



EVERY WOMAN MATTERS



A Report on Accessing Primary Health Care for
Black Women and Women of Colour in Ontario

April 2011

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Black Women and Women of Colour in Ontario**

Toronto, August 2010

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Funding Ontario Ministry of Health and
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Transition Fund (PHCTF), 2004-2006

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This study was conducted by Women's Health in Women's Hands Community Health Centre and the Factor-Inwentash Faculty of Social Work, University of Toronto in partnership with Sistering – A Woman's Place, Planned Parenthood of Toronto, Rexdale Community Health Centre, Parkdale Community Health Centre and with the support of Centre Francophone de Toronto, South Asian Women's Collective and Toronto Public Health.

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ISBN 978-0-9736431-7-6



This report and related documents may be downloaded from the Women's Health in Women's Hands website (www.whiwh.com).

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61% of the participants would prefer a female service provider.

Acknowledgements

A Collaborative Process to Achieve Access to Primary Health Care for Black Women and Women of Colour (henceforward, the Access Study) was a project conducted in partnership between Women's Health in Women's Hands Community Health Centre (WHIWH) and the Factor-Inwentash Faculty of Social Work, University of Toronto in collaboration with Sistering - A Woman's Place, Planned Parenthood of Toronto (PPT), Rexdale Community Health Centre (RCHC), and Parkdale Community Health Centre (PCHC) (See Appendix A for information about collaborating organizations). The Access Study was funded by the Ontario Ministry of Health and Long Term Care (MOHLTC) through its Primary Health Care Transition Fund (PHCTF).

The Access Study would not have been possible without the contributions of many people who invested hours of time to design, execute and document the project so its knowledge could be shared with others. We are grateful to all of the community members who were part of this process. We would also like to express our gratitude to the Ontario Ministry of Health and Long Term Care for recognizing the importance of this issue and providing the resources to explore it.

We must also make special mention of the women who participated in this project. Their willingness to share their experiences was crucial to its success. They reminded us on a daily basis of the importance of this work. We would like to recognize the contributions they made through their intelligence, insight and awareness of the issues affecting Black Women and Women of Colour, and their passion for seeking social justice to improve the lives of other women like themselves.

Although this project enabled us to hear the voices of many women, we realize that there are still women whose voices were not heard. It is our hope that this process will inspire initiatives that will bring forward voices that will encompass the full diversity of women's experiences across lines of sexuality, ethnicity, gender, class, religion, immigration status and other identities.

One of the valuable lessons we have learned from this experience is that marginalized women have much in common that influences their ability to achieve health and access health care, but there is also much that is specific to experiences within different social categories that must be included in our discussions of how to achieve an accessible and equitable health care system. As our participants repeatedly reminded us, **every woman matters.**

Executive Summary

This project was conducted in partnership between Women's Health in Women's Hands Community Health Centre and the Factor-Inwentash Faculty of Social Work, University of Toronto with collaboration from the agencies, Sistering - A Woman's Place, Planned Parenthood of Toronto, Rexdale Community Health Centre, Parkdale Community Health Centre. It was funded by the Ministry of Health and Long-term Care through its Primary Health Care Transition Fund.

The purpose of this report is to assist community members, researchers and health service providers (HSPs)¹ working to remove barriers and increase access to equitable, inclusive², primary healthcare in Ontario that address the challenges facing Black Women³ and Women of Colour⁴. This report summarizes the outcomes from a literature review, research study and pilot program developed as part of the project, *A Collaborative Process to Achieve Access to Primary Health Care for Black Women and Women of Colour* (hereafter referred to as the Access Study). Thus, the report presents highlights from the research study, the pilot program, the Logic Model: Pathway of Care and selected recommendations to address the disparities disproportionately affecting Black Women and Women of Colour who seek access to primary healthcare.

The Access Study

The Access Study interviewed 226 service users and 12 service providers to get frontline perspectives on the barriers that Black Women and Women of Colour encountered when attempting to access primary health care, and opportunities that facilitated access for these same populations. Women participating in the study were primarily from the Greater Toronto Area (81.7%), but included women from other highly populated areas such as the Peel, Halton and Hamilton regions.

The ethnic identifications of the service user participants were African (18.6%); Caribbean (28.6%); South Asian (28.1%); Latin American (17.1%); Mixed Race/Ethnicity (2.4%); and Other (5.2%). Most participants (90.9%) were born outside of Canada. The study also recruited to include particular priority populations and thus, twenty-two percent (22.5%) of the participants reported having a physical disability, while approximately ten percent (9.9%) self-identified as lesbian/bisexual, an additional ten

¹ This term also includes decision makers responsible for direct policy and resource allocation.

² Inclusive healthcare locates health within the context of socioeconomic realities while encompassing and incorporating the biological, socio-cultural and psychological and environmental dimensions of women's lives (Research participant, Access Study).

³ The term "Black Women" refers to Black African, African Caribbean, African Canadian and other women of African ancestry.

⁴ The term "Women of Colour" refers to South Asian or Latin American women and women of South Asian or Latin American ancestry.

percent (9.9%) identified themselves as HIV positive, and nearly nine percent (8.9%) identified themselves as homeless/underhoused. Seventy-nine percent of the sample reported a household income of less than \$25,000/per year and over ninety percent (91.3%) of the sample was supporting more than one (1) person on that income.

Data were collected using a survey, individual interviews and focus group interviews. Most women (45.1%) reported seeking primary health care to address chronic physical health conditions. They reported multiple barriers to health care access, particularly financial barriers created by travel (24.1%), user fees (35.1%), long distances to health care (20.4%), wait times for services (18.4%), competing family demands (17.3%), work obligations (23.6%) and other demands that prevented accessing services when they were available (29.3%).

Quantitative data revealed there were multiple ways in which services were not designed to accommodate the demands of these women's lives. Many of these experiences were specific to individual populations: for example, lack of accommodations for people with physical disabilities and lack of interpreters/ language-skilled staff for women who did not speak English.

Qualitative data further revealed that women faced healthcare situations with the knowledge and sometimes the expectation that they would encounter racism, homophobia, stigma and other types of social exclusion. These expectations contributed to aversions surrounding health care use.

The participants also provided information about facilitators of access to health care. Members of social support networks played important roles in aiding access, particularly friends (51.6%) and family (52.6%). Community-based nurses (29.2%) and social workers (22.9%) were also frequently cited as facilitating access, along with other personnel in social services. The project participants identified aspects of service that made access more acceptable and equitable: the most highly endorsed included having women service providers (61%), helpful intake staff/receptionists (64.3%), staff speaking the same language (47.8%), staff of varied cultural backgrounds (42.9%), and respect for gender, race, culture and other aspects of identity (72%).

The interviews for this study were conducted from 2005-2006. As far as we know, the Access Study is the largest research data set available detailing barriers, challenges and action steps that can facilitate equitable, timely and cost-effective access for Black Women and Women of Colour who are disadvantaged in accessing to primary health care services.

When the Access Study's initial findings revealed the acute marginalizations experienced by homeless/underhoused women, a pilot program was developed. Central elements of this pilot program were its location in a social service agency, the collaboration of multiple agencies in providing services, the provision of advocacy services to help women negotiate the health care system, equipping the service users with information

and tools to improve their experience in services, and training of service providers in anti-racist and anti-oppressive service delivery.

The pilot program's main activities took place once a week for three months at Sistering - A Woman's Place, a women's drop-in centre, and included offering primary health care services on-site, having a "Navigator" to facilitate women's involvement in the pilot, informing clients of their rights as users of the health care system, and training service providers on homelessness, mental health and anti-oppression.

The pilot program Navigator provided support and advocacy for 101 women. Nearly three-quarters (74%) of women received primary healthcare as part of the pilot program. Over forty percent (43%) participated in health education workshops. There was a sixty-two percent (62%) successful referral rate to a community health centre and over half (53%) of the women receiving referrals had multiple visits during the three month pilot phase. Nearly one-third (30%) of women participated in nine health education workshops conducted by nurse practitioners, nurses, mental health therapists, social work students and physicians. Eighteen percent (18%) of the participants accessed specialty clinics that they otherwise could not afford to attend. Referrals were also made for additional care from providers at other locations.

During the pilot study, a nurse practitioner and a nursing student were present every Thursday from 10 AM - 3 PM to offer basic primary health care services to women at Sistering - A Woman's Place. Fifty-two percent (52%) of female participants were able to receive primary healthcare services on site. Two out of every five women (40%) were able to be referred to a community health centre (CHC) during the pilot program and were able to keep their appointment.

Through the effectiveness of service provider training, client training on rights and entitlements, the skill of the pilot Navigator and the coordination of a referral process geared towards increasing access for specified populations, we were able to ensure primary healthcare access for 130 women over the course of the pilot (this number includes those that did not use the services of the Navigator).

The Access Study has already been referenced in work being done by Heritage Canada, The Health Quality Council, Interagency Coalition on AIDS and Development, Public Health Agency of Canada, The Community Health Centre Non-insured Task Force and The Canadian Women's Health Institute.

It is our hope that the dissemination of this report will increase the role service users will play in shaping a system that will better serve their needs.

The Report is organized into the following sections:

- **Section I** presents findings from the literature review and the data collection processes; focusing on the identified barriers and facilitators to accessing primary health care for Black Women and Women of Colour .
- **Section II** discusses the Primary Health Care Logic Model.
- **Section III** presents recommendations for approaches that can be implemented to decrease disadvantage for Black Women and Women of Colour in need of health care by intervening in the following sectors: Local Health Integration Networks (LHINs), Community Support Services (CSS), Community Care Access Centre (CCACs) and Community Health Centres (CHCs).



Section 1



41.7% women
were living in the
urban suburbs,
making it difficult
to access basic
health services.

Context

Universal health care is something to which most Canadians assume everyone has access because it is “guaranteed” by legislation. It is believed that if any Canadian is feeling unwell, injured or desires to engage in preventive health care, services are readily available. For some individuals, however, the path to health care is not that easy to navigate. Black Women and Women of Colour are among those groups of people that can experience difficulties.

Racism is recognized as overarching determinant of access and quality of healthcare for Black Women and Women of Colour. Individual and systemic experiences of racism can have a pervasive and devastating impact on population health and well-being (Ali & Massaquoi, 2001; Harrell, 2000; Lawson, Ridgers-Rose & Rajaram, 1999; Williams & Williams Morris, 2000; Wilson 2001). In addition, systemic racism exposes Black Women and Women of Colour to precarious situations that negatively affect their health and well-being.

Research indicates that impediments to receiving adequate and effective health care are intensified when women are also facing barriers linked to homelessness/underhousing (Ambrosia, Baker, Crowe & Hardill, 1992; Hatton 2001; Kushner, 1998), living with physical disability, (Ethno-racial People with Disabilities Coalition of Ontario [ERDCO], 1996; Masuda & Disabled Women’s Network Canada, 1999; Parish & Huh, 2006), being HIV-positive (Susser & Stein, 2000; Wainberg, 1999; Flynn, McKeever, Spada & Gordon-Garofalo, 2000) and/or being lesbian or bisexual (Hudspith & Bastedo, 2001; O’Hanlan, 1995; Stine, 2002; Mravcak, 2006). Due to their association with increased risk for poor health, these issues should be prioritized in investigating the health care experiences of Black Women and Women of Colour.

Based on an understanding of the potentially multiplicative effects of intersecting vectors of oppression on access to health care, the Access Project was designed to explore the experiences of Black Women and Women of Colour who identified as also having lived experiences related to poverty, homelessness, immigration status, sexual orientation, disability and/or HIV positive status. The study accessed those experiences by seeking out perspectives from service users and service providers because health care institutions often play a role in creating barriers and opportunities for access.

Poverty

It is well established that health can be negatively affected by low income or poverty (Ambrosio, Baker, Crowe, & Hardill, 1992; Daly, Armstrong, Armstrong, Braedley, & Oliver, 2008; Hatton, 2001; Kappel Ramji Consulting Group, 2002; Rachlis, 2008). Black Women and Women of Colour in Canada are often concentrated in sectors of the workforce that

are associated with low income and can live in poverty whether they are employed, underemployed or unemployed (Galabuzzi, 2005). Advocates assert that there has been little action taken to reduce poverty in Ontario or to address the negative income effects of provincial policies like decreased social assistance allowances, and more stringent eligibility criteria for assistance (Colour of Justice Network, 2007; Kushner, 1998). Therefore, Black Women and Women of Colour are increasingly vulnerable to living in poverty; this has consequences for maintaining health.

Homelessness

Research confirms that while visibly homeless⁵ people suffer from the same illnesses as the general population, they experience higher rates of chronic conditions such as recurrent bronchitis, hypertension, asthma, heart attacks, epilepsy, diabetes and stroke. These prolonged and recurrent conditions often stem from inadequate and unsafe shelter/housing (Ambrosio, Baker, Crowe, & Hardill, 1992; Hatton, 2001; Kappel Ramji Consulting Group, 2002; Khandor, & Mason, 2007; Kushner, 1998).

The experiences particular to homeless women from racialized communities, female immigrants and refugee women are conspicuously absent from the research literature. What data does exist identifies Black and Aboriginal Women as over-represented among visibly homeless in Toronto (Mental Health Policy Research Group, 1998). However, this research often overlooks the equally compelling threats to health faced by women living in inadequate or unstable housing. The so-called “hidden homeless” face health risks related to poverty, substandard housing, sexual harassment and increased exposure to violence and victimization (Kappel Ramji Consulting Group, 2002).

Immigration Status

According to the Ontario Women's Health Status Report, immigrant women arriving in Canada in good health experience a heightened risk of poor health post-migration due to employment and settlement-related stress, financial hardship, inadequate social support, changing health practices and systemic, cultural and economic barriers to appropriate health care (Stewart, Cheung, Ferris, Hyman, Cohen & Williams, 2002). Although it is clear that immigrant women and men experience a decline in health, it is also apparent that this is not accompanied by an increase in the use of health care services (Newbold & Danforth, 2003). Researchers tracking data from the longitudinal

⁵The visibly homeless include women who find shelter in emergency shelters or hostels and/or women who sleep in places considered unfit for human habitation, like doorways, vehicles, parks and abandoned buildings. Hidden homeless include women who may be temporarily living with family or friends, living in homes where they are vulnerable to family violence or conflict, or are staying with someone exclusively to obtain shelter. The underhoused include women who use such a large percentage of their income for housing that they are unable to afford other things vital to maintaining life and stability, those who are at risk of eviction, and those living in illegal or physically unsafe buildings or overcrowded households (Kappel Ramji Consulting Group, 2002).

National Population Health Survey suggest that this indicates unrecognized barriers to care that disproportionately affect immigrant populations (Newbold & Danforth, 2003).

Sexual Orientation

LGBT populations in Canada face significant barriers to achieving health both because their health needs can be poorly understood, and because health care institutions may not be inclusive or can be directly unwelcoming to them (Mulé et al., 2009). Although race, gender and culture are recognized as further contributing to marginalization in the system for these populations, we know little about specific issues affecting Black Women and Women of Colour who identify as lesbian or bisexual because the research has tended to focus on White, middle/upper class women (Wainberg, 1999). This limited focus has been challenged by calls to bridge the current gaps in lesbian health through research and action on health problems and how these gaps may vary along dimensions of race, ethnicity, social class, geographic region, immigration status and age (Ryan, Brotman & Rowe, 2000; Solarz, 1999).

Disability

Living with physical disability forces women to have frequent contact with the health care system. Black Women and Women of Colour with disabilities report that accessing health care is often problematic because they face several barriers including: negative attitudes from health care professionals; health care facilities that are architecturally inaccessible and house inadequate equipment, the lack of health promotion materials in alternate formats (including Braille, audio, large print), and no communication access for hearing impaired individuals; and services that are deficient in respecting privacy and confidentiality entitlements (DisAbled Women's Network Ontario [DAWN], 1994). The dearth of access to respectful and equitable health care results in a reduced quality of health services for racial minority women with disabilities. This, in turn, contributes to increased vulnerability and dependence upon others (ERDCO, 1996). In a study conducted with lesbians and bisexual women with disabilities, there were several reports of overt experiences of oppression and discrimination, which they described as "factors that negatively affected their sense of health" (Masuda & Disabled Women's Network Canada, 1999, p.1).

