LITERATURE REVIEW

Count Us In!
Inclusion and Homeless Women in Downtown East Toronto

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I. Background

Count Us In! is an exciting partnership project, funded by the Wellesley Institute, breaking new ground in research methodology and practice among marginalized populations. This Literature Review is a key component of the project.

Count Us In! developed a unique kind of participatory research called Inclusion Research. The purpose of Inclusion Research is to investigate how best to promote the health of marginalized groups through research and action. It asks: What are the systemic barriers that impede marginalized women from connecting to the services they need? What changes need to be made for health and social policies, programs and services to be more inclusive? And it models a way of working that includes marginalized groups in every part of the process. Women who are homeless or marginally housed – the Inclusion Researchers – were involved in searching the literature, designing the study, collecting and analyzing the information, and disseminating the results.

Count Us In! investigated, through focus groups, how health and social services in Toronto, and in the province of Ontario, can be made more inclusive and better promote the health and well-being of marginalized groups. Inclusion Researchers facilitated 11 focus groups with 58 women who are homeless or underhoused, to collect feedback on the health and social services that women use as well as the participants' ideas about how policies and services could be improved. *Count Us In!* aims to influence how governments and service providers plan, deliver and fund services for populations who are marginalized.

As a creative partnership, *Count Us In!* combined:

- the framework of Inclusion and the Determinants of Health, developed by Ontario Prevention Clearinghouse;
- the focus of listening to women through focus groups, carried out by Ontario Women's Health Network;
- a methodology of training people who are homeless as researchers, pioneered by Asset Mapping Research Project; and
- the field experience of Toronto Public Health (TPH) with homeless populations in downtown east Toronto.

The project was coordinated by a Working Group, comprised of representatives from the partner agencies; experts in community-based research, inclusion, and women's health in urban centers; and representatives from the Inclusion Researchers. The project applied inclusion principles to the terms of reference of the Working Group to ensure that the group had equitable membership, in terms of gender, race, class and age, over the life of the project. The project also recruited some of its working group members with current lived experiences of homelessness. Other factors and skill sets among working group members included:

- Research experience with communities living in Downtown East Toronto
- Effective networking and sharing of information
- Effective policy development skills
- Understanding and knowledge of systemic barriers, and experience developing anti-discrimination tools including policies, programs and trainings

- Experience with social change and social justice
- Understanding and support of feminist principles
- Experience working collaboratively with marginalized communities particularly around training and engagement strategies
- Board and committee experience.

The Literature Review informed the project throughout, assisting with choices in developing the line of questioning used in the research, the analytic themes that emerged from the data, and the recommendations for action. An Inclusion Researcher was directly involved in the Literature Review. The author, Inclusion Researcher, and editor of the Literature Review were members of the Working Group, available to the group to comment on issues discovered in the literature. This became an important aspect of our way of working.

The Literature Review explored key issues identified by the project, including poverty and homelessness, factors contributing to homelessness, the mortality rate of homeless women, diversity among homeless women, shelter and housing issues, health and inequality, health among homeless women, harm reduction, barriers to health for homeless women, and various governmental policies regarding homelessness, health, and housing. An Environmental Scan located the demographics of the target area in downtown east in relation to other communities in the City of Toronto. The Literature Review also investigated the very new literature on the relationship between inclusion and the determinants of health, starting with working definitions.

a. Inclusion and the Determinants of Health

Count Us In! used a framework, developed by the Ontario Prevention Clearinghouse, to explore inclusion issues among marginalized people in their use of programs and services related to the determinants of health. The framework was designed to explore the "feeling and reality of belonging" created by agencies and organizations delivering programs related to homeless and underhoused women.

The project used the following definition of inclusion:

> *"A society where everyone belongs creates both the feeling and the reality of belonging and helps each of us reach our full potential.*
>
> *The feeling of belonging comes through caring, cooperation, and trust. We build the feeling of belonging together.*
>
> *The reality of belonging comes through equity and fairness, social and economic justice, and cultural as well as spiritual respect. We build the reality of belonging together by engaging our society to ensure it."*
>
> *(Michael Fay, Count Me In!, Ontario Prevention Clearinghouse, 2005)*

The definition speaks to the importance of social, economic, cultural, racial and spiritual aspects of inclusion that are reflected among urban, rural, First Nations, and diverse populations in Canada. The definition also values both the feeling and the reality of belonging, and this became a key element in discovering how marginalized women seek

and use programs and services. The definition also indicates that the feeling and reality of belonging have an impact on health and well-being, leading to people reach their full potential.

Count Us In! used this definition to develop a line of questioning for focus groups of homeless and under-housed women to explore "feeling and reality of belonging" created by programs and services in downtown east Toronto, regarding services related to the determinants of health.

The determinants of health is a contemporary concept used to describe disparities in health between socio-economic groups, which experience varying degrees of health and well-being. It became apparent that one's status within society affected health positively or negatively, dependent on income, education and the means to survive. In Canada, the 1986 World Health Organization document on the basic health needs for nations was subsequently adapted by the Ottawa Charter for Health Promotion in a document that identified structural aspects of society as prerequisites for health, determined by the organization and distribution of economic and social resources. These were:

- Peace
- Shelter
- Education
- Food
- Income
- A stable ecosystem
- Sustainable resources
- Social justice
- Equity

In 1996 in a volume titled Health and Social Organization: Towards a Health Policy for the 21st Century (Blaine Brunner and Wilkinson, 1996), in the chapter called…. "The Social Determinants of Health: The Sociobiological Translation" (Tarlov. 1996), the environmental determinants of health were described as:

> "Inequalities in the social development of housing, education, social acceptance, employment and income that were translated into disease related processes." (Raphael. 2004)

Although this thinking has been criticized as having no basis in policy -- for example, there are no Ministries of Social or Physical Environments (Raphael. 2004) -- Health Canada has outlined and accepted a number of important factors as determinants of health:

- Income and social status
- Social support networks
- Education
- Employment and working conditions
- Physical and social environments
- Biology and genetic endowment
- Personal health practices and coping skills
- Healthy child development

- Healthy services
- Gender and culture (Health Canada. 1998).

The determinants of health identified for the purpose of this research are those that affect marginalized women in an urban environment such as downtown east Toronto. These factors are low-income status, gender, education, culture and coping skills, social supports and access to health services. The project sought to investigate whether the programs and services involved with these key determinants of health were inclusive, creating the feeling and reality of belonging among marginalized women who use them. We believe the connection between inclusion and the determinants of health, outlined in *Count Me In!* in 2005, is a new and interesting line of enquiry that informs and influences the methodology and analysis of research findings.

