Strongly agree

d) Education, including opportunities for post-secondary education/training

1	2	3	4	5	6	7
Strongly disagree			Neither agree nor disagree			Strongly agree

e) Accessing appropriate health care services, including services geared toward the health priorities of community members

1	2	3	4	5	6	7
Strongly disagree			Neither agree nor disagree			Strongly agree

f) Accessing other appropriate social services, such as community resource centres

1	2	3	4	5	6	7
Strongly disagree			Neither agree nor disagree			Strongly agree

g) Appropriate housing, including adequate social housing when necessary

1	2	3	4	5	6	7
Strongly disagree			Neither agree nor disagree			Strongly agree

4. What are some of the more common ways that community members themselves express their experience of racialization and/or racism and its impact on health? *(If necessary, probe with examples such as increased levels of stress; frustration regarding particular health services; concern about particular health conditions, etc)*
5. What has your organization seen or experienced when it comes to the overlapping impact on health of racialization and other forms of exclusion in the community such as discrimination based on physical disabilities, homophobia or other factors? (if needed, provide an example, such as seniors with disabilities from the Caribbean community, or gay South Asian youth).
6. Without disclosing information about particular agencies, what are some of the barriers and facilitators that your organization has experienced in working with partners and funders in your effort to serve and support racialized communities?
7. Is there anything further that you would like add about your organizations experiences related to the impact of racialization on health?

Appendix 4 - Focus Group Guide

THEME 1: GENERAL VIEWS AND EXPERIENCES OF RACISM

1. What does the word 'racism' mean to you?

- Can you give some examples of how people experience racism?
- Please describe your experiences of racism?
- Are you aware of a group of people that experienced racism?
- What are some forms of racism that they experienced?

2. Have you ever experienced racism?

- Looking for work?
- At work?
- At school?
- Recognition of your education or other job credentials?

3. Do you think racism affects your health?

- Caused you to call in sick/miss work/stay away from work?
- Caused you to avoid seeking health care services?
- Caused you to become ill over a period of time?
- Can you think of other ways racism may affect a person's health?

THEME 2: RACISM AND BARRIERS TO ACCESSING HEALTH SERVICES

4. Have you ever experienced racism trying to access health services? Health Services may include: hospitals, doctors, community health centre, nursing homes, walk-in clinics for example.

- Did you feel welcomed where you went for services?
- The service you required was not available in your preferred language?
- The services offered were not relevant to your culture?
- The services were too far away and inaccessible by public transportation?
- Were you afraid that your immigration status would be reported?
- The services required are not located in your neighbourhood?

THEME 3: EXPERIENCES OF RACISM WHEN USING SERVICES AND INTERACTING WITH PROVIDERS

5. Have you ever had an experience with a health service provider that you thought was racist?

- Have you ever been treated badly?
- Do you feel that you were treated differently from others?
- Did you feel uncomfortable with the health service provider?
- Were you offended by the way a health service provider treated you?
- Please tell us about your experience?

Appendix 5 - Consent Forms

Inner City Health Strategy Working Group
“Inner City Health: Experiences of Racialization and Health Inequity”

Focus Group Consent Form

WHO WE ARE: The Inner City Health Strategy Working Group is a group of community organizations, advocates and researchers who have joined together under the auspices of Hamilton Urban Core Community Health Centre to develop a strategy for addressing inner city health inequity and injustice with a focus on poverty and racism as the key co-determinants of health.

WHAT THIS STUDY IS ABOUT: The purpose of this study is to raise awareness about poverty and racism that racialized and marginalized people experience when seeking social and health services.

Racism is the belief that either directly or indirectly asserts that one group is inherently superior to others. Racism can be openly displayed in racial jokes and slurs or hate crimes, but can also be more deeply rooted in attitudes, values and stereotypical beliefs. In some cases, these are unconsciously held and have evolved over time, becoming embedded in systems and institutions, and also associated with the dominant group's power and privilege.

Racialization refers to the process by which individuals are treated differently and grouped together according to a small number of physical traits. It recognizes therefore that experiences of racism today – in all of its forms including stereotyping, discrimination and hate crimes – has historical roots in colonialism, slavery and the supporting ideological foundations.

ABOUT THE FOCUS GROUP: You have been invited to participate in a focus group as part of our research project. We would also like to hear about your experiences of poverty and racism in accessing health services and supports.

We have asked you to be a participant in this focus group because of your experience. You will be one of approximately 30 people participating in three small groups in three inner city locations. Once the opinions gathered in the focus groups have been gathered and summarized, a report will be written that will be used to influence and inform policy and decision makers, community organizations and associations and others interested in similar areas of work.