HIV positive status/AIDS

In 1991, Black communities constituted about two percent (2%) of the Canadian population and over eight percent (8.3%) of reported AIDS cases. Black Women make up the majority of women living with an HIV diagnosis in the Toronto Central LHIN. As noted in the Silent Voices of the HIV/AIDS Epidemic report, Black Women and Women of Colour have articulated the challenges and barriers to preventing and accessing

primary health care and competent health service providers (Tharao, Massaquoi, & Teclom, 2006). In it, women requested further support and recognition of their need for culturally competent AIDS service organizations (ASOs) and community health centres.

Conclusions

Being part of a socially marginalized group creates barriers to achieving health and accessing needed health care. Although this literature review has focused on the health care challenges of poor women, un/documented immigrants, lesbian/bisexual and transwomen, women with physical disabilities, HIV positive women and women living with AIDS, this project is underscored by an awareness that these social categorizations intersect and multiply in the lives of the women we were trying to reach. Correspondent experiences of marginalization based on racism/sexism/discrimination in combination with the challenges emerging from poverty, homelessness, physical disability, heterosexism directed against lesbian/bisexual identity and HIV stigma play significant roles in declining health statuses and difficulty achieving and maintaining good health (Amdrosio, Baker, Crowe, & Hardill, 1992; Atlantic Centre for Excellence in Women's Health, 2003; Daly, Armstrong, Armstrong, Braedley, & Oliver, 2008; Hatton, 2001; Kappel Ramji Consulting Group, 2002; Masuda, & Disabled Women's Network Canada, 1999; Rachlis, 2008).

In response to these findings, the Access Study paid particular attention to the implications of intersecting identities in the lived experiences and marginalization of Black Women and Women of Colour. Thus, in addition to its focus on Black Women and Women of Colour, the Access Study was designed to seek information from four identified subgroups within the population of Black Women and Women of Colour; homeless/underhoused women, women living with physical disability, HIV-positive women, and lesbian/bisexual women.

The Access Study

Research Design: Community-Based Research

Community Based Research (CBR) models are built on the assumption that communities are capable of articulating, acting upon and taking control of their collective concerns and challenges. It sees research as a tool for engaging communities in addressing social and political issues that limit their ability to participate fully in the society and negatively impact their health and wellness, cultural and environmental realities and socio-economic conditions. Community participation and input at every stage of the research is crucial for a CBR project.

In more participatory models of CBR, community members are involved from the very beginning and collaborate with researchers to identify research objectives. They are active participants, and not just subjects, in research studies leading to better health outcomes for their communities (U.S. Department of Health and Human Services, 2009; Harris, 2006; Williams, 2005). The Access Study began with partnering agencies (see Appendix A) identifying needs that affected the populations they served, and then a researcher was invited to work with agency representatives to develop a research proposal to address those issues.

The Research Team

Community Advisory Committee and Steering Committee: We created a Community Advisory Committee (CAC) that included Executive Directors of the collaborating community agencies, researchers/experts who have experience addressing the health care needs of Black Women and Women of Colour, and women who had expertise based on lived experience as part of the target populations. This committee met once every 3 months to provide advice and consultation to the researchers and Steering Committee. The Steering Committee included the researchers, the Project Coordinator and the Program Managers at the collaborating agencies. The Steering Committee met monthly to oversee the sampling, data collection and data analysis.

Research Coordinator & Interviewers: The research coordinator and the interviewers for this study were individuals with experience working with Black Women and Women of Colour in the health care sector. Most had also had lived experiences as part of the target populations. The research coordinator and interviewers received additional training to prepare them for interacting with the study participants and conducting focus groups and interviews. Members of the interview team were able to conduct interviews in languages other than English, including Tamil, Urdu and Spanish.

Sample

The Access Study sample consisted of 226 service users (21 focus groups with 140 participants and 86 individual interviews). We also conducted 12 interviews with service providers. The Access Study used stratified purposeful sampling, that is, it sought respondents from different subgroups of a population to show subgroup characteristics, and compare between groups (Strauss & Corbin, 1990). Twenty-one service user focus groups enabled the research team to sample from a wide range of experience in seeking and receiving health care services as Black Women and Women of Colour. The large number of focus groups also facilitated analysis of relevant differences across identity categories (i.e., Physically Disabled, Homeless/Underhoused, Lesbian/Bisexual, and HIV Positive). The individual interviews allowed us to hear more personal stories and sample across a range of experience while ensuring sufficient sub-sample numbers to ensure in-depth analysis (as recommended in Sandelowski, 1995).

Recruitment

Service users in focus groups and individual interviews were Black Women and Women of Colour between the ages of 18 and 65, capable of giving informed consent. Women were asked to self-identify as “Black” or “Woman of Colour” (African, Caribbean, Latin American, or South Asian origin) and further identify as having lived experiences of homelessness and precarious housing, lesbian/bisexual identity, physical disability and/or HIV positive status, if they judged it to be relevant. Interviewed service providers were also over the age of majority, had at least 1 year of professional experience working with the target population, and were capable of providing informed consent to participate in the study.

Service users were recruited through posted/distributed advertisements and information sessions in primary health care settings. Flyers in multiple languages were the primary mode of recruitment. Information sessions were also held in some primary health care agencies identified by the CAC. The Project Coordinator was available in person or by telephone at pre-arranged times on site to meet with interested participants, answer their questions about the study and screen for eligibility.

Compensation

All service user participants received \$20 for their participation in a focus group or individual interview.

Procedures

Interviews were conducted in collaborating agencies, in participants’ homes or at the Factor-Inwentash Faculty of Social Work, University of Toronto. All interviews began with a review of details of the study and the informed consent form. All participants gave consent to have their interviews audio-taped. Data collection instruments included a demographic questionnaire, and interview guides for the individual and group interviews. The demographic questionnaire asked structured questions about health care experiences, including barriers and facilitators to access.

Interviews with both service users and providers sought perspectives about positive and negative aspects of health care experiences for Black Women and Women of Colour, including experiences related to seeking and receiving health care, perceived needs and expectations for health care, and perceptions of appropriate spaces for Black Women and Women of Colour to receive help. Interview guides asked participants to discuss critical incidents that informed their perceptions of the system’s effectiveness in providing health care, areas of promising and problematic practices and factors that affected access to health care.

Ethical Considerations

Privacy and confidentiality were key issues in the data collection process. These procedures were explained before, during and after the focus groups and individual interviews. Participants' privacy was further assured by giving them the option of initialing, rather than signing, the consent forms. Participation was voluntary and participants could withdraw from the study any time, at their discretion.

All research documents identified participants by initials or pseudonyms only. No specific identifying information was collected or reported. Audiotapes were transcribed in full by a professional transcription service. Any identifying information disclosed during the interviews was deleted from the written records. Participants had the right to review, edit or erase the research tapes/transcripts associated with their participation. No names or other personal identifiers were or will be used in reports or publications emerging from the study.

Data Analysis

Focus groups and interviews were audio-taped and transcribed verbatim (with translation, when necessary). Data analysis was based on the grounded theory "conditional matrix" (Strauss & Corbin, 1990). In the context of this study, this method of analysis directed attention to micro processes (individual experiences in health care settings and other settings), the mezzo processes (movement between community spaces) and the macro processes (interactions between agencies and institutions that move people through the system). Data were reviewed by two independent coders to identify major codes and themes and then divided into finer sub-categories. A threshold of 80% was used to establish the inter-rater reliability for identification of subcategories. All transcripts were entered into NVivo (a software program for qualitative analysis) and coded electronically.

FINDINGS

Service User Participant Characteristics

All participants were given a socio-demographic questionnaire to complete but were also informed that completion was voluntary. For each question, we have reported the number of responses that were available for analysis.

Table 1. Socio-demographics of the sample

Category	Description
Age and Age categories (205 responses)	Mean = 40.6 (SD = 14.8) Range: 18-82 years Youth (18-29 years old): n=48, 21.5% Elders (65+ years old): n=34, 15.2%
Citizenship and Immigration status Country of Birth (209 responses)	Born in Canada: n=19, 9.1% Born outside Canada: n=190, 90.9%
Immigration/Citizenship (205 responses)	Non-status: n=13, 6.3% Refugee: n=22, 10.7% Visitor/Work/Student Visa: n=3, 1.5% Permanent Resident: n=50, 24.4% Canadian Citizen: n=117, 57.1%
# years in Canada (175 responses)	Mean=12.9 years (SD=11.0) Range: 0.33-49 years Less than 10 years: n=101, 57.7% 11 or more years: n=74, 32.7%
Ethnicity (210 responses)	African: n=39, 18.6% Caribbean: n=60, 28.6% Latin American: n=36, 17.1% South Asian: n=59, 28.1% Other: n=11, 5.2% Mixed Race/Ethnicity: n=5, 2.4%
Languages spoken (201 responses)	English only: n=63, 31.3% English plus other languages: n=85, 42.3% Other languages, no English: n=52, 25.9%

Table 1. Sociodemographics of the sample...continued

Category	Description
Intersecting identities identified in the study (213 responses)	Physical disability: n=48, 22.5% Lesbian/Bisexual Identity: n=21, 9.9% HIV Positive: n=21, 9.9% Homelessness: n=19, 8.9%
Highest level of education (206 responses)	No formal education: n=11, 5.3% Less than high school: n=49, 23.8% High school or equivalent: n=46, 22.3% Some college or university: n=40, 19.4% Completed college or university: n=60, 29.1%
Primary Work status (207 responses)	FT paid employment: n=29, 14% PT paid employment: n=36, 17.4% FT caregiver/homemaker: n=33, 15.9% Short-term disability: n=2, 1% Long-term disability: n=17, 8.2% Unemployed, seeking work: n=66, 31.9% Other: n=24, 11.6%
Income category - Annual income (171 responses)	\$14,999: n=107, 62.6% \$15K - \$24,999: n=28, 16.4% \$25K - \$29,999: n=11, 6.4% \$30K - \$39,999: n=18, 10.5% > \$40,000: n=7, 4.1%
# additional family members supported on household income (150 responses)	0: n=13, 8.7% 1: n=57, 38% 2: n=28, 18.7% 3: n=26, 17.3% 4: n=11, 7.3% 5 or more: n=15, 10%

Women participating in the study were primarily from the Greater Toronto Area but included women from the Peel, Halton and Hamilton regions. The ethnic identifications of the service user participants indicated that the sample represented all of the targeted groups. It is noteworthy that most of the participants (90.9%) were born outside of Canada. The study also recruited to engage particular priority populations and was successful in recruiting women who self-identified as members each of the designated groups: Just over twenty-two percent (22.5%) of the participants reported having a physical disability; approximately ten percent (9.9%) self-identified as lesbian/bisexual; an additional ten percent (9.9%) identified themselves as HIV positive, and nearly nine percent (8.9%) identified themselves as homeless/underhoused. Most participants

reported low household incomes and over ninety percent (91.3%) of the sample was supporting more than one (1) person on that income.

Service Use Patterns

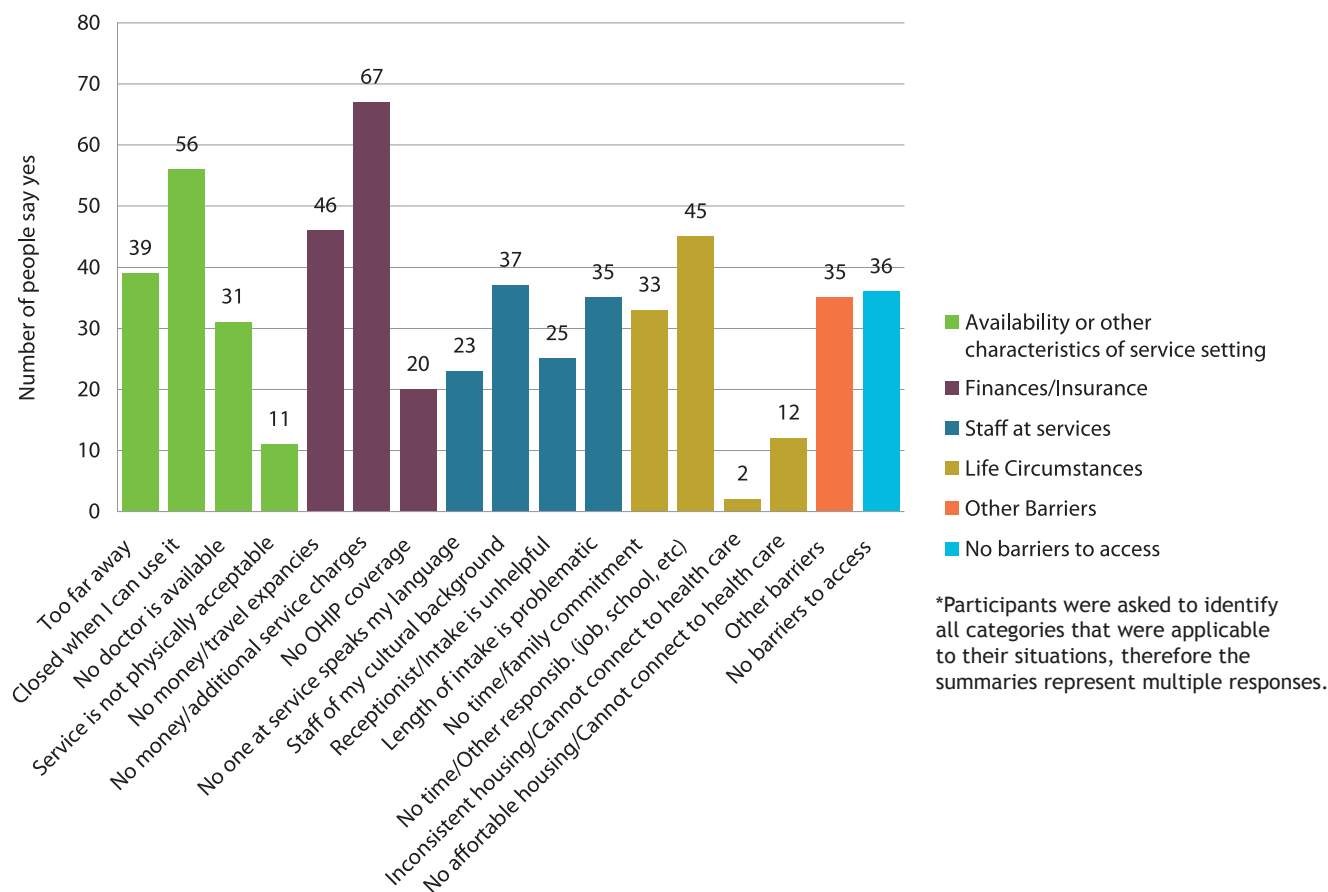
Questions about service use indicated that women in the sample attempted to access health care quite often, but qualitative data revealed that those experiences did not result in successful outcomes and often necessitated repeated attempts. The most common reason for accessing healthcare was the need to address a chronic physical health condition and most women sought care through physicians in private practice.