It is significant to note that at present there does not exist a body of literature on the relationship between marginalized women, inclusion, and the determinants of health. This project is, to the best of our knowledge, the first attempt to investigate that relationship, and the method chosen to do this was community-based research. All of the literature encountered in this review was derived from traditional health and social approaches to research for marginalized women. All aspects of the work taking place in this *"Count Us In!"* research represents the first of its kind, in building literature around the determinants of health and marginalized communities, influenced by the population who participated fully in the research who were also the respondents in this project.

II. Research Gaps

Although this project will add to the small body of literature relating to marginalized women, inclusion, and the determinants of health, it must be noted before beginning a review of existing literature, that there are serious gaps in the literature on health for homeless and marginalized people in urban areas. Hwang et al, 2005, discussed these gaps In the Canadian Journal of Public Health and, at present, there exists no research on homeless women in each of the following areas:

a. *Biomedical and medical care strategies*: Gaps in this area include research on:

   i. Interventions for homeless youth of families with children to address health problems other than mental illness or substance abuse.
   ii. The effectiveness of various models of primary care delivery for the homeless.
   iii. A focus on harm reduction programs that seek to minimize adverse health impacts among homeless substance users rather than focusing exclusively on abstinence e.g. safe injection sites for drug users and shelter –based controlled drinking programs in which residents are provided with alcohol on a metered schedule.

b. *Educational and behavioural strategies*: in this category, research gaps were identified as follows:

   i. Evaluation research was needed on health education programs for the homeless.

ii. Reports on behavioural and educational research interventions were missing.
iii. In depth descriptions of development and implementation processes are needed: such information could provide a valuable resource for service providers seeking to begin similar initiatives.
iv. A conceptual research on educational and behavioural interventions for homeless people.
v. Studies on how to make these interventions more accessible and appealing for the homeless population, with rigorous studies to evaluate the outcomes of such programs to benefit the motivation of individuals toward change through altered knowledge, attitudes, belief and values, enabling individuals to take action through skill building and availability and accessibility to supportive resources and rewards to reinforce positive action.

c. *Environmental strategies* have gaps in research as follows:

Opportunities for research to organize conceptual work and frame efforts through in depth evaluations to ensure that lessons learned and projects in the community for homeless people have measurable outcomes and translate information into a form of useful planning.

d. *Policy and Legislative strategies* need research in the following areas:

i. Work to examine the impact of various health and social policies on the lives of homeless people, particularly in the vital areas of welfare policy as it affects adults and families with children, policies that impact young women and practices in the child welfare system that may contribute to youth homelessness.

ii. Comparing policies in different jurisdictions and their impact on homelessness can provide important insights.

iii. Government frameworks on homelessness call for efforts to ensure accountability in reaching specific targets and goals, but little work takes place on policy evaluation, also information is needed to guide future policy making.

e. *Additional areas* identified as gaps in research, which will be mentioned further in this review, are:

i. Breast and Cervical cancer in homeless women.

ii. Reasons for the high death rate among homeless women inclusive of suicide rates.

ii. Emergency services in hospitals: use by homeless people.

The partners in *Count Us In!* will continue to advocate for action to fill these gaps in the literature.

III. Location of the Study Area

It is useful to identify the geographical area of the project before continuing with the review of the literature to understand some of the dynamics the Working Group anticipated in selecting the location of the project. The project was located in downtown east Toronto – Bloor Street on the North, Don Valley Parkway on the East, University Avenue on the West, and Lakeshore Boulevard on the South. This area is the location for several shelters and services for homeless people. Women who are the focus of our research make up a significant group in this population. Locations covered in the designated area of downtown east Toronto are:

- St. James Town
- Cabbagetown
- Church/Wellesley
- Upper Jarvis
- Regent Park
- Moss Park
- St. Lawrence

Within this geographic area, social and economic exclusion is a reality for the homeless population of women, the underhoused and those at risk of being homeless, who have not been counted, but are present on the streets, in the hostels, drop-ins and social housing located in downtown east Toronto. Any discussion about inclusion cannot take place without first examining the impact of social exclusion on women, children, families and communities who are most affected by exclusion. In a keynote address given by Wanda Thomas Bernard titled "Beyond Inclusion: Diversity in Women's Health Research" at a conference hosted in 2001 by the Maritime Centre for Excellence for Women's Health she stated…

> "The notion of social and economic exclusion stems from a critical perspective on definitions of poverty and the move from an individual to structural analysis."

She further noted that the Social and Economic Inclusion Project in that region played a crucial role in changing the discourse and advancing the agenda from poverty to exclusions and the goal of inclusion. The meaning of "social exclusion" has been very aptly described in the following anecdote from a report titled: "Social and Economic Inclusion: Will Our Strategies Take Us There?"

> "The real analytical utility of the concept of social exclusion is that it draws attention to the processes whereby people become deprived and the multidimensionality of the deprivation they face. The concept of social and economic exclusion moves us beyond the class biased model of poverty to the structural realities that underpin the real exclusion that marginalized people face." (DasGupta, Monica. 2001)

Homeless people have been socially and economically excluded within a structure that has deprived them of multiple services. It is the health and welfare of the women within this group in downtown east Toronto that this literature review addresses, in preparation

for research on the effects of this social and economic exclusion on their lives. There are many pathways to homelessness, and these are often a complex interaction of facts at the individual level. This can be childhood experiences, low educational attainment, lack of job skills, family breakdown, mental illness and substance abuse. This also includes high housing costs, labour market circumstances, decreased public benefits, racism and discrimination.

There is a tendency for Social Scientists to look at social factors such as exclusion, marginalization and economic forces, whereas Health Researchers focus on risk factors. For the purposes of this research, where the social determinants of health are being used as benchmarks, there exists awareness that social factors impact health considerably. As such this work will represent a multi-disciplinary approach between the two disciplines. The common denominator between social and health factors being that of poverty.

IV. Homelessness "A Reality in Toronto"

The most recent Toronto Report Card on Homelessness (2003) comprised of city data from the Mayor's office has reported:

> "In 2002, the year when the latest statistics were formulated, 31,985 people stayed in Toronto's emergency shelters, of this amount, 4,779 were children."