Everyone in the focus group will be sharing their experiences regarding topics such as racism and the impact on health and wellness, access to health and social services, poverty and the impact on health for example. The focus group meeting will last about two hours, including a short break. Ground rules for respectful participation and maintaining confidentiality will be discussed at the beginning of each focus group.

During the focus group meeting we will be taking notes to make an accurate record of what is said including your comments. There is no right or wrong answers to the questions that will be raised in the group; the important thing is for you to share your experience and opinions. To

compensate you for your time for attending the meeting, you will receive \$30. We will also provide bus tickets to help with your transportation to and from the meeting site if you need such assistance.

The notes and information from the focus group will be kept confidential. Only the Working Group involved in this project will have access to the information collected that will be used for analyzing and preparing the report. This information will be kept in a locked place. No one else will see your responses. We will only report summarized results, so your identity will be unknown. We will not disclose any information that can be identified with you, nor connect your name to any information we present.

Your participation in this focus group is entirely voluntary. We do not feel that there is any risk to you in participating and you can decide not to participate at any time. There is no penalty for not participating in or withdrawing from the focus group. After the focus group you may ask for your input to be removed before publication of the final report. We would also be happy to provide you with a copy of our report in a timely manner once it is completed. You will also get a copy of this consent form.

If you have any questions about the focus group meeting please feel free to speak the Focus Group Facilitator.

If you have any questions or comments, or would like to know more about the study please contact:

Denise Brooks, Executive Director
Hamilton Urban Core Community Health Centre
71 Rebecca Street. Hamilton ON, L8R 1B6
Ph: 905-522-3233 Fax 905-522-5374
Email: dbrooks@hucchc.com

Your signature indicates that you have read the information provided above or it has been explained to you and that you agree to participate in the focus group and that you can withdraw at any time.

_____ Date:

_____ Participant

Signature

Inner City Health Strategy Working Group

Key Informant Interview Consent Form

WHO WE ARE: The Inner City Health Strategy Working Group is a group of community workers, advocates and researcher who have joined together under the auspices of Hamilton Urban Core Community Health Centre to develop a strategy for addressing inner city health inequity and injustice with a focus on poverty and racism as the key co-determinants of health.

TITLE OF RESEARCH PROJECT: “Inner City Health: Experiences of Racialization and Health Inequity”

WHAT THIS STUDY IS ABOUT: The purpose of this study is to raise awareness about poverty and racism and other barriers that confront racialized and marginalized people when seeking social and health services. Racialization refers to the process by which individuals are differentiated into a hierarchy of racial groups according to a small number of physical traits. It recognizes therefore that contemporary experiences of racism – in all of its forms including stereotyping, discrimination and hate crimes – have their historical roots in colonialism, slavery and their supporting ideological foundations. The interview will, therefore, examine the role and impact of racism and other forms of marginalization in your community. More specifically, it will discuss the experiences of racialized community members when accessing social and health services.

Your contribution to this study will take the form of a telephone interview. We ask that you consider the following before engaging in this interview. Your agreement will be considered as confirmation of your willingness to participate in the study. A copy of the consent form will then be sent to you by email or fax and your signature will serve as confirmation of your agreement to participate.

CONSENT AND RIGHTS OF RESPONDENT:

1. Your responses to the interview questions will be noted by the interviewer, in point form and later transcribed or typed. The transcriptions (excluding names and other identifying details) may be viewed by the project group and analyzed as part of the study.
2. This study is deemed to have minimum risk. All responses to the interview questions will remain anonymous.
3. All recorded materials from the interviews will be stored in a secure location until the completion of the final report; afterwards, they will be destroyed. All printed materials from the interviews will be shredded.
4. Your participation in this interview is entirely voluntary. Your consent may be withdrawn and participation in the study discontinued at any time. There is no penalty for not participating in or withdrawing from the study once the interview has been initiated. If, at any point during the interview, you wish to withdraw from the study, we will respect your decision to withdraw immediately.

5. The findings of our study will be written up as feedback for policy and decision makers, community organizations and associations and others interested in similar areas of work. The written work may include quotations from the interviews, but names and other individual identifiers will not be used.
6. After the interview is complete, you may ask for your input to be removed before publication of the final report, and you are entitled to a copy of this report in a timely manner after publication.

Confirmation and Consent

I confirm that I freely agree to participate in the Inner City Health: Experiences of Racialization and Health Inequity”. I have been informed about what this involves and I agree to the use of the findings as described above.

Signature: _____

Name: (please print) _____

Date: _____

Contact Details

If you have any questions or comments about the study or your interview, please contact:

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