Table 2. Service Access Data

Category	Description
Frequency of Service Use - # times/year (180 responses)	Mean=10.5 visits per year (SD=16.9) Range: 0-168 0-4 visits: n=79, 36.2% 5-12 visits: n=68, 31.2% 13+ visits: n=71, 31.4%
Primary reason for seeking healthcare (82 responses)	Preventive health care: n=10, 12.2% Emergency care: n=2, 2.4% Pain/Injury: n=5, 6.1% Chronic physical health condition: n=37, 45.1% Chronic mental health condition: n=6, 7.3% Sexual/Reproductive health: n=6, 7.3% Counselling: n=6, 7.3% Other: n=3, 3.7% Variety of reasons: n=7, 8.5%
Primary site for seeking health care	Hospital/emergency rooms: n=6, 7.4% Private practice physician: n=43, 53.1% Community Health Care Centre: n=19, 23.5% Primary Social service setting: n=1, 1.2% Walk-in Clinic: n=3, 3.7% Alternative/Complementary Care: n=6, 7.4% Other: n=3, 3.7%
Preferred language for receiving services (187 responses)	English: n=113, 60.4% English or other languages: n=29, 15.5% Languages other than English: n=44, 23.5% American Sign Language: n=1, 0.5%
Access to service/service provider speaking preferred language (176 responses)	Yes: n=132, 75% No: n=44, 25%

Barriers to health care access

Fig1: experienced barriers to health care access

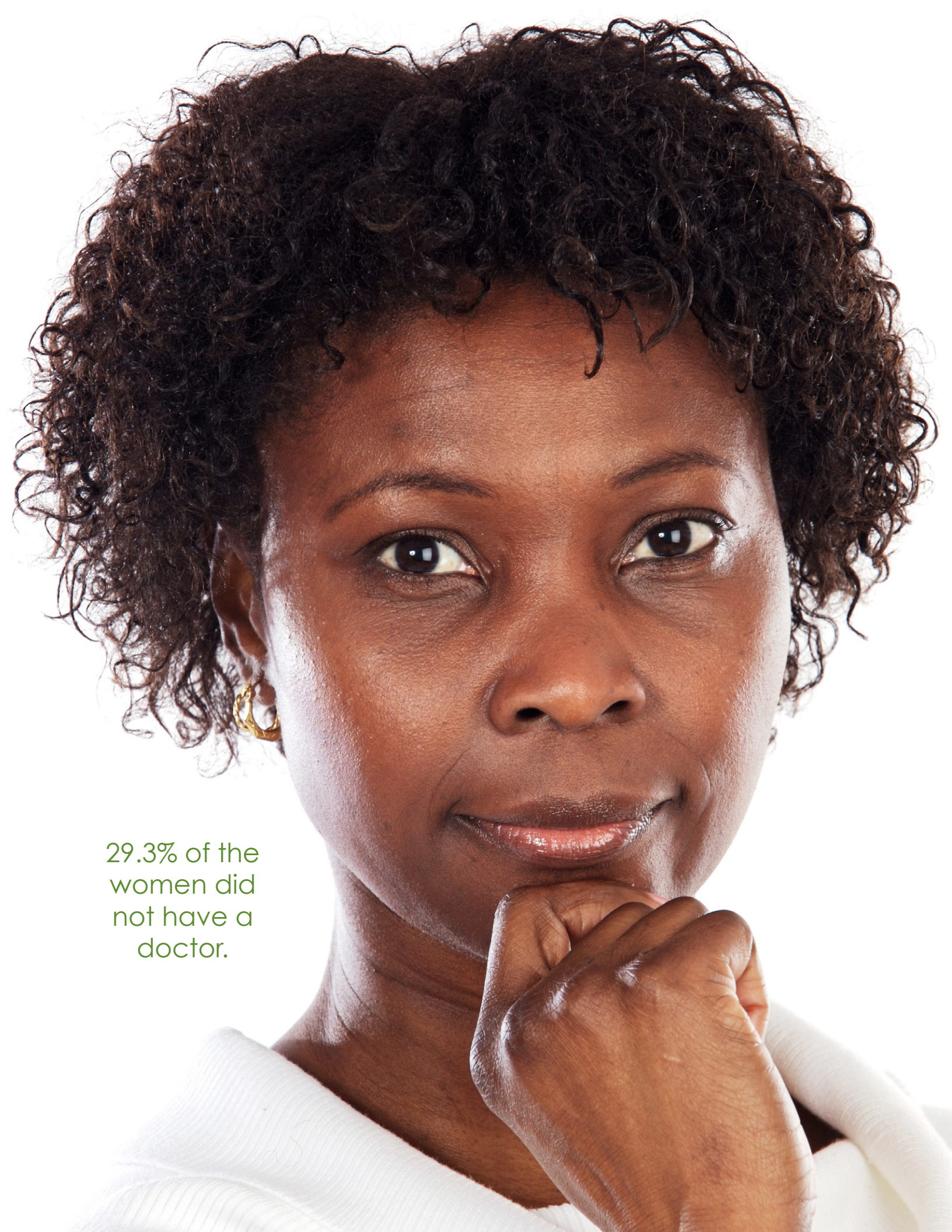


Women reported multiple barriers to health care access, including financial barriers created by travel expenses (24.1%), user fees (35.1%), long distances to health care (20.4%), wait times for services (18.4%), competing family demands (17.3%), work demands (23.6%) and other obligations that prevented accessing services when they were available (29.3%).

For individuals with limited budgets, high housing costs often absorb most of the household income. In an effort to lower rent and live in better-maintained and sometimes larger units, many people move beyond inner-city neighbourhoods. However, living in the suburbs often means it is harder to get to adequate, equitable health services as they are typically concentrated in and around urban cores.⁶

41.7% women were living in the urban suburbs, making it difficult to access basic health services.

⁶ United Way Research and Reports about increasing poverty by postal code in Toronto; <http://unitedwaytoronto.com/whoWeHelp/reports/povertyByPostalCode.php>

A close-up portrait of a Black woman with short, dark, curly hair. She is looking directly at the camera with a slight smile. Her right hand is resting under her chin. She is wearing a white, ribbed top. The background is plain white.

29.3% of the
women did
not have a
doctor.

Women's voices:

Some of the good doctors are not located in very accessible areas...so those are big barriers (Research Participant).

It takes me an hour to get to my doctor, I mean the closest (Research Participant).

Yah, accessibility...Every major service here in Toronto, as you go out more westward or eastward [905 area code], it's really less accessible...Like for my visual impairment, I have to come downtown to the General Hospital to see the specialist, right? But if it were in Oakville, it would be more convenient (Research participant).

Availability of Doctors

Several focus groups raised concerns about the difficulty of finding a family doctor and not being able to leave a doctor that was unsatisfactory because of the risk of being without healthcare. Many women complained about lack of cultural competence among doctors and their strict adherence to the western medical model. Participants also expressed a need for "quality control" to ensure doctors are devoting enough time to their patients. Although some expected to receive better care from doctors who were members of their ethno-racial or cultural communities, one participant described how this could still be a problem:

29.3% of the women did not have a doctor.

Women's voices:

Well, they are running the practice very traditionally as if they were back home, so to speak...You know, they are extremely cheap when it comes to the environment... They figure it's their own people, so they don't have to really treat them good (Research Participant).

⁶ United Way Research and Reports about increasing poverty by postal code in Toronto; <http://unitedwaytoronto.com/whoWeHelp/reports/povertyByPostalCode.php>

Additional Fees Not Covered by OHIP

Thirty-five percent (35.1%) of the respondents mentioned supplementary charges as a barrier for accessing health care. Although the health care system is understood to be free of charge, participants indicated that user fees were increasingly being charged with particularly harsh consequences for women with chronic healthcare problems. De-listing of services from the Ontario Health Insurance Plan (OHIP) was described as creating significant barriers for low and middle-income women. Women without supplementary health care benefits from employment were also affected by user fees. For women without OHIP coverage, health care access was even more difficult. Women described making decisions to not address health care problems because they could not afford the added costs and feared going into debt if they required care in an emergency.

45.1% of the sample was living with chronic health care conditions

Women's voices:

I was moved to a single room because my baby had jaundice and needed treatment. After going home, I got a bill for over \$800! I was shocked because nobody told me I would be charged. I can't pay that kind of money
(Research Participant).

Lack of Travel Money

Financial pressures were also an issue for getting to health care. Given the choice between meeting demands like paying for rent or attending to the needs of other family members, women would often forgo treatment. Low household incomes, lack of affordable housing and the need to live away from the urban core where services were more readily available converged in barriers to addressing health care needs.

24.1% women did not have enough travel money to access health care services

Women's voices:

For 25 dollars, the school George Brown will clean your teeth but guess what? George Brown is at the other end of the city. I need 25 dollars and I need two streetcar tickets to get there and you know what? That's a lot. That's a lot
(Service Provider)

Lengthy Wait Times

Many of the interviewed women, especially those with children, were concerned about wait times. Some women mentioned that sometimes they needed to pack lunch for a morning appointment as they knew the wait time would be long. Emergency rooms were highly criticized for their inability to cater to people in a timely and priority-based fashion.

18.4% women cited lengthy wait times as a major barrier for them.

Waiting lists for services were also identified as a problem for these women. Many described incidents in which they were told they needed to follow up with other services or physicians, but then received the information that they would have to wait several weeks or months for an appointment. Women found this very discouraging and it contributed to their not being able to attend to health problems in a timely manner.

Women's voices:

It's not worth waiting in the Emergency Room for hours and hours and hours for nothing, you know? I'm sure you've all experienced that. You know sometimes, I just get sick, and I'm vomiting. I don't care. I just don't want to go. It's just not worth the effort - the vomiting isn't as bad as the hospital
(Research Participant).

Emergency rooms?...No...we try to avoid those...The long, long waiting time.... You virtually have to be on the core of dying for them to pay attention to you. And I know people that have exaggerated their conditions and they've been paid attention to. I should have said that (laughter)....I've actually spent 20 hours waiting in an emergency room and I came in an ambulance, so that's why I avoid them. And then I got transported to another hospital
(Research Participant).

I don't know why can't they have a schedule...Especially if you wait with kids. It's not a joke. It's not a joke to wait for so long
(Research Participant).

Well, waiting lists are tedious and long. Something needs to be done about that
(Research Participant).

Issues affecting Women Across the Racial/Ethnic Groups

The majority of the women in the study were born outside of Canada (90.9%), representing a wide range of lengths of time in Canada (3 months to 49 years). Participants identified immigrant status and ethnic/racial minority status as creating specific barriers related to poor access to information about health care services, and discriminatory experiences when dealing with health service providers. In addition, women who were non-native English speakers encountered significant communication problems due to the unavailability of service providers speaking languages other than English. These issues were most pronounced for women who had immigrated to Canada within the last ten years.

12% of participants reported no one spoke their language at the service they accessed

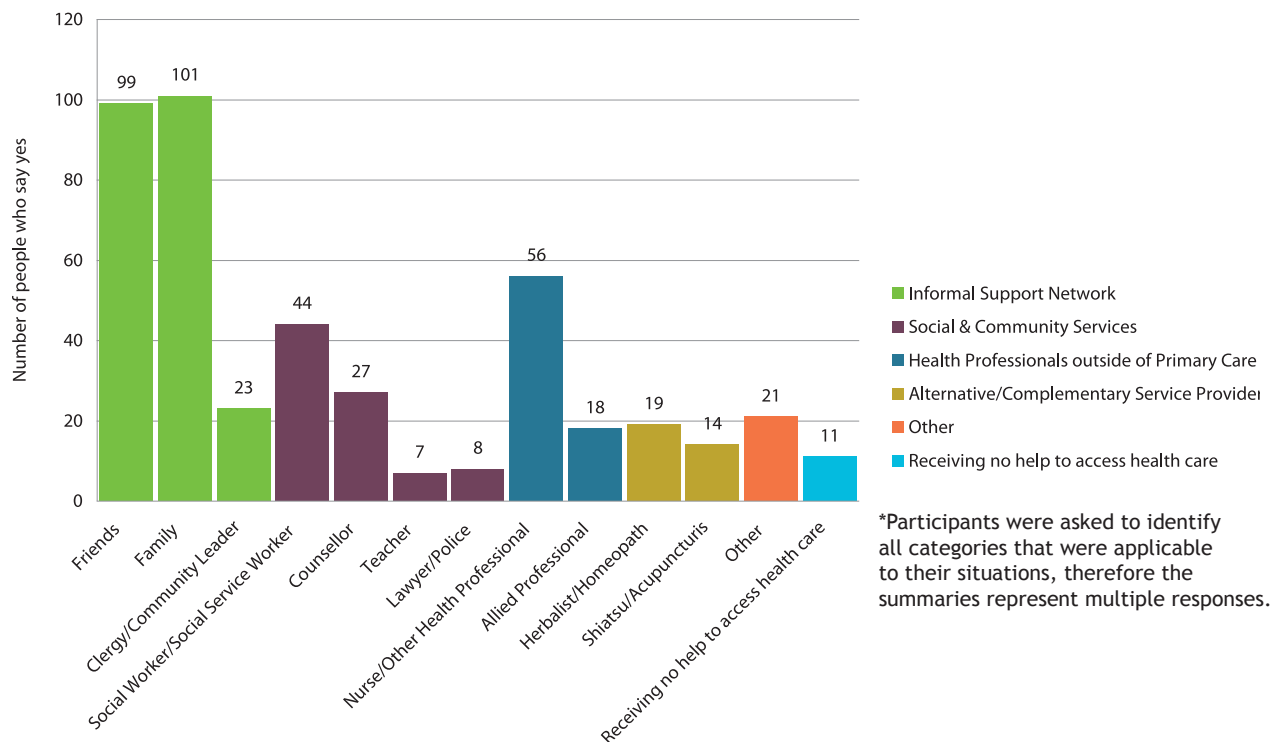
Facilitators of Health Care Access

Participants revealed that they were finding ways to overcome barriers to health care access and the community played an important role in helping them do this. Fifty-two percent (51.6%) of the women reported that they were assisted by friends and families in accessing health care services. The use of personal networks to secure health services reflected the resourcefulness of these women, but also called attention to the difficulties faced by those that were socially isolated. In addition to receiving assistance from friends and family, participants reported that service providers outside the health care system helped them in accessing health care services.

The respondent's stories revealed that community supports were trusted resources for providing assistance with navigating the health care system, but service providers also observed that many of these services and agencies were not equipped or resourced to provide such services. The information gathered about where women were making contact prior to receiving health care services was valuable for identifying potential points for facilitating access, but also raised concerns about why women like the participants were forced to take less direct routes to health care.

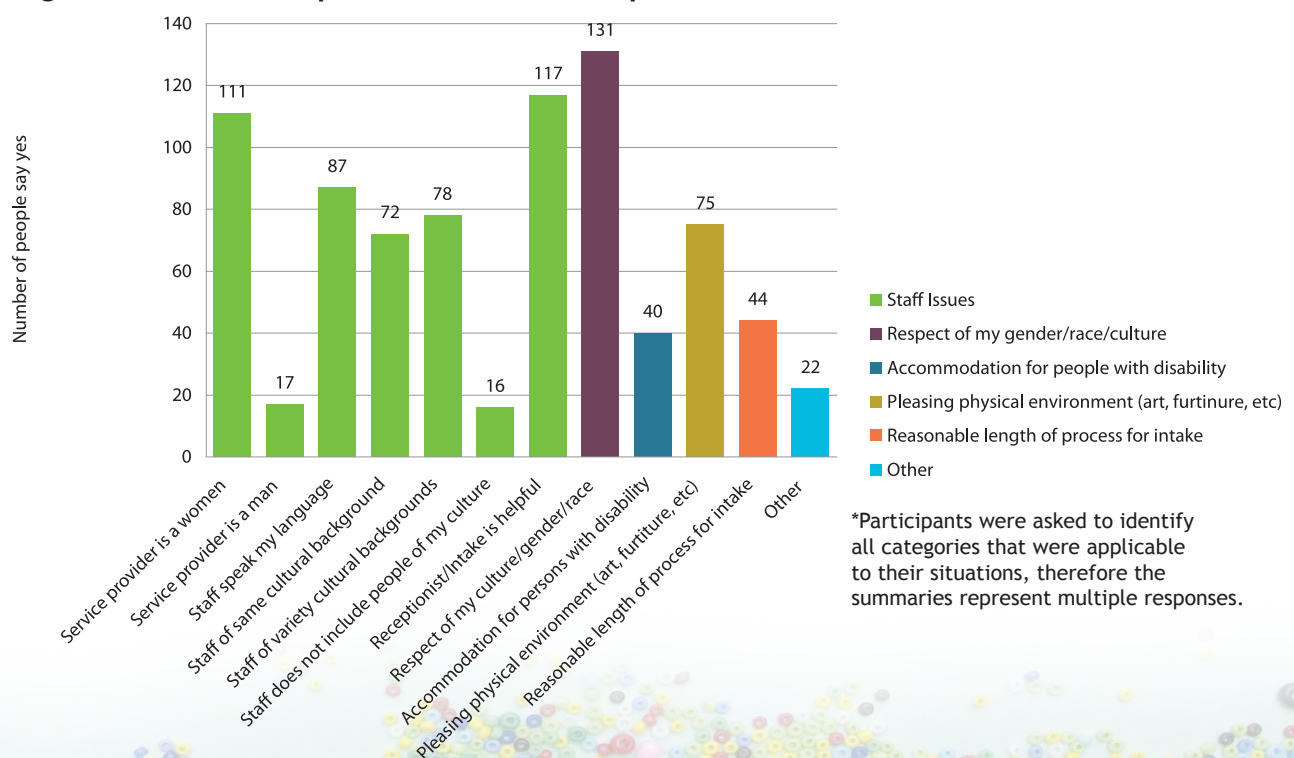
12% were assisted by clergy and/or community leaders
22.9% received assistance from a social worker
14% from a counselor
4.2% via lawyers/police

Fig 2. People that help women access health care



Participants also identified several factors that they saw as priorities for the health care they received (see Fig 3)

Fig 3. Priorities and preferences for acceptable health care



Respect for Gender, Race and Culture

Having service providers who were respectful of gender, race and cultural issues were a priority for the majority of interviewed women. Service users were concerned about the lack of anti-racism/anti-oppression skills and cultural competence in the health sector and repeatedly identified the need for a holistic, anti-racist and anti-oppressive approach to service delivery.