It is important to note, that a significant proportion of homeless people do not access hostels and shelters. Single people remain the largest group of people using emergency shelters according to the available numbers. It is interesting to note that on Thursday, September 15, 2005, the Toronto Disaster Relief Committee, a homeless advocacy group managed to get the Community Services Committee in the City of Toronto to agree that a count of homeless people in Toronto should take place through interviews in parks, shelters and streets, one night in the spring of 2006, to estimate the approximate numbers. The survey was conducted, but results were not available at the time of publication.

Although homeless counts have taken place in Vancouver, Edmonton, New York and Chicago, there are objections to doing so in Toronto. The main objection is that such a survey is a threat to the privacy of the people being surveyed. Michael Shapcott from the Disaster Relief Committee points out that there is also a danger in undercounting, as this will be a threat to funding for shelters, food programs and homeless services, if a scientific reliable method is not introduced to count the homeless in Toronto. Shapcott felt that approximately 4,000 to 5,000 people avoid the shelter system in Toronto each night (Gonad, Gabe, City Hall Bureau. 2005).

Far more significant, however, has been the increase in one-parent families using shelters, which increased by 51% between 1990 and 2002. After a slight decline in 2000-2001, the numbers again rose by 200 single parent families using shelters in 2002. Despite decreases in stays in municipal shelters for families parented by fathers, there has been an increase in stays over an average of 1.5 months for mother-led, one-parent families. Since 1990 there have been 6.500 households whose accumulated days of stay in shelters was more than one year (Toronto Community and Neighbourhood Services. 2003).

It is significant that the episodic use of homeless shelters by families and individuals rose by 24% between 1990-2002. However, the majority of episodic users were single persons, men being the most prevalent repeat users. 1,334 households used the shelter system at least once every year between 1998 and 2002; this factor was due to rampant evictions for families who cannot afford to pay rent.

Despite living in an economically viable city that has a successful business district, with a strong social service sector, homelessness is a stark reality in Toronto. One only has to stroll through the streets of the city, parks and alleyways to see people living on our streets, in which panhandling has noticeably increased. With no age restrictions, people are homeless, many deciding to permanently live outside without collecting welfare cheques or other benefits available to them. The weather makes little difference to homeless people who do not wish to live in shelters for reasons of safety, or the desire to be free from rules and regulations. Toronto's Disaster Relief Committee (1998) stated that homelessness in this city increased by 40% between 1988 and 1999.

V. Poverty and Homelessness

A report from The National Council on Welfare Rates (2003) determined that 552,300 people, representing one quarter of Toronto's population live in poverty. In the years 2000-2002 only 3% of new housing construction was for rental units (873 units) compared to 97% for homeownership. Rents rose by 31% from1997 to 2002; only 20% of private rental apartments renting for less than $800.00. Twenty-five percent of tenants in Toronto have annual incomes below $20,000; 250,000 households pay more than 30% of their income in rent, 20% pay more than 50%. The social housing waiting list now stands at 71,000 households. More rental units have opened up since the increase in house purchases has taken place, however rental prices have not dropped significantly to affect homeless people.

In 2003, the "Toronto Report Card on Housing and Homelessness**,**" prepared by the City of Toronto every 2 years, gave an extensive and detailed report on homelessness. The report stated that, over the past 20 years, senior levels of government have not responded adequately to the changing social and economic needs of the population in general. Toronto has traditionally attracted people from throughout Canada who seek to find a means to survive, in addition to the people who live here. This has not changed. What has taken place is that critical programs have had funding cuts over the time period. Since 1993, the Federal Government has not funded social housing, neither has the province of Ontario since 1995. Social assistance benefits were cut in the province by 21.6% in 1995, and in 1998 rent controls were eliminated.

These actions left the 'working poor' which comprises those on minimum wage, newcomers to the city and people not able to be fully employed, faced with a struggle to survive on less income in a housing market where rents increased. Added to this was the decision to reduce psychiatric beds without providing additional supportive housing, community supports, or an income to access the majority of rental units. Homelessness therefore increased in response to this environment during the past decade, which has continued into the new millennium.

It seems fair to report that some levels of government are now paying attention to the plight of the homeless. Programs and services have been initiated in the past 5 years through local non-profits to fill existing gaps in the system that have adversely affected people living on the margins of society, such as single parents, immigrants and refugees. Recent programs such as the Supporting Community Partnership Initiative and Off the Streets and Into Shelters have Municipal, Provincial, and Federal support. A performance measurement has been put in place, monitored by the City's Shelter Housing and Support Division, working with funded community agencies through reports and evaluations, to improve the understanding of the impact of programs and services on the lives of the homeless and those "at risk of being homeless."

VI. Factors Contributing to Homelessness

The most significant social factors influencing the relationship to the home and homelessness for women are their marital backgrounds and housing status during marriage, education and training, current and past social relationships, psychological state, knowledge of the housing system and the advice and support from institutional agencies (Watson and Austerberry. 1986). In Canada the women over-represented at the extreme end of the continuum are of Aboriginal descent, members of visible minority groups and persons with disabilities. Young women between the ages of 12-24 make up one third to one half of youth who are homeless. Other over-represented groups include children from the child welfare system, lesbian and gay youth, aboriginal youth and recent refugees and immigrants in the City of Toronto (Canadian Housing and Renewal Association. 2002).

Single mothers comprise a large group of homeless women. This group is five times more likely to have incomes that fall below the Low Income Cut Offs (LICOs), a system widely used to measure the amounts of money spent on food, shelter and clothing in Canada. If the amount is disproportionate to what is considered acceptable, people are considered to be living in poverty. Statistics on Aboriginal single mothers were particularly alarming, as 73% of them live below the LICOs (Statistics Canada. 2000).

In the 2000 Statistics Canada LICO report for Ontario, it was further reported that in this province more women fell below the LICOs than men. This ratio was 17% vs. 15%. Single women were at their highest level ever in shelter use in that year – when 5,683 used shelters in Toronto. It is important to note, however, that shelter beds do not adequately serve women with substance use and /or mental health issues. Women in general can be counted among the numbers of "hidden homeless" in the city. Many homeless women are couch surfers with friends, staying with relatives, and moving around in order not to enter shelters and hostels (Lenon, S. 2000).

VII. Mortality Rate for Homeless Women

Homeless women are at high risk for illness, and homeless people have a higher death rate than the general population. Mortality rates among homeless men have been examined to a great extent; however, among homeless women this is not the case. A study done by Angela M. Cheung and Stephen W. Hwang, "Risk of Death Among Homeless Women" (2004) noted that in Toronto, mortality rates were 515 per 100,000 person years, among homeless women 18-44 years.