72% of the women believed respect for race, gender and culture is an important aspect of the healthcare experience.

Women's voices:

All [they] see is the race and the disability and the head gear [hijab]. And it really, really, disappointed me. And I think that's when I started to recognize what being racially judged was all about and how it, you know, like compounded with everything else
(Research Participant).

I want to emphasize the cultural sensitivity element. I went into a GTA hospital for a procedure that was a disaster from beginning to end. They expected me to change into one of those "gownies", and sit in public. And then she thought that a substitute for my head gear [hijab] would be the nice little nursing caps. Surgical caps.... It's embarrassing for anybody... It was just so stupid...and then I have to parade through the entire hospital to go to the operating room. And she didn't get it. She didn't get it at all
(Research Participant).

Female Service Providers

The preference for female service providers was very commonly expressed among the respondents. They did not think, however, that having only female service providers was the solution to access challenges. Interestingly, nine percent (9.3%) of participants expressed preference for male service providers. It was clear that many interviewees were seeking gender sensitivity in their service providers: something that must be prioritized along with cultural sensitivity training for service providers.

61% of the participants would prefer a female service provider.

Helpful and Polite Receptionists /Intake Workers

Interviewed women reported that a helpful, respectful reception at the point of entry to services increased their chances of success in receiving the care and attention they needed. They also indicated that off-putting experiences with receptionists or others at the first point of contact made health care an aversive experience. This was particularly important for women with children and women with physical disabilities.

64.3% of the women said that a helpful receptionist makes a big difference.

Women's voices:

I would go to a place where you feel welcome. Somewhere where you don't get that look or feel
(Research Participant).

Pleasing Physical Environment

Many women talked about how a pleasing physical environment and a family-like atmosphere may encourage them to go back to the same place. They expressed the belief that the physical environment was an indication of the respect and concern that the service had for its clients. They also expressed that the location of the service was important for making it accessible.

41.2% of the women said they wanted to receive services in a pleasant and comfortable physical environment.

Women's voices:

[The health care service] should be like... somewhere in the centre wherever is the center...for every body, convenient for people. It must be a convenient place that everybody can take a TTC or the train what ever to get there...Maybe in a community centre or something like that
(Research Participant).

Staff of Varied Cultural Backgrounds

The study participants stressed the importance of having services that were culture and gender sensitive, multilingual and client-centred. Although there were women who specifically wanted to have service providers from their own cultural backgrounds (39.6%), more women wanted to access services in which a variety of racial and ethnic backgrounds were represented among the service providers. Only 8.8% suggested that they preferred to be in a service that did not have any staff who shared their ethnic background.

42.9% of the women wanted services with staff of varied cultural backgrounds

Women's voices:

We'd just like to have any nationality but they must be nice and they have to know how to talk to patients
(Research Participant).

Staff Speaking Multiple Languages

Women reported that service providers that spoke multiple languages, especially the client's first or primary language would greatly enhance access and the quality of services.

As the study was designed to also look at how barriers to health care affected women in the priority groups (homeless/underhoused; lesbian/bisexual identity; living with physical disability; HIV positive), we also did analyses to explore what were specific issues affecting these groups. These analyses are presented in the following sections. Quantitative summaries of the data provided by each priority group are provided in Appendix E.

47.8% of the women preferred having staff speaking their own languages

Although this presentation of the data emphasizes a particular identity endorsed by the participant, it is important to note that in each of the priority groups, women represented intersecting identities, representing different ethnic groups and simultaneous membership in other priority groups. Accordingly, their descriptions of discrimination and marginalization should be understood as demonstrating the interlocking affects of oppression in the lives of Black Women and Women of Colour.

Barriers and Facilitators for homeless and underhoused women

Nineteen women (8.9%) identified themselves as homeless/underhoused. Notably, almost half of them reported a physical disability. Though in need of ready access to care (over 42% accessed health care at least 13 times per year), homeless participants reported multiple barriers. The most significant access barrier identified by homeless/underhoused participants was health care costs. Thus, despite state-sponsored medical coverage, paying for services not covered by provincial medical insurance and/or paying for travel to services facilities negatively affected participants' access to medical care.

Homeless/
under housed
women
accessed
health services
an average of
19.2 times per
year.

Women's voices:

I think too much about the money for pay. This is the problem and I no go to see the doctor, because sometime I don't have the money. I don't have the money for xxx, for pay, for this, for the teeth, you know. This is the problem, and I have a big infection over there, almost I have some piece almost come out, and I use the xxx all time

(Research Participant).

A lot of our women don't call the ambulances anymore because it cost them 35 dollars, you know. ODSP does not pick it up

(Service Provider).

Homeless/underhoused women also pointed to lengthy wait-times as a significant barrier to access (see Appendix C for the other major barriers identified by homeless/under housed women).

While lack of financial resources created barriers to health care access, health care access was facilitated by positive interpersonal interactions in health care facilities. Homeless/underhoused women articulated that the nature and attitude of the staff at health care sites is extremely important. They also wanted female service providers, respect for diversity among staff and a pleasing physical environment.

Participants reported that being subjected to stigma and discrimination is common for homeless women accessing health care services. They are often treated as undesirable and inconvenient clients. Courteous, helpful behaviour at the point of entry to care

would facilitate access to health care just as repeated negative experiences would keep homeless/underhoused women away.

Women's voices:

*I often feel like...I go, I talk about a concern and I walked out there no better than I walked in. He'll question me when I say I want to get ... a test on, you know check out something... [He would ask,] "Well, why do you think that? How long have you had that"? And...it's almost, it feels like an interrogation actually-where I don't know how to define what I'm feeling myself
(Research Participant).*

Family and friends play a major role in the homeless/under housed women's access to health care as do various social service and religious care providers. Women who identified as being part of this priority group indicated that they received more assistance from social service/religious/criminal justice systems than other women. Although these contacts could eventually lead to getting help, they were viewed as a far from ideal conduits to care.

Women's voices:

*In relation to police involvement in the healthcare system, I would think that that is not one of the best kinds of linkages for Women of Colour. That there is the whole issue of what's going in the police department what they are calling racial profiling but what's called straight discrimination; which is systemic. That and linking women to the healthcare system and it's not great for barriers and you know when we're talking about youth and the kind of barriers... Language and the lack of credibility in the health system...
(Service Provider).*

Barriers and Facilitators for Women Living with Physical Disability

Forty-eight (22.5%) participants identified themselves as living with a physical disability. Over sixty percent (61.1%) identified having chronic health conditions that required health care and nearly 3 in 4 respondents (72.2%) access private practice physicians.

These women identified discrimination as a regular stressor when accessing health care and also indicated that long wait times and supplemental costs limited access to assistive devices, specialists and rehabilitative care. In addition, women told many stories about the need to constantly advocate for themselves in order to receive services to which they were entitled.

Women living with physical disability accessed health care an average 11.1 times a year.

Women's voices:

I think you really have to be assertive and you really have to advocate for yourself and that's sickening because you have to advocate for yourself and be assertive in every area of your life as an immigrant woman, as a lesbian, as a woman of colour...And especially dealing with disability issues
(Research Participant).

Yeah, OHIP doesn't cover very much. No glasses anymore or your eye tests. It's a difficult life, for many of us...You have to pay everything out of pocket
(Research Participant).

When I had surgery, there was no interpreter again. There's a nurse, you know you push the button and the nurse comes, and again that took a really long time. Um, I was in a lot of pain, I needed to use the bathroom so I was pushing the button, and they knew that I was deaf, so I ended up having to yell out and then they came right away. So you know, I had to scream...but that was the only way that somebody would come
(Research Participant).

Lack of available of services, additional charges and family responsibilities were also identified as barriers to accessing care. Female service providers, accommodations for physical disability and helpful front office staff emerged as major facilitating priorities for women living with physical disability (See Appendix C).

Barriers and Facilitators for Lesbian and Bisexual Women

Twenty-one women (9.9%) who participated in the Access Study identified themselves as lesbian or bisexual. Over forty percent (43.8%) were living with chronic health conditions that made them seek health care.

The biggest challenge identified by the interviewed lesbian and bisexual women was attitudes of health service providers. Homophobia often materialized in encounters with services and forced women to tolerate negative behaviours in exchange for receiving care. Further, many health service providers and their respective institutions lacked practical knowledge about health care issues affecting lesbian and bisexual women, making them feel as if they were not receiving appropriate or adequate services.

Lesbian & bisexual identified women accessed health care services at average 7.2 times per year

Women's voices:

She's not exactly the greatest counselor because I mean, she's not really queer positive and you know I don't really feel comfortable having her be my counselor because that's such a big part of my life, you know
(Research Participant).

If they assume you're lesbian they might not tell you about birth control and other things that need to be factored
(Research Participant).

Moreover, these women spoke eloquently about how mundane processes like filling out intake forms reminded them that they were not recognized as participants in the health care system.

Women's voices:

I feel like as person who is of mixed race and who is queer and who doesn't always say "lesbian" when I, like I, usually say "queer" because it encompasses more... Feeling like I don't fit into the box of the different referral places, sometimes it's frustrating. It's nice to have the "other" option as opposed to this or that
(Research Participant).

All of the lesbian/bisexual participants felt that a provider respectful of their sexual identities along with their gender, race, and culture would increase their health care access and make their experiences more positive. However, in the interim, they faced the same impediments identified by other women in the sample.

Most of the women in this priority group identified support from family and friends as a major facilitator to accessing health care. Female service providers, helpful receptionists and cultural diversity as well as diversity of sexual orientation among staff would help these women navigate the health care system (See Appendix C for details).

Barriers and Facilitators for HIV positive Women

Twenty-one (9.9%) of the interviewees identified as HIV positive. The barriers identified by these women were similar to those identified by other women in the sample, but there were some specific differences. For example, discrimination was the most commonly endorsed barrier in this group.

HIV positive women accessed health care an average 5.4 times a year

Women's voices:

A nurse ...she was so scared to have my blood test done, you see, it mean she have to put a needle in your fingers. Take some blood, put a little monitor, you know and check your blood sugar. So to do that was...for her she was so, you know, because she knows I'm HIV positive, she was so scared of doing that. So it makes me feel like a... you know. They have to think about it. Human beings [are] human beings, even if you're not HIV positive or you are HIV positive or something (Research Participant).

I knew I was HIV positive. When I came here I went to have my blood done for immigration. So he did the test... (He said) "You know what you have HIV2, so go find yourself a doctor." You know, that is something I didn't...you know, for me it was easy because I knew I'm HIV positive but for somebody for somebody who's not, he's gonna fall down. You don't tell people you have a terminal disease like this with no compassion you know (Research Participant).

HIV positive participants were very concerned by the lack of knowledge and skills that many health care practitioners' had for working with clients that diagnosed with HIV/AIDS. Training of health professionals, they believed, could also help to minimize stereotyping and mistreatment of HIV positive women seeking health services.

Women's voices:

Somebody that treats you with respect and dignity, not somebody that [because of your HIV status], looks at you like something is wrong with you. And I think that we need more educational programs to educate these service providers how to relate to people in different circumstances because sometimes you go to hospital and because they know your status, they just look like you are scorned or "I can't touch you" or "Something is wrong with you", you know. And I don't think that's fair

(Research Participant).

Participants reported that they expected service providers to be more empathetic, especially when delivering HIV positive diagnoses. One service provider reported that many of her clients have had negative experiences with service providers when it came to getting their test results.

Women's voices:

I had a woman tell me that doctors have no business doing HIV testing. So her experience was that the doctor who tested her for HIV, she never got any pre-test counselling. She never got any post-test counselling. Never called her to tell her, her results. She just came to his office to find out, for something else. She wasn't feeling well, something else. And then he just... said: "Oh, no, no, no. I called you. Did you get my message?" She said: "Uh no. I just I came here from uh from work." He said: "Okay, here, sit down. You're HIV positive." That's all she got

(Service Provider).

A client tested positive and...she explain[ed] to the doctor that [she wanted to disclose to her boyfriend]. Then the doctor asked where the boyfriend comes from and the woman said he's a white, and the doctor said "How can, how dare you black woman date a White man" The doctor seem[ed] to be accusing that lady of dating a White man when she has HIV, but she didn't know she had HIV. She tested positive afterwards. The doctor said, (mimicking voice) "I'm going to refer you to a Black doctor who's going to treat you for that". That's what happened to that woman

(Service Provider).

In addition to the wider societal discrimination experienced by HIV positive people, the three major barriers to health care system access identified by this group of participants were lack of accessible services, travel expenses and supplemental charges. Twenty

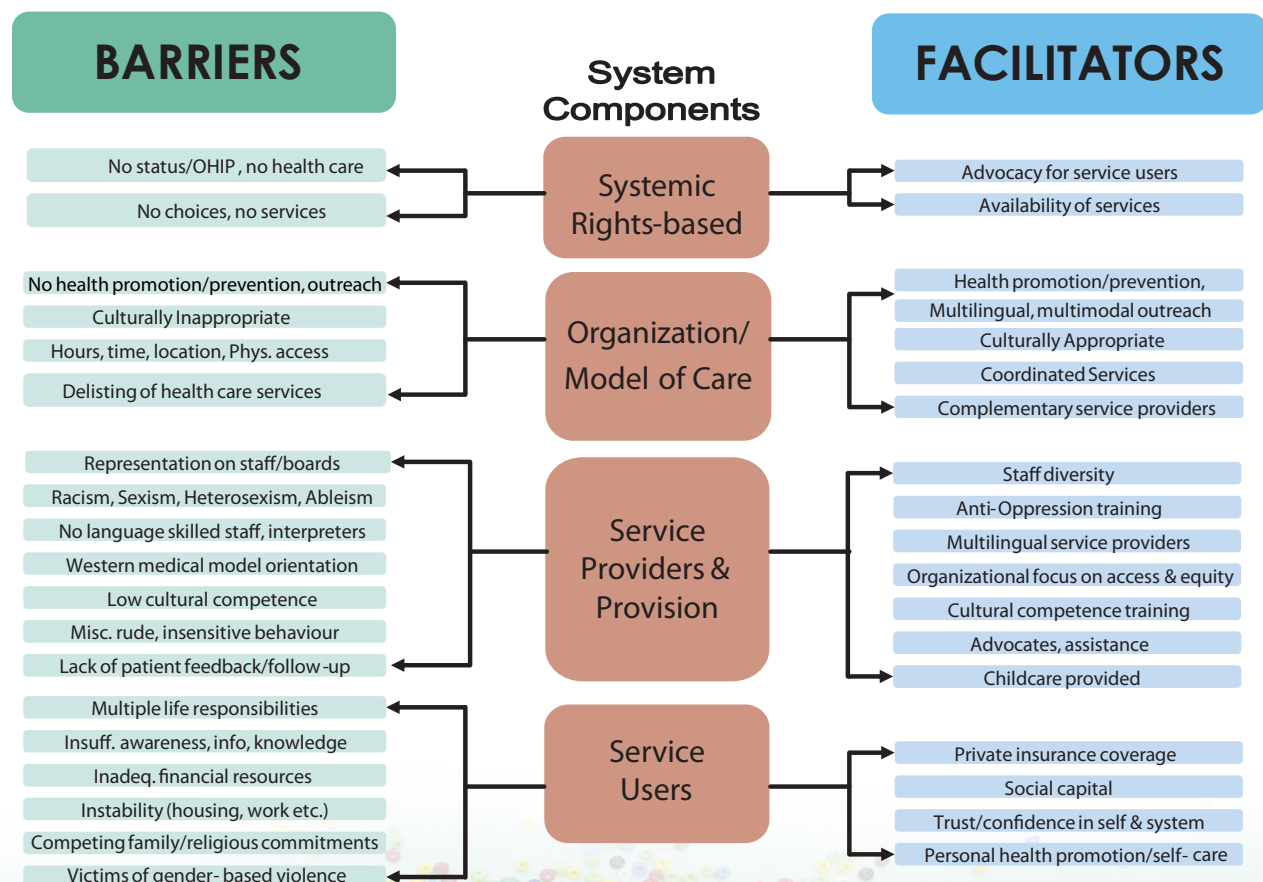
percent (20.4%) of these individuals also identified distance from desired health care services as a barrier. This issue was repeated as a concern in focus group discussions.