In an article entitled, “Dying in the Shadows: The Challenge of Providing Health Care for Homeless People” (2004), James J. O’Connell stated that data compiled in Toronto by Hwang and Cheung showed that there is a 10-fold disparity in mortality rates between Toronto’s homeless and housed women, and this is 3 to 5 times higher than those among the general public. This gives rise to a public health crisis that can no longer be ignored. He further stated:

> “Homelessness is a prism that refracts the failures of society’s key sectors, especially housing, welfare, education, healthcare and corrections. This complex social phenomenon thwarts simple definitions and resists easy solutions. The often-romanticized hobos and skid-row denizens of past lore have been joined by families with children, runaway and “throwaway” adolescents, struggling minimum wage workers and fragile elderly people.”

VIII. Diversity in Homeless Women

> “Homeless women comprise a large and diverse population, encompassing many sub-groups, including teenagers, lone parents, single women, abused women, aboriginal women, immigrant and refugee women and senior women. Among the population of homeless women are also those with severe and persistent mental illness as well as those with chronic and infectious diseases. Homeless women, however, do share a number of common features of which poverty and social isolation are central.” (“Health Status of Homeless Women. An Inventory of Issues,” Consulting Matrix, Inc., September. 2002)

Women who are single generally account for one quarter of the homeless population in urban centers (Goering, Tolomiczenko, Wayslenki, Boydell and Halman. 1997). Toronto is no exception, as single women account for one in four homeless persons in this city.

Homelessness is usually triggered by a sudden trauma or accumulation of disadvantages. Bearing in mind women’s declining income and the lack of affordable housing, traumas can include domestic violence, sexual assault, job loss, bankruptcy, eviction, illness, accident or disease, the death of a partner or caregiver, discharge from a mental hospital or prison and being “thrown out” by a partner or parent. In addition disadvantages that homeless women share include lack of education, illiteracy, chronic illness or disability, discrimination, a history of sexual or emotional abuse, a history in the child welfare, mental health or criminal justice systems and being born into a family with addictions or dysfunctions (Raising the Roof. 2001).

There are different descriptions for homelessness, and these fit with the circumstances surrounding the homeless person’s situation. Women who live outdoors and in places not intended for habitation, also those living in shelters are viewed as “absolutely homeless.” Women staying with friends or family temporarily are described as “couch surfers” or “doubling up.” Those “at risk” of being homeless are people who spend too much of their income on rent, or those living in substandard and/or unsafe housing conditions (Frankish, James, Hwang, Stephen, Quantz, Darryl. 2005).

It is appropriate to note here that homelessness is increasing in Toronto, a society where adequate funds are available to provide implementation of the social determinants of health to ensure good living standards.

a. Domestic Violence

Domestic violence is one of the reasons for homelessness among women. In 2004, the Canadian Centre for Justice Statistics stated the most frequent form of victimization was violence at the hands of a spouse or partner, reported at 62%, with women being 85% of those victims. These facts have also contributed to the rate of poverty among women.

In immigrant and refugee families in Canada, this violence is compounded by additional vulnerabilities, such as a lack of proficiency in the official language, conditions of poverty, unemployment and underemployment and frequent social isolation which newcomers face, often referred to as the "sponsorship effect." This impacts psychological and physical health of women negatively ("Domestic Violence Key to Understanding Homelessness," Smith, Ekua. 2004).

It has been reported that as many as 80% of homeless mothers have had experiences with physical abuse and that violence has been a major factor in their becoming homeless. Among homeless women who are substance abusers, up to 97% are estimated to be victims of domestic violence. It has been found that addicted women suffer more frequent and pervasive sexual and emotional abuse, including incest and rape. In treating addicted homeless women, clinicians must understand that they are likely to be treating victims of multiple traumas (Demin et. al. 2002).

b. Immigrant and Refugee Women

The rate of family poverty among recent immigrants in the city is about 45%, compared to an overall city poverty rate of 19%, and a national rate of 14.7%. About 30% of the immigrant family population and one-third of the visible minority family population now live in these situations. Women of color are more likely to find themselves isolated in communities of poor and ethno-cultural people (Khosla, P. 2003).

United Way of Greater Toronto and Canadian Council on Social Development's "Poverty by Postal Code" (2004), showed an increase in the number of "higher poverty neighborhoods" over the past 20 years, with North York and Scarborough showing the greatest increases, going from 7-36 high poverty, meaning a poverty rate of 40% or greater. This document further states that 1/3 of Canada's immigrants who arrived within the last 10 years live in the Greater Toronto Area.

With little wage security, cut backs in welfare and other income security programs, those who are not homeless are at great risk of homelessness. In these groups, immigrant and refugee women experience the highest rates of poverty. This can be evidenced in poverty among ethno-racial single women in Toronto with a range from 75% for those of Latin – American origin, to 59% among South Asian women, and 48% among those of European Origin (Khosla. 2003).

c. Homeless Same Sex Couples

In research undertaken by the author, homeless same sex female couples did not feel they suffered more than others did where discrimination in healthcare took place. However, this differed in shelters where they were treated differently, and could not share sleeping space with each other, except in one location, which was not very comfortable for women. They were discriminated against in the delivery of healthcare also, but many locations within the city are user friendly for the women, one being the Sherbourne Health Centre (Miles B. 2003)

In 2003, a disturbing report came from two native women who were lesbians, during a focus group on the topic of Same Sex Couples and Health. The women lost their housing because of disputes with the landlord, were unable to find safe housing, and were living on the streets, not being able to find accommodation in homeless shelters with each other. One was not well in the winter. She was given a bed in a shelter, but her partner was not allowed to stay in the same shelter, as same sex couples are not housed together in most women's shelters. They heard of one shelter that would allow this, and got two beds there, but felt discriminated against by the shelter staff, who called them abusive names, and made fun of their sexual preference. They eventually left and went back to the living on the streets, until the partner who was ill recovered sufficiently to once more live outside.

Some 3 months later the women reported they had found a sympathetic landlord who offered them housing, where they had lived comfortably for the past 6 weeks, and hoped they would never be on the streets again, as this was not a comforting experience for both women (Miles, B. 2003).

d. Homeless Transgendered Persons/Women

Transgendered persons who are in the process of becoming women found it difficult to secure housing for themselves. Their creative solutions such as shared accommodation are a credit to the group, but permanent housing would give a great deal of stability, although this eluded them in most instances. Great personal strides can be made if one has a place to return to each day, that is solely ones own. This also removes the stigma of displacement within society. In previous research, the author of the literature review has interviewed transgendered women, as well as listened to them in focus groups on topics regarding their gender differences.

One thing that was clearly voiced by transgendered people was that the medical profession needs better training in, and more understanding of, transgender health and social concerns. In a focus group of 14 people who identified themselves as transgender, only three of the people present had family physicians. In requesting them to describe themselves, some said they were gender benders, cross-dressers, drag queens transvestites and transsexuals. We agreed their genders were not clear to themselves, as the majority felt uncomfortable as men, and therefore began the process through hormones, surgery, and changes in appearances to become women. There was great distrust among them about the healthcare system, and this was based solely on experiences throughout their lives as transgendered people. They also reported that they were in many instances treated as if they were mentally ill.

Public education is lacking on the physical and emotional challenges faced by transgender communities. They experience a lack of understanding and stigma that begins within their own families and into their communities, impacting on all aspects of their lives. It leads to feelings of alienation and isolation. A strong and active sub-culture of transgendered people exists in Toronto; this speaks to the lack of acceptance and understanding that has taken place due to discrimination as a result of confused gender identity.

Based on the information from some focus group attendees, the sex trade provides an outlet for survival, as jobs in the mainstream sectors are elusive to them. Though this is controversial for some transgendered people, others feel that because of the lack of support systems particularly with regard to hormone treatment, they have no alternative. The sex trade can be very dangerous with regard to physical health, with respect to STDs, HIV positive contacts, being beaten or sexually abused, and emotionally being treated as an outcast in society. Seeing this as the only viable way to make a living, presents a bleak picture for transgendered individuals.

Members of the group noted that, if they were ill, they looked after each other. Several of those present were using illegal drugs, and this created difficulty with hormone treatments. When they became ill, the hospitals were not welcoming, and detox centres kept them only for a day or two.

On a more hopeful note, this group of transgendered people seemed fully aware of their place in the world, albeit very discouraging. They were working to change the situation for themselves, no matter how long it took, also regardless of methods to obtain funds to bring this about. Overall, their situation is a sad reflection on our society, more so the healthcare system should be the one place where solutions are provided for people who undergo sexual trauma in their lives. There is great need to create change through education and ultimately understanding (Miles B. 2003)

IX. Shelter Use

Heterosexual women who enter shelters tend to remain there longer than men. Women stay an average of 7 days, whereas men stay 2 to 3 days. This fact is in part due to the support given to abused women, in particular those with children, who need longer periods to recover from traumatic experiences. Assistance is offered with food, accommodation, transportation, clothing, legal aid, social assistance, education, job training, community resources and referrals. Other reasons for women's longer term use of the shelter system is that, compared to their male counterparts, they often present with more complex mental and physical health needs, have children with them, and require more extensive treatment and intervention (City of Toronto. 1999).

The Feminization of Poverty written by D. Belle in 1990 painted a picture that is still prevalent today. The reasons for increase in women's homelessness are correlated. Women who are lone parents are now the highest users of the shelter system. Women are significant among the group in low paying jobs; this in turn is accompanied with a low status in society.

X. Housing in Toronto Today

Housing in the Canadian context no longer reflects shelter from the environment. In a recent article titled "Housing and Social Inclusion" housing has been described as:

> "A gateway through which we connect to our immediate environment and society at large, that now has connotations of social status, belonging to community, a centre to gather with friends and family and a direct bearing on the extent to which we experience social inclusion or exclusion." (Chisholm, Sharon. 2005.)

Conversely, low-income housing can either improve or decrease women's capacity to control their own lives, depending on its location, management and standard (Neal, Rusty. 2004)

In the report, "Decade of Decline" by the United Way for Greater Toronto and the Canadian Council on Social Development (2002), the 1990s was described as:

> "…a turbulent decade in Toronto with economic, social and political changes that had direct impacts on the welfare of the citizens."

The decade started with a recession that cut deep into the economy and turned out to be much worse than anyone predicted. It was also marked by significant changes at the provincial and municipal levels where the heavy housing costs were downloaded to cash strapped city. In order to pay for housing and other heavy infrastructural costs, such as transportation and childcare that were also downloaded, the budget of the City of Toronto was strained. As a result, the social safety net changed in Toronto, with affordable housing being one of the major casualties.

At the same time, the level of household income decreased considerably, rates of poverty rose, and the income gap between wealthy and well off households and those with lower incomes widened. Middle-income families in Toronto went from being better off at the start of the decade, to worse off by the end of it. Single parents were the real sufferers in this decline, with women and children, refugees and newcomers being the most affected.

Lone parent families in Toronto had their income decline in the 1990's by 18% from $29,900 to $24,600 by the end of the decade, a loss of $5,300 in real income. The decline was worse in Toronto than in all of Canada, where it fell by 4%, although the median income of lone-parents in Toronto at the end of the decade was slightly higher than the entire country. Toronto's cost of living and housing were among the highest in the country.

While the recognition is made that lack of housing is the real reason for the extent of homelessness in Canada, at present low-income housing is not a priority with the housing industry. Condominiums are now aimed at the middle-income market, and private developers have no incentives to build low-income housing. When the Federal Government gave permission for mixed housing, this was not the case. In 1993 this practice ended, and the Canadian Mortgage and Housing Corporation stopped funding non-profit and co-operative housing in that year. The Centre for Equality Rights in Accommodation reports that these changes were combined with the inability of poor

people to obtain assistance with mortgages and housing, also the decline of real income for middle and low-income families in Toronto (CERA. 2002).

In 1999 a Federal Ministry of Homelessness was created to address national concerns on Homelessness. The focus has been on research and emergency shelter provision. It has allocated only limited funds to the sustained building of affordable housing. As the CERA article aptly states:

> "…homelessness relates to more than simply housing. Any review of the causes of homelessness needs to consider a much wider range of government programs and policies than housing programs per se." (CERA. 2002).

The Centre for Equality Rights in Accommodation's recommendations identify lack of affordable housing resulting in homelessness for a large section of the population, as the most obvious reason for women's inequality. Changes in this regard could be done through regulation of rental housing, programs that give incentives to home ownership, and in particular assistance given to Aboriginal women to obtain and maintain suitable housing. It was suggested this could take place through Income Assistance programs (known as social assistance and welfare throughout Canada), the National Child benefit program and Employment Insurance programs.