Women's voices:

I think the location is a big issue too because you don't want to be travelling an hour to access services and the environment has to [be] comfortable...You want to walk in there and feel [comfortable]
(Research Participant).

Women who identified as HIV positive experienced a cross-section of the barriers similar to those experienced by other women but reported pronounced experiences of racial discrimination and HIV-related stigma. It is notable, however, that these women demonstrated great energy for self-advocacy and also had superior knowledge of issues regarding disclosure and their rights in health care.

Fig 4. PHC Access Framework for Black Women & Women of colour



Conclusions

Figure 4 summarizes the themes and categories derived from analysis of the qualitative and quantitative data provided by our participants.

These findings were used as a foundation to develop the Primary Health Care Logic Model that would underlie the piloting of an alternative model of care to increase access for women like those who participated in the study. Both qualitative and quantitative data analyses suggested that this pilot program should focus on homeless/underhoused women. This priority group not only represented all of the priority groups and ethnic groups in the study, but they emerged as the most severely marginalized group of women in our study.



64.3% of the women said that a helpful receptionist makes a big difference.

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Section 2

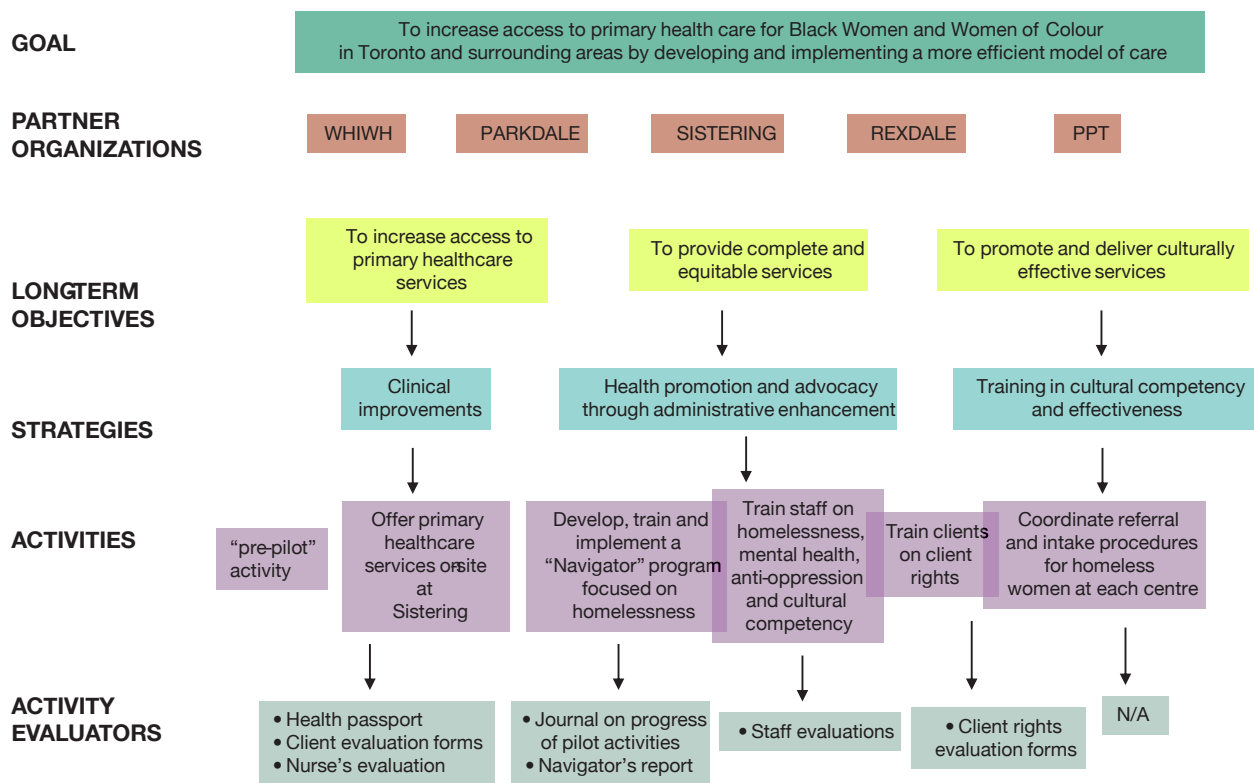
A close-up portrait of a woman with dark hair and a purple tank top. She has a visible injury on her forehead, with a small amount of blood and a red mark. She is looking directly at the camera with a serious expression. A necklace with a circular pendant is visible around her neck. The background is plain white.

12% of
participants
reported no
one spoke
their language
at the service
they accessed

Primary Health Care Logic Model

The Primary Health Care Logic Model (hereafter Logic Model) is a visual tool used to describe an inclusive health care model designed to enhance primary medical care access for heterogeneous populations of Black Women and Women of Colour. This Logic Model was developed after research data analysis and served as a guide to the elaboration of a more accessible health care model.

fig 5. Primary Health Care Logic Model



In principle, the Logic Model describes a process which a) sees an individual's health as an outcome of socio-economic, bio-psychological, cultural and environmental realities; b) involves a holistic definition of health and healthcare needs; and c) includes alternative approaches to improving access to quality primary care.

The Logic Model describes one of the collaborative project's overarching long-term goals of developing a more efficient model of care in order to improve the primary health care access of Black Women and Women of Colour in the Greater Toronto Area.

Focusing on homeless/underhoused individuals in the sample, five Toronto-area agencies⁷ worked together to develop and implement strategies aimed at increasing access to equitable health care services delivered in culturally competent contexts. These improvements were to be achieved through three modes; 1) clinical improvements; 2) health promotion and advocacy through staffing; and 3) the provision of cultural competency training. Thus, while primary health care services were offered at one partner agency, others supported the development of the Navigator initiative (an advocacy program serving underhoused/homeless participants), offered patients' rights seminars and trained each agency's personnel to coordinate referral and intake procedures that best addressed participant needs. Finally, each activity's impact was assessed through multiple approaches involving client and staff.

The main activities took place once a week for 3 months at Sistering - A Woman's Place a women's drop-in centre, and included offering primary health care services on-site, having a Navigator to facilitate women's involvement in the pilot, informing clients of their rights as users of the health care system, and training service providers on homelessness, mental health and anti-oppression.

Forty-seven service providers participated in training on homelessness, mental health, anti-oppression and cultural competency. Thirty-two (32) service users and eleven (11) service providers participated in client's rights training sessions. The Navigator provided support and advocacy for 101 women during the pilot phase of the study. Seventy-four per cent of the participants received primary healthcare at the pilot site. Forty three percent (43%) participated in health education workshops. There was a sixty-two percent (62%) successful community health centre referral rate and over half (53%) of the women receiving referrals made multiple visits during the 3 month pilot phase. Thirty-nine (39) women participated in nine (9) Health Education workshops conducted by nurse practitioners, nurses, mental health therapists, social work students and physicians. Twenty-three (23) women accessed specialty clinics which they otherwise could not afford to attend. Referrals were also made for additional care from these providers at other locations.

A nurse practitioner and a nursing student were present on Thursdays from 10 AM-3 PM to offer basic primary health care services to women at Sistering - A Woman's Place. Close to seventy (68) women were able to receive primary healthcare services. Over half (52%) were able to be referred to community healthcare during the pilot and were able to keep their appointment. Half of those referred made multiple visits during the 3 month pilot .

Through the effectiveness of service provider training, client rights and entitlements training, the skill of the pilot Navigator and the coordination of a referral process

⁷The partner organizations: Women's Health in Women's Hands, Parkdale Community Health Centre, Sistering, Rexdale Community Health Centre and Planned Parenthood Toronto.

geared towards increasing access for a specified population, we were able to ensure access to primary healthcare for 130 women over the course of the pilot.

An effective primary healthcare system is one in which communities can improve their health in a system that not only addresses their expectations but also meets their needs. This means ensuring equitable access to those marginalized populations who have traditionally faced barriers. This project not only raises awareness about issues of social inclusion for Black women and Women of color but also acted as a consultative process for primary healthcare stakeholders who have been traditionally absent from the discussion of primary healthcare renewal.



Section 3



42.9% of
the women
wanted
services
with staff of
varied cultural
backgrounds

Recommendations

Introduction

The Access Study is a landmark research study documenting the health care access experiences of Black Women and Women of Colour in Ontario. After engaging the largest participant sample of any comparable study, we offer that these project-related recommendations must contribute to the growing body of knowledge used for evidence-based decision-making and serve as invaluable guides to reform initiatives designed to increase equitable access to health services.

The Access Study themes and recommendations are grounded in the following understandings and commitments:

- An understanding that equity of health care access is required for those who have historically faced barriers
- A commitment to promotion of widely adopted best practices and standards which sustain and encourage equitable access to quality healthcare for Black Women and Women of Colour
- An understanding of the necessity of anti-racist, anti-oppressive community-based frameworks of practice
- An understanding that primary healthcare services must be offered in ways that value and respond to the cultural and racialized experiences of individuals
- A commitment to providing communities the opportunity to identify and define community needs, capacities and strengths
- A commitment to supporting communities with the collection and analysis of reliable information related to their changing environments and needs
- A commitment to sustainable collaboration among primary health care professionals, community organizations and academic institutions.

Access Study Themes and Recommendations

Intersecting Marginalizations Create Complex Barriers to Health Care Access

While seeking service through the Ontario health care system, Black Women and Women of Colour are more likely to be affected by multiple and intersecting marginalizations. Factors such as racism, organizational insensitivity, poverty, homelessness, immigration status, sexual orientation, disability, and HIV positive status operate as structural barriers and complicate health care access and medical system navigation for the province's Black Women and Women of Colour. Discrimination has no place in health care provision.

RECOMMENDATION (advocacy, education, practice, policy): Ensure anti-racist/anti-oppressive practices and policies are employed by Health Service Providers in areas of training, employment and procedure.

RECOMMENDATION (advocacy, education, practice, policy): Revise and/or update Health Service Provider accreditation standards to reflect specific and practical anti-racist/anti-oppressive primary healthcare reform and renewal practices.

RECOMMENDATION (advocacy, education, practice, policy): Publish regular reports detailing compliance with anti-racist/anti-oppressive accreditation standards.

RECOMMENDATION (advocacy, education, practice, policy): Support short- and long-term anti-racist/anti-oppressive initiatives through LHIN earmarked sector funding, that is, as a percentage of total funding disbursed to agencies⁸.

RECOMMENDATION (advocacy, education, practice, policy): Ensure representation of affected demographics in development, implementation and evaluation of reform initiatives.

RECOMMENDATION Develop and implement holistic, culturally competent, anti-racist and anti-oppressive approaches to health care service delivery.

Extra-systemic health care facilitators: Navigators (Health Care System Advocates)

Study participants often overcame systemic barriers to access through the use of community support: friends, family members, community advocates or other trusted persons who assisted participants health system navigation.

The Access study also included the hiring of a Navigator, an educator/advocate who worked with female participants to negotiate the provincial health care system's complexity. Participants noted that Navigators bridged the access gap between them, as Black Women and Women of Colour, and the primary care system.

RECOMMENDATION (education, advocacy): Recruit Navigators to personally advocate for (marginalized) women and assist their journey through the primary care system.

RECOMMENDATION (research): Study the role(s) and use of non-medical community support individuals for health care access.

⁸LHINS have responsibility over the following providers: Hospitals, Community Care Access Centres, Community Support Services, Long-term Care, Mental Health and Addictions Services, Community Health Centres.

Travel Distances and related costs

In an effort to lower their housing costs, many individuals on limited budgets may move beyond inner-city neighbourhoods. Unfortunately, medical services tend to be concentrated in and around urban cores, thus making distance and related travel costs barriers to adequate and equitable health services.

RECOMMENDATION (advocacy): Provide discounted transportation vouchers (and requisite budgetary allowances) to HSPs for limited income clients faced health-care related travel.

RECOMMENDATION (policy): Findings from the Access Study indicate that health care facilities should be added to the Toronto Central LHIN, the Mississauga Halton LHIN, Central West LHIN, Central LHIN, Central East LHIN, Hamilton Niagara Haldimand Brant LHIN, and Champlain LHIN to reflect the increased population density in these regions.

Medical Staff Availability and Related Wait Times

Participants reported that difficulties finding doctors who might accept new patients often meant that they were unable to leave the care of an inappropriate practitioner for fear of then being doctor-less. Study participants' lack of choice amongst medical professionals meant they might be faced with continuing to see doctors who lacked cultural and/or gender competence, spent minimal time with patients and/or who exclusively adhered to the western medical model. In addition, the dearth of medical practitioners contributes to lengthy waiting times in practitioners' offices and long waitlists for appointments with specialists.

RECOMMENDATION (policy): Geographically- and demographically- targeted recruitment of physicians and nurse practitioners who reflect diversities in ethnicity, race, sexual orientation, gender (including transgender), culture and language. These professionals' practices would reflect anti-oppressive, anti-racist and gender-sensitive methods.

RECOMMENDATION (practice): Implementation of more effective triage practices to reduce service wait-times.

RECOMMENDATION (advocacy): Recruit and train more female/female identified doctors and health service providers.

Fees not covered by provincial health care funding

While individuals often refer to Canada's "free" health care system, the costs of many medical and health-care related services are paid for out-of-pocket by patients. The levy of supplemental fees is widespread throughout the state-funded system. Black

Women and Women of Colour experience these additional charges and growing inventory of services no longer covered through governmental funding as obstacles to equitable health care access.

RECOMMENDATION (advocacy, immediate): Stop medical service de-listing

RECOMMENDATION (advocacy): Reinstate vision and chiropractic care coverage for individuals and families.

RECOMMENDATION (advocacy, practice): Create incentives for specialists and institutions whose services are not covered by provincial funding to provide sliding scale fees which reflect socio-economic realities.

Health service providers' lack of knowledge and skills about HIV and AIDS

Many participants who self-identified as HIV-positive lamented medical practitioners' lack of knowledge and skill regarding HIV and AIDS. Participants were also disappointed by the lack of empathy offered by HSP employees regarding chronic illness diagnosis and treatment (including when first being informed of seropositive status).

RECOMMENDATION (practice, education): Require practitioner training regarding the top five demographic-specific chronic diseases including HIV/AIDS.

RECOMMENDATION (practice, education): Develop basic certificates in partnership with accredited service delivery organizations with established records of advocacy and anti-oppressive practice. Training should be updated biennially (every two years).

RECOMMENDATION (policy): Allocate sufficient additional staffing and funding for agencies with demonstrated commitments of appropriately and effectively serving Black Women and Women of Colour living with HIV/AIDS and other chronic illnesses.

Immigration Status, Language and Healthcare Access

A majority of the study participants were born outside of Canada. Many identified immigration status as an impediment to health care service.

RECOMMENDATION (education, advocacy, policy): Recognize access to health care as a human right accorded to all despite immigration status. Among women whose first language was not English, a dearth of service providers offering translation or service in women's preferred languages interfered with the clear communication necessary for effective health care.

RECOMMENDATION (practice): Support practitioner and employee supplemental language acquisition.

RECOMMENDATION (practice): Provide access to translation services for equitable access to health care.