XI. Health and Inequality

The National Council of Welfare in 1990 pointed out the relationship between incomes and health. People with high incomes in Canada enjoyed better health than those with low incomes, despite the availability of universal healthcare. Another study in 1996 by the same group stated that 47% of low-income Canadians rated their health as excellent or good, as against 73% in the high-income group. In a 1999 a study by a Federally appointed committee on population health stated that:

> "There is strong evidence that the health of a given population depends on the equality of income distribution rather than on average income. The greater the disparities between rich and poor people, the greater the health consequences." ("Federal, Provincial and Territorial Advisory Committee on Population Health." 1999)

They further reported that there was evidence to determine the "health gap" in Canada is directly related to the "income gap." This is passed on to immigrants and refugees who enter Canada, particularly visible minorities. Aboriginal people have the lowest levels of healthcare overall. Urban areas such as Toronto are indicative of these findings. With single women being the lowest income earners, as well as the caregivers and often the economic mainstays in their families, the comparative status of their health falls on the downside of the "health gap."

XII. Homeless Women's Health

This section of the literature review will deal with the actual health problems faced by women who are homeless. Significant proportions of these illnesses are commonly

found in the downtown east Toronto, and much of the literature has been researched in this geographic area.

a. Research in Canada

Canadian research shows that there is a wide range of health problems among homeless people; also that men and women suffer similar problems, but to different degrees. Women have very high incidences of illness and injury, higher mortality rates, diabetes, heart disease, arthritis and musculoskeletal disorders (Crowe C. 1993). Homelessness itself has an adverse impact on health and crowded shelters result in exposure to infectious diseases as well as infestations with scabies

There is also a high degree of Hepatitis A, B and C among homeless people in Canadian cities. Hepatitis B and C has increased by the prevalence of intravenous drug use (Roy et al. 2001). Homeless women have an increased risk of tuberculosis and AIDS because of overcrowding in shelters and lack of ventilation. TB among the homeless is complicated because of follow-up loss, non-adherence to therapy, prolonged infectivity and drug resistance. Homeless people can have positive skin tests without actively having TB (Advisory Council for the Elimination of Tuberculosis. 1992).

Hwang (2001) found that respiratory diseases including tuberculosis, were common among the homeless, and this was heightened by late diagnosis, prolonged infection, non-adherence to treatment and drug resistant strains. The risk of contracting infectious diseases is heightened by the crowded conditions in shelters. Influenza and cold, which are easily treatable in the general population, become serious problems for the homeless due to stress, exposure to extreme temperatures, and the lack of timely and ongoing healthcare (Silver & Panares. 2000).

Homeless young women have a high degree of pregnancy, as well as HIV infection from intravenous drug use. Sexual and reproductive health are major issues for homeless women, in particular female youth between the ages of 14–17 who live on the streets. 21% of homeless women have been raped in the past year, and there is a disproportionate amount of unintentional injuries, due to falls or being struck by vehicles. Drug overdoses add to high mortality rates on the streets of Toronto. There are also a large range of chronic medical conditions such as seizures, chronic obstructive pulmonary disease hypertension, and diabetes that are not controlled in homeless women. Oral and dental health is also very poor (Frankish, James; Hwang, Stephen and Quantz, Darryl. 2005).

In addition to the health problems of homeless women, and despite the fact that Canada does have universal healthcare, homelessness is a daily struggle to survive. Barriers exist in access to mental healthcare and substance abuse treatment. Prescription medications cannot be easily obtained, and following medical recommendations are almost impossible. Homeless people are hospitalized five times more than the general public and stay in the hospital longer than other low-income patients (Provincial Task Force on Homelessness. 1998).

The last overall survey found in the literature for the purposes of this review on the health status of homeless men and women in Toronto took place in 1991. At that time 458 people were used as a representative sample to study their health conditions. This study found that among that population the following existed: allergies/hay fever, angina,

arthritis/rheumatism, asthma, diabetes, emphysema, chronic bronchitis, epilepsy, head injury, heart attack, hypertension, gastrointestinal problems, muscular-skeletal disorders, neurological disorders and stroke (Ambrosio et al.1992). It was also found that many individuals in non-sheltered environments had much worse health than those in shelters (Gelberg & Linn. 1989).

Sleep deprivation and exhaustion were common among the homeless. Crowded shelters do not provide safe conditions and ventilation to allow sleep. It was found that 50% of the homeless population slept less than 6 hours at night (Ambrosio et. al. 1992).

Added to this was lack of access to adequate amounts of nutritious food. Bunston and Breton (1990) compared the daily food intake of single homeless women using hostels and drop in centers to Canada's Food Guide, and found that the average number of servings in each of the four food groups was below the recommended number, even when they do have sufficient food available. Homeless women and their dependants often have diets that contain high levels of saturated fats and lack sufficient vitamins and minerals because most of their affordable food is the least healthy (Silver & Panares. 2000). Homeless women and children are at constant risk of malnutrition, which has negative health implications.

Another outstanding problem is that of skin diseases, including cellulites, impetigo, venous stasis diseases, scabies and body lice, which are common in the homeless population. Foot conditions are prevalent and include corns, calluses and immersion foot. These are prolonged and caused by inadequate footwear and exposure to moisture or long periods of walking or standing also the lack of shower and laundry facilities (Hwang. 2001).

In a recent report from Street Health in Toronto, where 360 homeless people were studied, 55% said they had at least one serious physical health condition. Over 50 % of this amount said they had more than one serious health condition. Thirty-three percent with serious health conditions had no heath care provider, while 50% were unable to follow their healthcare providers' advice regarding medication, vitamins and lifestyle changes needed to treat their illnesses.

One-half of those with serious conditions live on less than $10 per day, and 49% do not receive any government income benefits. Twenty-four percent of those researched received Ontario Works and only 20% receive Ontario Disability Benefits (Khandor. 2005).

XIII. Specific Health Concerns for Homeless Women

A comprehensive research report entitled "Health Status for Homeless Women: An Inventory of Issues" by Consulting Matrix Inc. in 2002 gave the most concise and relevant recent data on the health of homeless women in Toronto. The following information was taken from this research, which refers directly to similar data found in a variety of articles in many instances, based on homeless women in downtown east Toronto. Excerpts from this report are as follows:

a. Family Planning

Homeless women may have little control over the timing and circumstances surrounding conception. Sexual victimization, engaging in prostitution as a means of economic survival, unavailability of contraception, uncertain fertility, and the desire for intimacy may all result in unplanned pregnancy (Silver & Panares. 2000). Approximately 13% of Toronto's homeless women surveyed by Ambrosio et. al. in 1992 indicated they were pregnant. In 1998, a Public Health survey in Toronto found that 300 babies were born to homeless women annually (Bernstein & Lee. 1998).