RECOMMENDATION (advocacy): Facilitate the recognition of education and qualifications for foreign-trained medical professionals.

Environmental Facilitators

Health care access is not exclusively about medical professionals and procedures. Often, the first person a medical care-seeking participant encountered was an Intake worker or receptionist. Participants reported that encounters with helpful staff members working in pleasing, local office environments supported their efforts to access health care. Multicultural and multilingual staff were also organizational assets.

RECOMMENDATION (practice): Encourage client-focused working environments and staffing.

RECOMMENDATION (practice): Encourage the hiring and retention of multilingual support staff.

Conclusion: A Call to Action

Effective primary healthcare allows individuals to improve and sustain their well-being in need-responsive systems which embody the universal protections and entitlements. The Access Study's innovative bringing together of service users and providers in in-depth discussions regarding crucial health care access issues for Black Women and Women of Colour raise awareness regarding their social inclusion while privileging their knowledge and experiences as healthcare stakeholders. This project's consultative processes integrated participants whose experiences have been traditionally absent from discussions of primary healthcare renewal and reform. It is essential that the valuable information and insights offered by the participants and HSPs are privileged in future health care reform discussion and initiatives. Black Women and Women of Colour deserve appropriate, consistent, affordable and timely access to primary health care because **every woman matters**.



Appendices

Appendix A: Partner Organizations

Sistering – A Woman's Place:

Sistering - A Woman's Place has been supporting homeless, underhoused and low-income women in the Toronto community since 1981. Its mandate includes community development, support for homeless/under housed women, housing support and advocacy. The organization provides valuable practical assistance like showers, laundry facilities, clothing, some transportation, referrals, advocacy support and life skills workshops. Between 1987 and 1999, Sistering experienced a 459% increase in the number of women seeking services. Sistering continues to play a leading advocacy role in bringing attention to the plight of homeless/underhoused women in Toronto.

Planned Parenthood Toronto (PPT):

PPT is a Community Health Centre, offering a full range of primary health care services including physicals, STI testing and counselling services related to sexual health promotion for youth and women of reproductive age. Its services also include flu shots, workshops on relevant topics and a peer-run phone, e-mail and MSN chat service for teens. PPT offers services for young parents and training for other service providers in the Toronto area.

Rexdale Community Health Centre (RCHC):

RCHC supports and advocates for the physical, economic, social and mental wellbeing of individuals in its diverse catchment area through primary health care, community social support, health promotion, collaborations and partnerships, community development and social action. The Centre is committed to building and supporting a healthier community. This includes the physical, economic, social and mental health of all community members. Its activities are supported by strategic partnerships and collaborations.

Parkdale Community Health Centre (PCHC):

PCHC is dedicated to ensuring responsive, accessible, and innovative primary health care services for its mandated communities. An integrated approach to the delivery of quality health care services underlines PCHC's service delivery mechanism. Like other community health centres, PCHC also espouses a social determinant of health perspective and its services include assessments of the biological, socio-cultural, psychological and environmental aspects of the lives of local residents and the wider community.

Women's Health in Women's Hands Community Health Centre (WHIWH):

WHIWH is a pro-choice, anti-racist, multilingual, participatory community health centre for women of diverse backgrounds in Metropolitan Toronto and surrounding municipalities. We are committed to working from an inclusive feminist, pro-choice, anti racist, anti-oppression and multilingual participatory framework to address the primary health care needs of racialized women from South Asian, African, Latin American and Caribbean communities

Factor-Inwentash Faculty of Social Work, University of Toronto:

The Factor-Inwentash Faculty of Social Work is distinguished by its emphasis on evidence-based practice, by its practicum education and by a governing structure that brings together teaching faculty, field instructors, students, alumni, the profession, the administration, and the University as partners in the realization of the Faculty's mission. The Faculty's current program of teaching and research is organized around four areas of specialization; children and their families; mental health and health; diversity and social justice; and gerontology. Within its commitment to academic and practice excellence, the Faculty of Social Work seeks to select a student body that is reflective of Canada's racial, religious, class, age, differential ability and gender identity.

Appendix B: Facilitators to Access Audit Tool

The following questions provide a practical approach to identifying how HSPs, their respective institutions, policy makers and researchers can take meaningful action toward decreasing barriers and increasing facilitators to primary healthcare for Black Women and Women of Colour living with multiple and intersecting marginalizations.

Respect for Gender, Race and Culture:

1. Has the organization dedicated financial and human resources to facilitating integration of concrete anti-racist, anti-oppression practices throughout all aspects of the organization?
2. Are concrete items identified in the Strategic Plan?
 - Accountability measures?
 - Organizational tracking of contracting/hiring practices and results?
 - Organizational tracking of race, gender etc. stratification and associated paycales?
3. Have staff received anti-racism and anti-oppression training addressing gender, race and culture (at beginner, intermediate and advanced levels)?
4. Are staff required to refresh training annually and demonstrate practical improvement in performing their duties?
5. Are performance appraisals designed to meaningfully capture improvement of skills and professional understanding of gender, race and culture?

Female Service Providers:

6. How many female service providers that are reflective of the population being served are positioned throughout the organizational hierarchy who have strong professional training, receive appropriate pay as well as possess anti-racist, anti-oppression skills are on staff?

Helpful receptionists and Intake staff:

7. Are receptionists and intake staff reflective of the population being served? (e.g., multilingual?)
8. Have receptionists and intake staff received anti-racist/anti-oppression training? Annually? At beginner, intermediate and advanced levels?
9. Are receptionists and intake staff trained to respectfully assist people living with disabilities?
10. Are receptionists and intake staff 'child friendly'?

Pleasant physical environment:

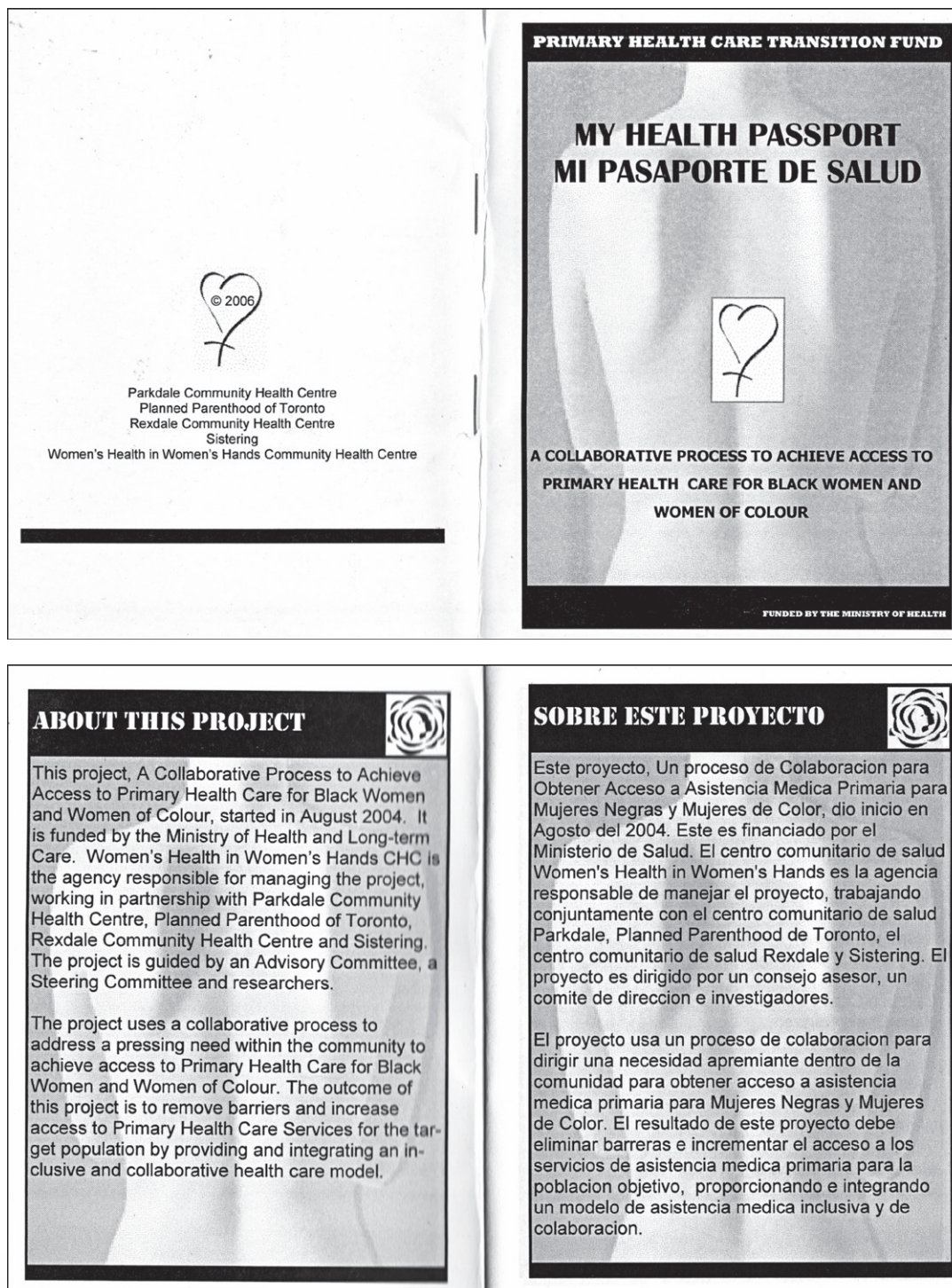
11. Is the physical environment aesthetically pleasing? For example, are floors, walls and furniture in good condition and co-ordinated?

12. Are surroundings accessible to people living with physical disabilities? Can people with physical disabilities move freely without assistance to the reception area, bathroom, in and out of service providers offices?

Staffing: Race, Sexual Orientation and Culture

13. Are staff of varied cultural, racial, sexual orientation and religious backgrounds?
14. Are staff of varied cultural, racial, sexual orientation and religious backgrounds positioned throughout the organizational hierarchy, who have strong professional training, receive appropriate pay as well as possess anti-racist, anti-oppression skills are on staff?
15. Do clients have a choice regarding who their providers will be?

Appendix C: Health Passport



IMPORTANT NUMBERS



Emergency: **911**
Police: (416) 808-2222
Fire Department: (416) 338-9050
Crime Stoppers: 1-800-222-8477

Hostel Service Intake

(Emergency Housing): (416) 397-5637
 Assaulted Women's Helpline: (416) 863-0511
 Daily Bread Food Bank: (416) 203-0050
 Distress Line: (416) 408-4357
 Gerstien Centre (online counseling): (416) 929-5200
 Rape Crisis Centre: (416) 597-8808
 Street Help: (416) 392-3777

Sistering Drop-in Centre:(416) 926-1946
 Women's Health in
 Women's Hands CHC:(416) 593-7655
 Parkdale CHC:(416) 537-2455
 Planned Parenthood of Toronto: ... (416) 961-0113
 Rexdale CHC:(416) 744-0066

NUMEROS IMPORTANTES



Emergencia: **911**
Policia: (416) 808-2222
Cuerpo de Bomberos: (416) 338-9050
Crime Stoppers: 1-800-222-8477

Central Intake

(Alimentación de emergencia): (416) 397-5637
 Assaulted Women's Helpline: (416) 863-0511
 Daily Bread Banco de Comida: (416) 203-0050
 Distress Line: (416) 408-4357
 Centro Gerstein (consejería online): (416) 929-5200
 Rape Crisis Centre: (416) 597-8808
 Street Help: (416) 392-3777

Sistering Drop-in Centre:(416) 926-1946
 Women's Health in
 Women's Hands CHC:(416) 593-7655
 Parkdale CHC:(416) 537-2455
 Planned Parenthood of Toronto:(416) 961-0113
 Rexdale CHC:(416) 744-0066

MY IMPORTANT NUMBERS / MIS NUMEROS IMPORTANTES



Emergency Contacts / Contactos de emergencia:

Name / Nombre: Telephone # / Telefono

My health provider is / Mi proveedora de salud es:

Name / Nombre: Telephone # / Telefono

Other numbers / otros numeros:

Name / Nombre: Telephone # / Telefono

IMPORTANT DATES / FECHAS IMPORTANTES

[illegible]

CLIENT BILL OF RIGHTS



1. I have a right to receive quality care and treatment in a safe, supportive and comfortable environment that respects my social, cultural and spiritual needs
2. I have a right to care and treatment that meet professional standards by qualified staff committed to my well-being
3. I have a right to know the name and title of my health care provider
4. I have a right to be treated with respect, consideration and dignity, and with protection of my need for privacy.
5. I have a right to be listened to and to have my concerns taken seriously without ridicule.

DECLARACION DE DERECHOS DE LA CLIENTE



1. Tengo el derecho de recibir atencion y tratamiento de calidad en un entorno seguro, solidario y comodo que respete mis necesidades sociales, culturales y espirituales.
2. Tengo el derecho de recibir atencion y tratamiento por profesionales calificados, comprometidos con mi bienestar.
3. Tengo el derecho de saber el nombre y la posicion de quien me asiste.
4. Tengo el derecho de ser tratada con respeto, consideracion y dignidad, protegiendo mi necesidad de privacidad.
5. Tengo el derecho de ser escuchada y que mis preocupaciones sean tomadas en cuenta seriamente sin ponerme en ridiculo.

CLIENT BILL OF RIGHTS



6. I have a right to ask questions and to receive prompt and reasonable responses to my questions.
7. I have a right to refuse to participate in treatment or medication recommended by my health care provider
8. I have a right to obtain a second opinion on any treatments, surgical procedures or health decisions recommended by my health care provider
9. I have a right to access and understand my medical records
10. I have a right to confidentiality of all information related to my care, which will remain confidential unless I have provided written consent to release such information

DECLARACION DE DERECHOS DE LA CLIENTE



6. Tengo el derecho a preguntar y recibir una respuesta inmediata y razonable a mis preguntas.
7. Tengo el derecho a negarme a cualquier tratamiento o medicamentos recetados por mi proveedora de salud.
8. Tengo el derecho de obtener una segunda opinion sobre cualquier tratamiento, operacion o decision sobre mi salud que me fuera recomendada por mi proveedora de salud.
9. Tengo el derecho de ver y entender mis reportes medicos.
10. Tengo el derecho a la confidencialidad de toda la informacion relacionada a mi atencion, y se mantendra confidencial, a menos que de un consentimiento escrito para difundir dicha informacion.

CLIENT BILL OF RESPONSIBILITIES



1. I have the responsibility to arrive for my appointments on time.
2. I have the responsibility to notify the Centre if I need to cancel an appointment.
3. I have a responsibility to learn about my body and how it works.
4. I have a responsibility to follow the treatment plan my health care provider and I have agreed upon.
5. I have a responsibility to treat my health care provider with respect and courtesy.

DECLARACION DE RESPONSABILIDADES DE LA CLIENTE



1. Tengo la responsabilidad de llegar puntualmente a mis citas.
2. Tengo la responsabilidad de llamar al Centro si necesito cancelar una cita
3. Tengo la responsabilidad de aprender como funciona mi cuerpo
4. Tengo la responsabilidad de seguir/continuar/implementar el tratamiento que haya acordado con mi medica
5. Tengo la responsabilidad de tratar a mi medica y/o proveedora de salud con respeto y cortesia

CLIENT BILL OF RESPONSIBILITIES



6. I have a responsibility to tell my health care provider that I need more information or that I do not understand her instructions.
7. I have a responsibility to report unexpected changes in my condition to my health care provider.
8. I have a responsibility to learn as much as I can about my health care problems so that I can make the best choices.
9. I have a responsibility to look after my body to the best of my ability.

DECLARACION DE RESPONSABILIDADES DE LA CLIENTE



6. Tengo la responsabilidad de pedir mas informacion o decir que no entiendo las instrucciones que me dice mi medica y/o mi proveedora de salud
7. Tengo la responsabilidad de comunicar cualquier cambio en mi salud, a quien me asiste
8. Tengo la responsabilidad de aprender lo mas que pueda sobre mis problemas de salud para poder tomar las mejores decisiones
9. Tengo la responsabilidad de atender mi cuerpo de la mejor manera posible

MEDICAL HISTORY / HISTORIA MEDICA	MEDICAL HISTORY / HISTORIA MEDICA
<p>Allergies / Alergias:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Current Medications / Medicamentos en Uso:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Immunizations / Inmunizaciones/Vacunas:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Medical History / Historia Medica:</p> <p>_____</p> <p>_____</p> <p>Past diagnoses and treatment/ Diagnosticos pasados y tratamientos:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Medical surgeries / Cirugias:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Additional information / Informacion Adicional:</p> <p>_____</p> <p>_____</p> <p>_____</p>

YOUR VISIT / SU VISITA ...	YOUR VISIT / SU VISITA ...
<p>Reason / Motivo:</p> <p>_____</p> <p>Recommended Treatment by provider / Tratamiento Recomendado por Proveedora:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Follow up recommended? / Seguimiento Recomendado? Yes/Si <input type="radio"/> No/No <input type="radio"/></p> <p>Feelings about visit / Impresion de la visita?</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Reason / Motivo:</p> <p>_____</p> <p>Recommended Treatment by provider / Tratamiento Recomendado por Proveedora:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Follow up recommended? / Seguimiento Recomendado? Yes/Si <input type="radio"/> No/No <input type="radio"/></p> <p>Feelings about visit / Impresion de la visita?</p> <p>_____</p> <p>_____</p> <p>_____</p>

MY BLOOD PRESSURE* MI PRESION ARTERIAL~



Date Fecha	Blood Pressure (systolic / diastolic) Presion Arterial (Sistolico/diastolico)

* NOTE: Normal blood pressure (BP) should be $\leq 140/90$
If you are diabetic your BP should be $\leq 130/80$
If you have kidney problems your BP should be $\leq 125/75$
(does not apply if you are ≤ 18 years old or pregnant)

~ NOTA: Presion Arterial (PA) normal debe ser $< 140/90$
Si usted es diabetica su presion arterial debe ser $< 130/80$
Si usted tiene problemas con sus riñones su PA debe ser $< 125/75$
(esto no se aplica si usted es < 18 años de edad o si usted esta)

MY BLOOD SUGAR* MI GLUCOSE/ AZUCAR EN LA SANGRE~



Date / Fecha	Blood Sugar (mmol)

* NOTE: Blood sugar range when fasting should be 4-7 mmol
Blood sugar range after meal should be 5-10 mmol
(does not apply if you are ≤ 18 years old or pregnant)

~ NOTA: El parametro de la azucar en la sangre (glucosa) cuando esta en ayunas debe ser 4-7 mmol
El parametro de azucar en la sangre (glucose) despues comer debe ser 5-10 mmol.
(esto no se aplica si usted es < 18 años de edad o si usted esta embarazada)

NOTES & THINGS TO REMEMBER / NOTAS & COSAS A RECORDAR



Lined area for notes and things to remember.

NOTES & THINGS TO REMEMBER / NOTAS & COSAS A RECORDAR



Lined area for notes and things to remember.

ABOUT THIS PASSPORT



The **"My Health Passport"** is a handy tool to help support you and other women in getting the health care you need. It will allow you to feel more in charge of your own care by keeping up to date information about your health. You will be able to take this passport with you wherever you go, and keep track of your visits and health information.

Please feel free to let us know how you like the **"My Health Passport"** by contacting Women's Health in Women's Hands at (416) 593-7655 Ext 232.

Thank you!

ACERCA DE ESTE PASAPORTE



"Mi Pasaporte de Salud" es un instrumento practico para ayudar a apoyarla y otras mujeres en la adquisicion de la asistencia medica que usted necesita. Este le permitira sentirse mas responsable de su cuidado manteniendo la informacion sobre su salud. Usted sera capaz de llevar este pasaporte a cualquier parte donde vaya y mantener sus visitas y su informacion de salud.

Por favor sientase libre de avisarnos como le gusta **"Mi Pasaporte de Salud"** contactando Women's Health in Women's Hands at (416) 593-7655 Ext 232.

Gracias!

Appendix D: Priority Group Data

Homeless/Underhoused Women

Number of women in the database identified as living with homelessness = 19

Category	Description
Age and Age categories (19 responses)	Mean = 40.94 (SD = 12.0) Range: 24-62 years Youth (18-29 years old): n=3, 15.8% Elders (65+ years old): n=1, 5.3%
Citizenship and Immigration status Country of Birth (18 responses) Immigration/Citizenship (19 responses) # years in Canada (13 responses)	Born in Canada: n=5, 27.8% Born outside Canada: n=13, 72.2% Non-status: n=2, 10.5% Refugee: n=3, 15.8% Visitor/Work/Student Visa: n=0 Permanent Resident: n=3, 15.8% Canadian Citizen: n=11, 57.9% Mean=14.5 years (SD=11.6) Range: 1.0-37.0 years Less than 10 years: n=7, 36.8% 11 or more years: n=6, 31.6%
Ethnicity (19 responses)	African: n=7, 36.8% Caribbean: n=0 Latin American: n=5, 26.3% South Asian: n=5, 26.3% Other: n=1, 5.3% Mixed Race/Ethnicity: n=1, 5.3%
Languages spoken (19 responses)	English only: n=5, 26.3% English plus other languages: n=11, 57.9% Other languages, no English: n=3, 15.8%
Intersecting identities identified in the study (19 responses)	Physical disability: n=8, 42.1% Lesbian/Bisexual Identity: n=3, 15.8% HIV Positive: n=0 Homelessness: n=19, 100%

Description of the participants continued

Category	Description
Highest level of education (19 responses)	No formal education: n=0 Less than high school: n=3, 15.8% High school or equivalent: n=2, 10.5% Some college or university: n=8, 42.1% Completed college or university: n=6, 31.6%
Primary Work status (19 responses)	FT paid employment: n=0 PT paid employment: n=9, 47.4% FT caregiver/homemaker: n=0 Short-term disability: n=0 Long-term disability: n=3, 15.8% Unemployed, seeking work: n=5, 26.3% Other: n=2, 10.5%
Income category – Annual income (19 responses) # additional family members supported on household income (14 responses)	0 - \$14,999: n=15, 78.9% \$15K - \$24,999: n=3, 15.8% \$25K - \$29,999: n=0 \$30K - \$39,999: n=1, 5.3% > \$40,000: n=0 0: n=1, 7.1% 1: n=9, 64.3% 2: n=1, 7.1% 3: n=2, 14.3% 4: n=0 5 or more: n=1, 7.1%
Geographic location of home (18 responses)	Toronto Urban core (M4, M5, M6): n=10, 55.6% Toronto Urban suburbs (M1-M3, M7-M9): n=4, 22.2% Outside of Toronto (non-M postal code): n=4, 22.2%

Service Experiences for Homeless/Underhoused Women

Table 2. Service Access Data

Category	Description
Frequency of Service Use - # times/year (19 responses)	Mean=19.2 visits per year (SD=24.9) Range: 2.0-104.0 0-4 visits: n=6, 31.6% 5-12 visits: n=5, 26.3% 13+ visits: n=8, 42.1%
Primary reason for seeking healthcare (15 responses)	Preventive health care: n=0 Emergency care: n=0 Pain/Injury: n=0 Chronic physical health condition: n=9, 60.0% Chronic mental health condition: n=4, 26.7% Sexual/Reproductive health: n=1, 6.7% Counselling: n=1, 6.7% Other: n=0 Variety of reasons: n=0
Primary site for seeking health care (15 responses)	Hospital/emergency rooms: n=1, 6.7% Private practice physician: n=9, 60.0% Community Health Care Centre: n=3, 20.0% Primary Social service setting: n=1, 6.7% Walk-in Clinic: n=0 Alternative/Complementary Care: n=1, 6.7% Other: n=0
Preferred language for receiving services (19 responses)	English: n=14, 73.7% English or other languages: n=2, 10.5% Languages other than English: n=3, 15.8% American Sign Language: n=0
Access to service/service provider speaking preferred language (18 responses)	Yes: n=14, 77.8% No: n=4, 22.2%

Table 3. People that help homeless/underhoused women access health care (19 responses)

Individuals/Groups	Number/% of participants
Informal Support Network	Friends: n=11, 57.9% Family: n=6, 31.6% Clergy/Community Leader: n=4, 21.1%
Social & Community Services	Social /Social Service Worker: n=9, 47.4% Counsellor: n=6, 31.6% Teacher: n=2, 10.5% Lawyer/Police/Parole Officer: n=7, 36.8%
Health professionals outside of primary care	Nurse or other health professional: n=8, 42.1% Allied professional e.g., chiropractor: n=1, 5.3%
Alternative/Complementary Service Provider	Herbalist/Homeopath/Naturopath: n=3, 15.8% Shiatsu/Acupuncturist: n=2, 10.5%
Other	n=4, 21.1%
Receiving no help to access health care	n=0

Table 4. Experienced barriers to accessing primary health care services for homeless/underhoused women (19 responses)

Barrier	Participants reporting experience
Availability or other Characteristics of Service Setting	Health Care service too far away: n=6, 31.6% Health Care service closed when I can use it: n=6, 31.6% No doctor available that is accepting patients: n=6, 31.6% Health Care service is not physically accessible: n=1, 5.3%
Finances/Insurance	No money to pay for travel to service: n=9, 47.4% No money to pay for additional charges at service: n=11, 57.9% No OHIP coverage: n=2, 10.5%
Staff at services	No one at service speaks my language: n=1, 5.3% Staff of my cultural background at service: n=4, 21.1% Receptionist/Intake is unhelpful or impolite: n=4, 21.1% Problematic length of process for intake: n=7, 36.8%
Life circumstances	Not enough time due to family commitments: n=4, 21.1% Not enough time due to responsibilities, e.g., job, school: n=4, 21.1% Inconsistent housing – cannot connect to health care: n=1, 5.3% No affordable housing – cannot connect to health care: n=3, 15.8%
Other barriers	n=9, 47.4%
No barriers to access	n=0

Table 5. Priorities and preferences for acceptable health care for homeless/underhoused women (19 responses)

Aspects of Comfort/Preference	participants endorsing relevance
Staff Issues:	
Service provider is a woman	n=17, 89.5%
Service provider is a man	n=5, 26.3%
Staff speaking my language	n=8, 42.1%
Staff of same cultural background as me	n=10, 52.6%
Staff of a variety of cultural backgrounds	n=8, 42.1%
Staff does not include people of my cultural background	n=2, 10.5%
Receptionist/Intake is helpful and polite	n=12, 63.2%
Respect of my gender, race, culture etc.	n=15, 78.9%
Accommodation for persons with disabilities	n=8, 42.1%
Pleasing physical environment, e.g., art, furniture, etc.	n=9, 47.4%
Reasonable length of process for intake	n=4, 21.1%
Other	n=2, 10.5%

Women Living with Physical Disability

Number of women in the database identified as living with physical disability = 48

Category	Description
Age and Age categories (48 responses)	Mean = 47.3 (SD = 14.7) Range: 22-81 years Youth (18-29 years old): n=5, 10.4% Elders (65+ years old): n=7, 14.6%
Citizenship and Immigration status	
Country of Birth (48 responses)	Born in Canada: n=4, 8.3% Born outside Canada: n=44, 91.7%
Immigration/Citizenship (46 responses)	Non-status: n=0 Refugee: n=2, 4.3% Visitor/Work/Student Visa: n=0 Permanent Resident: n=10, 21.7% Canadian Citizen: n=34, 73.9%
# years in Canada (40 responses)	Mean=18.4 years (SD=11.6) Range: 1.3-49 years Less than 10 years: n=14, 29.2% 11 or more years: n=26, 54.2%

Description of the participants continued

Category	Description
Ethnicity (48 responses)	<p>African: n=3, 6.3%</p> <p>Caribbean: n=10, 20.8%</p> <p>Latin American: n=4, 8.3%</p> <p>South Asian: n=24, 50.0%</p> <p>Other: n=5, 10.4%</p> <p>Mixed Race/Ethnicity: n=2, 4.2%</p>
Languages spoken (42 responses)	<p>English only: n=8, 19.0%</p> <p>English plus other languages: n=17, 40.5%</p> <p>Other languages, no English: n=16, 38.1%</p>
Intersecting identities identified in the study (48 responses)	<p>Physical disability: n=48, 100.0%</p> <p>Lesbian/Bisexual Identity: n=5, 10.4%</p> <p>HIV Positive: n=1, 2.1%</p> <p>Homelessness: n=8, 16.7%</p>
Highest level of education (44 responses)	<p>No formal education: n=2, 4.5%</p> <p>Less than high school: n=10, 22.7%</p> <p>High school or equivalent: n=7, 15.9%</p> <p>Some college or university: n=12, 27.3%</p> <p>Completed college or university: n=13, 29.5%</p>
Primary Work status (47 responses)	<p>FT paid employment: n=6, 12.8%</p> <p>PT paid employment: n=6, 12.8%</p> <p>FT caregiver/homemaker: n=9, 19.1%</p> <p>Short-term disability: n=0</p> <p>Long-term disability: n=8, 17.0%</p> <p>Unemployed, seeking work: n=11, 23.4%</p> <p>Other: n=7, 14.9%</p>
Income category – Annual income (41 responses)	<p>0 - \$14,999: n=29, 70.7%</p> <p>\$15K - \$24,999: n=5, 12.2%</p> <p>\$25K - \$29,999: n=4, 9.8%</p> <p>\$30K - \$39,999: n=2, 4.9%</p> <p>> \$40,000: n=1, 2.4%</p>
# additional family members supported on household income (32 responses)	<p>0: n=0</p> <p>1: n=17, 53.1%</p> <p>2: n=7, 21.9%</p> <p>3: n=4, 12.5%</p> <p>4: n=2, 6.3%</p> <p>5 or more: n=2, 6.3%</p>

Description of the participants continued

Category	Description
Geographic location of home (37 responses)	<p>Toronto Urban core (M4, M5, M6): n=12, 32.4%</p> <p>Toronto Urban suburbs (M1-M3, M7-M9): n=20, 54.1%</p> <p>Outside of Toronto (non-M postal code): n=5, 13.5%</p>

Service Experience

Table 2. Service Access Data for women with Physical Disability

Category	Description
Frequency of Service Use - # times/year (47 responses)	<p>Mean=11.1 visits per year (SD=13.9) Range: .00-52</p> <p>0-4 visits: n=16, 34.0% 5-12 visits: n=12, 25.5% 13+ visits: n=19, 40.4%</p>
Primary reason for seeking healthcare (18 responses)	<p>Preventive health care: n=1, 5.6% Emergency care: n=0 Pain/Injury: n=2, 11.1% Chronic physical health condition: n=11, 61.1% Chronic mental health condition: n=2, 11.1% Sexual/Reproductive health: n=1, 5.6% Counselling: n=1, 5.6% Other: n=3, 3.7% Variety of reasons: n=0</p>
Primary site for seeking health care (18 responses)	<p>Hospital/emergency rooms: n=0 Private practice physician: n=13, 72.2% Community Health Care Centre: n=3, 16.7% Primary Social service setting: n=0 Walk-in Clinic: n=0 Alternative/Complementary Care: n=1, 5.6% Other: n=1, 5.6%</p>
Preferred language for receiving services (32 responses)	<p>English: n=21, 65.6% English or other languages: n=3, 9.4% Languages other than English: n=7, 21.9% American Sign Language: n=1, 03.1%</p>
Access to service/service provider speaking preferred language (31 responses)	<p>Yes: n=25, 80.6% No: n=6, 19.4%</p>

Table 3. People that help women with physical disabilities access health care (33 responses)

Individuals/Groups	Number/% of participants
Informal Support Network	Friends: n=17, 51.5% Family: n=17, 51.5% Clergy/Community Leader: n=4, 12.1%
Social & Community Services	Social /Social Service Worker: n=10, 30.3% Counsellor: n=3, 9.1% Teacher: n=0 Lawyer/Police/Parole Officer: n=2, 6.1%
Health professionals outside of primary care	Nurse or other health professional: n=8, 24.2% Allied professional e.g., chiropractor: n=4, 12.1%
Alternative/Complementary Service Provider	Herbalist/Homeopath/Naturopath: n=5, 15.2% Shiatsu/Acupuncturist: n=2, 6.1%
Other	n=5, 15.2%
Receiving no help to access health care	n=3, 9.7%