A study by Street Health in Toronto found that, while most of the pregnant homeless women received prenatal care, a sizeable proportion were not eating to sustain adequate health. One-third of those who had delivered their last baby in the hospital had nowhere to go after discharge.

Despite being at risk for unplanned pregnancies, homeless women are unable to use birth control because their desired method may not be readily available to them. With little access to healthcare facilities and benefits, this forces them to rely on methods that do not require prescription, e.g. condoms. Barriers such as unwilling partners, memory loss and theft may limit successful use of condoms. Doctors are reluctant to suggest other methods such as intrauterine devices because of the lack of follow-upon the part of homeless women (Ambrosio et al. 1992)

b. Sexually Transmitted Diseases

Sexually Transmitted Infections (STI's) are high among homeless women. Gelberg and colleagues (2001) estimate that as many as six in ten homeless women have had an STI. A Chicago study indicated that 30% of Pap smears were abnormal (Johnstone, Tornabene & Marcinak. 1993). The proportion of women with chlamydia, gonorrhea and trichomontasis was 3%, 6% and 26% respectively. This study highlights the importance of providing homeless women with routine gynaecological care.

Homeless women also have an increased risk for HIV/AIDS. Unprotected heterosexual contact and injection drug use are the two primary methods through which women become infected with HIV/AIDS. Gynaecological symptoms including abnormal vaginal discharge, bleeding between periods, burning during urination and itching, swelling and redness in the vaginal area are also common among this population (Wenzel et al. 2001).

c. Breast and Cervical Cancer

Breast cancer is the most frequently diagnosed cancer in Canada; the rates have increased steadily since the early 1982. Cervical cancer rates have, however, declined in recent years. Early age of first intercourse, multiple sex partners, infection with human papillomavirus (HPV) smoking and low socio-economic status make some more susceptible to the disease. At present the only proven strategy to reduce the incidence and mortality of breast and cervical cancer is early detection through mammography and Pap tests (Health Canada. 1999, Health Canada. 1998). There is no research available for these cancers on homeless women; however, the incidence being higher in lower socio-economic groups indicates that they are very susceptible to these diseases.

d. Violence Against Women

Violence against women is one of the precursors to homelessness. Once homeless, violence continues and intensifies, through threats and fear, resulting in homeless women beginning a downward spiral in health. Beyond the immediate painful physical injuries, the consequences of violence include social isolation, post-traumatic stress disorder, clinical depression, generalized anxiety disorders and substance abuse. Many women report anger, fear and becoming more cautious and less trusting, all of which can act as barriers to accessing healthcare services (Statistics Canada. 1993).

e. Mental Illness

75% of homeless single women in Toronto suffer from some type of mental illness. 49% are victims of childhood sexual abuse and 51% are victims of childhood physical abuse ("Women's Mental Health." Canadian Mental Health Association. 2005). De-institutionalization and the decrease in welfare levels are cited as the main reasons for increases in the numbers of mentally ill women who are homeless in the city.

The argument for de-institutionalization is quite valid; however, the development of community supports in the east end of the city and elsewhere have not kept up with the volume of mentally ill women who are on the streets of Toronto. This has created the term "absolute homelessness," leaving a larger number of people who are homeless to access care through emergency departments of hospitals. This is often linked with substance use, psychotic and affective disorders (Hwang. 2001).

However, contrary to popular misconceptions, only a small proportion of the homeless population suffers from schizophrenia. This disease has a lifetime prevalence of only 6% among the homeless people, with the largest amount among single women, who are less likely to have substance abuse problems than men. Female heads of homeless families have lower rates of both substance abuse and mental illness than other homeless people ("Mental Illness and Pathways into Homelessness." 1998).

De-institutionalization has affected women much more than men. Women are likely to have dependent children for whom they are responsible. If women who are homeless have a strong relationship to the world of paid work, that is the best indicator of whether they will be able to find a new home or not. However, if the women are ill they will not be able to work. As such, having paid work has little impact on homelessness, because women who are mentally ill have difficulties in managing their life situation, including the home and their children. In a housing crisis therefore, paid work makes very little difference to these situations (Johnson. 1999).

"The Golden Report on Homelessness" stated: "there is a broad agreement that about a third of the homeless population suffers from mental illness, but the percentage varies considerably according to age and gender." Mental health conditions on the streets of Toronto among homeless women range from those who experience depression, to those recovering from trauma, and those with more serious psychiatric disorders, including schizophrenia and mood disorders, for instance. Depression rates in the homeless population are higher than that of the general population.

f. Substance Abuse

Evidence suggests that between 16% and 26% of homeless women have substance abuse disorders (Silver & Panares. 2000). Substance abuse in early adult life, along with other adverse life events, including unstable housing, sexual and physical victimization, and parental mental illness and substance abuse, have been found to be correlated with homelessness (Goering et al. 1997; Nyamathi, Bayley, Anderson, Keenan & Leeke. 1999).

In the "Research Lessons and Priorities" by Frankish, Hwang and Quartz, published by the Canadian Journal of Public Health in 2005**,** the relationship between mental health and homelessness was seen as complex. This paper suggests that homelessness has an adverse effect on people's health. However, addiction and or mental illness are contributing factors to the onset of homelessness itself, this in turn worsens the situation. Addictions and mental illness were found to be far more prevalent in homeless people than in the population in general. The research showed that 60% of homeless men have alcoholic disorders, whereas homeless single women were more likely to have mental illness.

g. Concurrent Disorders

It is a common occurrence for homeless people to have a combination of mental health and substance abuse problems. Homeless women use alcohol and drugs to temporarily alleviate symptoms of their mental illness (Silver & Panares. 2000). In fact, it was found that three-quarters of those with a lifetime diagnosis of mental illness also had a diagnosis of substance abuse (Goering et al. 1997). Women who are lone parents and homeless, however, have lower rates of both mental illness and substance abuse (Shinn et al. 1998).