Table 4. Experienced barriers to accessing primary health care services for women with physical disabilities (33 responses)

Barrier	Participants reporting experience
Availability or other Characteristics of Service Setting	Health Care service too far away: n=11, 33.3% Health Care service closed when I can use it: n=9, 27.3% No doctor available that is accepting patients: n=3, 9.1% Health Care service is not physically accessible: n=6, 18.2%
Finances/Insurance	No money to pay for travel to service: n=5, 15.5% No money to pay for additional charges at service: n=11, 33.3% No OHIP coverage: n=0
Staff at services	No one at service speaks my language: n=2, 6.1% Staff of my cultural background at service: n=4, 12.1% Receptionist/Intake is unhelpful or impolite: n=7, 21.2% Problematic length of process for intake: n=6, 18.2%
Life circumstances	Not enough time due to family commitments: n=3, 9.1% Not enough time due to responsibilities, e.g., job, school: n=9, 27.3% Inconsistent housing – cannot connect to health care: n=0 No affordable housing – cannot connect to health care: n=1, 3.0%
Other barriers	n=13, 39.4%
No barriers to access	n=3, 9.1%

Table 5. Priorities and preferences for acceptable health care for women living with physical disabilities (33 responses)

Aspects of Comfort/Preference	participants endorsing relevance
Staff Issues:	
Service provider is a woman	n=24, 72.7%
Service provider is a man	n=4, 12.1%
Staff speaking my language	n=16, 48.5%
Staff of same cultural background as me	n=13, 39.4%
Staff of a variety of cultural backgrounds	n=14, 42.4%
Staff does not include people of my cultural background	n=3, 9.1%
Receptionist/Intake is helpful and polite	n=19, 57.6%
Respect of my gender, race, culture etc.	n=24, 72.7%
Accommodation for persons with disabilities	n=16, 48.5%
Pleasing physical environment, e.g., art, furniture, etc.	n=14, 42.4%
Reasonable length of process for intake	n=7, 21.2%
Other	n=4, 12.1%

Women identifying as Lesbian or Bisexual

Number of women in the database identifying as lesbian or bisexual = 21

Category	Description
Age and Age categories (21 responses)	<p>Mean = 29.1 (SD = 7.3)</p> <p>Range: 18-45 years</p> <p>Youth (18-29 years old): n=11, 52.4%</p> <p>Elders (65+ years old): n=0</p>
<p>Citizenship and Immigration status</p> <p>Country of Birth (21 responses)</p> <p>Immigration/Citizenship responses) (19</p> <p># years in Canada (11 responses)</p>	<p>Born in Canada: n=9, 42.9%</p> <p>Born outside Canada: n=12, 57.1%</p> <p>Non-status: n=0</p> <p>Refugee: n=1, 5.3%</p> <p>Visitor/Work/Student Visa: n=0</p> <p>Permanent Resident: n=3, 15.8%</p> <p>Canadian Citizen: n=15, 78.9%</p> <p>Mean=11.9 years (SD=9.6)</p> <p>Range: 2.0-28.5 years</p> <p>Less than 10 years: n=7, 33.3%</p> <p>11 or more years: n=4, 19.0%</p>
Ethnicity (21 responses)	<p>African: n=2, 9.5%</p> <p>Caribbean: n=6, 28.6%</p> <p>Latin American: n=3, 14.3%</p> <p>South Asian: n=4, 19.0%</p> <p>Other: n=3, 14.3%</p> <p>Mixed Race/Ethnicity: n=3, 14.3%</p>
Languages spoken (21 responses)	<p>English only: n=6, 28.6%</p> <p>English plus other languages: n=14, 66.7%</p> <p>Other languages, no English: n=1, 4.8%</p>
Intersecting identities identified in the study (21 responses)	<p>Physical disability: n=5, 23.8%</p> <p>Lesbian/Bisexual Identity: n=21, 100%</p> <p>HIV Positive: n=2, 9.5%</p> <p>Homelessness: n=3, 14.3%</p>

Description of the participants continued

Category	Description
Highest level of education (21 responses)	No formal education: n=0 Less than high school: n=4, 19.0% High school or equivalent: n=0 Some college or university: n=4, 19.0% Completed college or university: n=13, 61.9%
Primary Work status (21 responses)	FT paid employment: n=5, 23.8% PT paid employment: n=7, 33.3% FT caregiver/homemaker: n=0 Short-term disability: n=0 Long-term disability: n=1, 4.8% Unemployed, seeking work: n=4, 19.0% Other: n=4, 19.0%
Income category – Annual income (21 responses)	0 - \$14,999: n=11, 52.4% \$15K - \$24,999: n=2, 9.5% \$25K - \$29,999: n=3, 14.3% \$30K - \$39,999: n=2, 9.5% > \$40,000: n=3, 14.3%
# additional family members supported on household income (19 responses)	0: n=0 1: n=13, 68.4% 2: n=4, 21.1% 3: n=2, 10.5% 4: n=0 5 or more: n=0
Geographic location of home (20 responses)	Toronto Urban core (M4, M5, M6): n=18, 90.0% Toronto Urban suburbs (M1-M3, M7-M9): n=2, 10.0% Outside of Toronto (non-M postal code): n=0

Service Experiences

Table 2. Service Access Data for lesbian and bisexual women

Category	Description
Frequency of Service Use - # times/year (19 responses)	Mean=7.2 visits per year (SD=5.0) Range: 1-20 0-4 visits: n=7, 36.8% 5-12 visits: n=10, 52.6% 13+ visits: n=2, 10.5%
Primary reason for seeking healthcare (16 responses)-	Preventive health care: n=2, 12.5% Emergency care: n=0 Pain/Injury: n=2, 12.5% Chronic physical health condition: n=7, 43.8% Chronic mental health condition: n=2, 12.5% Sexual/Reproductive health: n=1, 6.3% Counselling: n=0 Other: n=1, 6.3% Variety of reasons: n=0
Primary site for seeking health care (16 responses)	Hospital/emergency rooms: n=0% Private practice physician: n=9, 56.3% Community Health Care Centre: n=3, 18.8% Primary Social service setting: n=0 Walk-in Clinic: n=1, 6.3% Alternative/Complementary Care: n=3, 18.8% Other: n=0
Preferred language for receiving services (18 responses)	English: n=15, 83.3% English or other languages: n=0 Languages other than English: n=3, 16.7% American Sign Language: n=0
Access to service/service provider speaking preferred language (19 responses)	Yes: n=14, 73.7% No: n=14, 26.3%

Table 3. People that help lesbian and bisexual women access health care (20 responses)

Individuals/Groups	Number/% of participants
Informal Support Network	Friends: n=14, 70.0% Family: n=10, 50.0% Clergy/Community Leader: n=1, 5.0%
Social & Community Services	Social /Social Service Worker: n=3, 15.0% Counsellor: n=2, 10% Teacher: n=1, 5.0% Lawyer/Police/Parole Officer: n=1, 5.0%
Health professionals outside of primary care	Nurse or other health professional: n=7, 35.0% Allied professional e.g., chiropractor: n=6, 30.0%
Alternative/Complementary Service Provider	Herbalist/Homeopath/Naturopath: n=8, 40.0% Shiatsu/Acupuncturist: n=3, 15.0%
Other	n=3, 15.0%
Receiving no help to access health care	n=2, 10.0%

Table 4. Experienced barriers to accessing primary health care services for lesbian and bisexual women (20 responses)

Barrier	Participants reporting experience
Availability or other Characteristics of Service Setting	Health Care service too far away: n=5, 25.0% Health Care service closed when I can use it: n=6, 30.0% No doctor available that is accepting patients: n=4, 20.0% Health Care service is not physically accessible: n=1, 5.0%
Finances/Insurance	No money to pay for travel to service: n=6, 30.0% No money to pay for additional charges at service: n=10, 50.0% No OHIP coverage: n=1, 5.0%
Staff at services	No one at service speaks my language: n=0 Staff of my cultural background at service: n=7, 35.0% Receptionist/Intake is unhelpful or impolite: n=3, 15.0% Problematic length of process for intake: n=7, 35.0%
Life circumstances	Not enough time due to family commitments: n=1, 5.0% Not enough time due to responsibilities, e.g., job, school: n=9, 45.0% Inconsistent housing – cannot connect to health care: n=1, 5.0% No affordable housing – cannot connect to health care: n=2, 10.0%
Other barriers	n=10, 50.0%
No barriers to access	n=0

Table 5. Priorities and preferences for acceptable health care for lesbian and bisexual women (20 responses)

Aspects of Comfort/Preference	participants endorsing relevance
Staff Issues:	
Service provider is a woman	n=17, 85.0%
Service provider is a man	n=1, 5.0%
Staff speaking my language	n=12, 60.0%
Staff of same cultural background as me	n=10, 50.0%
Staff of a variety of cultural backgrounds	n=16, 80.0%
Staff does not include people of my cultural background	n=2, 10%
Receptionist/Intake is helpful and polite	n=17, 85.0%
Respect of my gender, race, culture etc.	n=20, 100%
Accommodation for persons with disabilities	n=10, 50.0%
Pleasing physical environment, e.g., art, furniture, etc.	n=12, 60.0%
Reasonable length of process for intake	n=9, 45.0%
Other	n=5, 25.0%

Women Identifying as HIV Positive

Number of women in the database identified as living with HIV/AIDS = 21

Category	Description
Age and Age categories (21 responses)	Mean = 36.5 (SD = 6.5) Range: 22-51 years Youth (18-29 years old): n=2, 9.5% Elders (65+ years old): n=1, 4.8%
Citizenship and Immigration status	
Country of Birth (21 responses)	Born in Canada: n=0, Born outside Canada: n=21, 100%
Immigration/Citizenship responses)	(18 Non-status: n=1, 5.6% Refugee: n=4, 22.2% Visitor/Work/Student Visa: n=1, 5.6% Permanent Resident: n=4, 22.2% Canadian Citizen: n=8, 44.4%
# years in Canada (20 responses)	Mean=11.9 years (SD=11.3) Range: .33-34 years Less than 10 years: n=11, 52.4% 11 or more years: n=9, 42.9%
Ethnicity (21 responses)	African: n=9, 42.9% Caribbean: n=6, 28.6% Latin American: n=2, 9.5% South Asian: n=3, 14.3% Other: n=1, 4.8% Mixed Race/Ethnicity: n=0
Languages spoken (21 responses)	English only: n=8, 38.1% English plus other languages: n=11, 52.4% Other languages, no English: n=2, 9.5%
Intersecting identities identified in the study (21 responses)	Physical disability: n=1, 4.8% Lesbian/Bisexual Identity: n=2, 9.5% HIV Positive: n=21, 100% Homelessness: n=0

Description of the participants continued

Category	Description
Highest level of education (21 responses)	<p>No formal education: n=0, 0%</p> <p>Less than high school: n=1, 4.8%</p> <p>High school or equivalent: n=7, 33.3%</p> <p>Some college or university: n=5, 23.8%</p> <p>Completed college or university: n=8, 38.1%</p>
Primary Work status (20 responses)	<p>FT paid employment: n=1, 5.0%</p> <p>PT paid employment: n=1, 5.0%</p> <p>FT caregiver/homemaker: n=1, 5.0%</p> <p>Short-term disability: n=2, 10.0%</p> <p>Long-term disability: n=9, 45.0%</p> <p>Unemployed, seeking work: n=3, 15.0%</p> <p>Other: n=3, 15.0%</p>
Income category – Annual income (19 responses)	<p>0 - \$14,999: n=8, 42.1%</p> <p>\$15K - \$24,999: n=9, 47.4%</p> <p>\$25K - \$29,999: n=1, 5.3%</p> <p>\$30K - \$39,999: n=1, 5.3%</p> <p>> \$40,000: n=0</p>
# additional family members supported on household income (18 responses)	<p>0: n=1, 5.6%</p> <p>1: n=5, 27.8%</p> <p>2: n=6, 33.3%</p> <p>3: n=2, 11.1%</p> <p>4: n=1, 5.6%</p> <p>5 or more: n=3, 16.7%</p>
Geographic location of home (18 responses)	<p>Toronto Urban core (M4, M5, M6): n=10, 55.6%</p> <p>Toronto Urban suburbs (M1-M3, M7-M9): n=6, 33.3%</p> <p>Outside of Toronto (non-M postal code): n=2, 11.1%</p>

Service Experiences

Table 2. Service Access Data for HIV Positive women

Category	Description
Frequency of Service Use - # times/year (21 responses)	Mean=5.4 visits per year (SD=3.2) Range: 1-12 0-4 visits: n=10, 47.6% 5-12 visits: n=8, 38.1% 13+ visits: n=3, 14.3%
Primary reason for seeking healthcare (12 responses)	Preventive health care: n=1, 8.3% Emergency care: n=0 Pain/Injury: n=0 Chronic physical health condition: n=10, 83.3% Chronic mental health condition: n=0 Sexual/Reproductive health: n=0 Counselling: n=0 Other: n=0 Variety of reasons: n=1, 8.3%
Primary site for seeking health care (12 responses)	Hospital/emergency rooms: n=0 Private practice physician: n=9, 75.0% Community Health Care Centre: n=0 Primary Social service setting: n=0 Walk-in Clinic: n=0 Alternative/Complementary Care: n=2, 16.7% Other: n=1, 8.3%
Preferred language for receiving services (20 responses)	English: n=18, 90.0% English or other languages: n=0 Languages other than English: n=2, 10.0% American Sign Language: n=0
Access to service/service provider speaking preferred language (18 responses)	Yes: n=13, 72.2% No: n=5, 27.8%

Table 3. People that help HIV positive women access health care (21 responses)

Individuals/Groups	Number/% of participants
Informal Support Network	Friends: n=7, 33.3% Family: n=7, 33.3% Clergy/Community Leader: n=5, 23.8%
Social & Community Services	Social /Social Service Worker: n=5, 23.8% Counsellor: n=3, 14.3% Teacher: n=0 Lawyer/Police/Parole Officer: n=0
Health professionals outside of primary care	Nurse or other health professional: n=5, 23.8% Allied professional e.g., chiropractor: n=1, 4.8%
Alternative/Complementary Service Provider	Herbalist/Homeopath/Naturopath: n=1, 4.8% Shiatsu/Acupuncturist: n=2, 9.5%
Other	n=2, 19.5%
Receiving no help to access health care	n=3, 14.3%

Table 4. Experienced barriers to accessing primary health care services for HIV positive women (21 responses)

Barrier	Participants reporting experience
Availability or other Characteristics of Service Setting	Health Care service too far away: n=4, 19.0% Health Care service closed when I can use it: n=5, 23.8% No doctor available that is accepting patients: n=1, 4.8% Health Care service is not physically accessible: n=2, 9.5%
Finances/Insurance	No money to pay for travel to service: n=5, 23.8% No money to pay for additional charges at service: n=8, 38.1% No OHIP coverage: n=2, 9.5%
Staff at services	No one at service speaks my language: n=0, 10% Staff of my cultural background at service: n=1, 4.8% Receptionist/Intake is unhelpful or impolite: n=0 Problematic length of process for intake: n=1, 4.8%
Life circumstances	Not enough time due to family commitments: n=3, 14.3% Not enough time due to responsibilities, e.g., job, school: n=3, 14.3% Inconsistent housing – cannot connect to health care: n=0 No affordable housing – cannot connect to health care: n=0
Other barriers	n=1, 4.8%
No barriers to access	n=7, 33.3%

Table 5. Priorities and preferences for acceptable health care for HIV positive women (13 responses)

Aspects of Comfort/Preference	participants endorsing relevance
Staff Issues:	
Service provider is a woman	n=7, 53.8%
Service provider is a man	n=0
Staff speaking my language	n=3, 23.1%
Staff of same cultural background as me	n=3, 23.1%
Staff of a variety of cultural backgrounds	n=5, 38.5%
Staff does not include people of my cultural background	n=1, 7.7%
Receptionist/Intake is helpful and polite	n=9, 69.2%
Respect of my gender, race, culture etc.	n=9, 69.2%
Accommodation for persons with disabilities	n=3, 23.1%
Pleasing physical environment, e.g., art, furniture, etc.	n=4, 30.8%
Reasonable length of process for intake	n=4, 30.8%
Other	n=0