XIV. Harm Reduction in Toronto

With regard to marginalized, homeless and isolated women in downtown east Toronto, harm reduction is one of the major factors that play a part in their lives.

a. Definition of Harm Reduction

The City of Toronto has defined harm reduction as:

> "A holistic philosophy and a set of practical strategies that seek to reduce the harm associated with drugs, alcohol, solvents and the harmful use of other substances and prescribed medications. While quitting drugs may not be realistic or desirable for everyone, harm reduction recognizes that substance use and its consequences must be addressed as public health and human rights issues, rather than criminal issues." (Special adHoc Committee on Harm Reduction. 2002)

There is a lack of gender-based studies on women who are homeless and harm reduction in Toronto. Studies on substance abuse of homeless women provide a range of estimates from 16%-26%, which appears to be low. There is the need to move

homeless women towards detoxification since stabilization of their housing is impossible without addressing substance abuse issues (Means. 2001).

b. Detox Closures in Toronto

In a disturbing report on September 22, 2005 from the Canadian Harm Reduction Network, St. Stephen's Community Centre, in Toronto stated the following:

> "On July 21st 2005 a group of substance users, community agencies, frontline workers and citizens mobilized to create the Coalition Against Detox Closures. This Coalition came together to address the lack of consultation, participation and information in the Ministry of Health's (MOH) decision regarding detox services and the addictions sector in general.
>
> The Ministry of Health (MOH) and Toronto Withdrawal Management Services (TWMS) are currently restructuring detox services in the Greater Toronto Area. The changes have included a closure of CAMH's 501 Detox; and, although the detox at 16 Ossington was scheduled to close at the end of October, the MOH has indicated some willingness to keep it open for a period of time, although no details of their intent are known at this time."
> (Website information: http://www.xcom.hostingisfree.com/)

XV. The Canadian Government vs Health, Homelessness and Housing

In 2000, Alan Rock, The Federal Minister of Health, announced the formation of the Commission on the Future of Health Care in Canada, under the leadership of Roy Romanow. His job was to engage Canadians in a dialogue to determine healthcare preferences, in the midst of a privatization debate on the topic. His findings would influence the long-term sustainability of healthcare, as well as changes to the system to ensure accessibility for all Canadians.

The Romanow Report, "Building on Values: The Future of Health Care in Canada" (2002), included 47 detailed, cost-effective recommendations with the inclusion of time frames for implementation purposes.

The first Ministers' Conference on National Health Care was held in February 2003 to discuss the Romanow Report. The prime minister, premiers and territorial leaders convened to implement many of the findings regarding healthcare. They agreed on some major improvements to the system, as outlined in the first Minister's Health Accord as follows:

- $16 billion, five year fund for primary care, home care and catastrophic drug coverage
- $13.5 billion in new funding to the provinces over three years
- $2.5 billion cash infusion for 2003
- $600 million for information technology
- $500 million for research.

However, the premiers pointed out that they were getting only half of what Romanow recommended at present. The territorial leaders did not even sign the agreement, arguing that the North would be receiving the same per capita as the rest of the country, despite much higher costs. What should be noted, though, is that in 2001, 71% of Canada's healthcare income came from public funds, compared to 44% in the US and about 85% in Denmark, Norway and Sweden. The other 29% of Canada's health spending came from private insurance and direct out-of-pocket, expenses by Canadians. (OECD Health Data. 2003).

In a Toronto Star article on Saturday, September 16, 2005, titled "Romanow Fears 'End to Medicare," it was reported that he said…… "buying healthcare violates the Charter Court ruling and this is a 'body blow' to Canada." Romanow slammed the Supreme Court of Canada's decision to strike down Quebec's ban on private health insurance in a hard-hitting speech in Toronto. He accused the four-judge majority that found in favour of the Jacques Chaoulli case, a physician who wanted to operate a private hospital, and George Zeliotis, his patient, who was left on a waiting list for a hip operation.

This Romanow saw as …"the clear implication of a violation of the Canadian Charter, in which the court basically said that the prohibition of private health insurance enacted by a democratically elected provincial government was bad policy. It also could mark the beginning of the end of universal healthcare in Canada." (Tracey Tyler: Legal Affairs Report. 2005)

A more immediate concern for the homeless population was the front page article in the Toronto Star on September 15, 2005 titled "Wrong Patients Crowding ER: Study," by the Canadian Institute of Health, which pointed out that only 1% of people using emergency services required life saving treatment. As the literature review showed, the majority of homeless people who need healthcare use the emergency services in hospitals.

Data collected in 2003-2004, most of which came from Ontario hospitals, found that one in ten Canadians waited three hours or more for medical assistance. One half were seen by a doctor within 51 minutes and 10% waited ten minutes or less. Crowding in emergency services is becoming a problem, with real emergencies being affected by long waiting periods. The report stated that in Toronto, patients treated in emergency rooms were far more likely to be ill than in other areas, no reason was given for this (Toronto Star, Debra Black. 2005).

On Thursday, September 15, 2005, the Toronto Star reported on a study by Social Watch, a coalition of 400 non-government organizations in 50 countries. Economist Armine Yalnizyan wrote the Canadian section. The study indicated that poverty is rising among children and new immigrants and the middle class is finding it increasingly difficult to afford education and housing, and there are 250,000 Canadians living on the streets.

The study also indicated that:

> "Between 1997 and 2003 Canada's economy was the fastest growing among G-8 countries, expanding 55 per cent in real terms. The gross national product has surpassed $1 Trillion. However, Federal spending stands at 11 percent of the economy, down from 16 percent in 1993-94, well below historic averages.

Only 38 per cent of unemployed workers receive government benefits, down from 75 percent in the early 1990s.

More than 1.7 million households live on less than $20,000 a year, and most are precariously housed. They do not own their homes and spend more than 30 per cent of income on rent.

Despite repeated promises there is no national child care program."

The criticism was that Ottawa has focused overwhelmingly on economic growth, dramatically limiting its role and severely limiting social transfers.

In response to the growing numbers of homeless people in cities and rural areas across Canada, The Federal and Provincial governments announced in spring 2005 that they would begin spending $602 Million on affordable housing across Ontario. In Toronto there are over 63,000 on waiting lists for affordable units (Gonda, Gabe. City Hall Bureau. 2005). This could make a difference to the city, however, the process of downloading funds has so far proved to be discouragingly slow.

XVI. Reducing Homelessness

"Homeless and Health in Canada" by Hwang et. al. in the Canadian Journal of Public Health (2005) presents four clusters, developed from literature, theory and past experience that should be examined regarding homelessness and healthcare. These were:

A. Biomedical and medical care strategies: These focus on medical interventions to improve health status and includes primary healthcare programs, clinical services through outreach programs, psychiatric treatment teams and substance abuse treatment. Purely bio-medical interventions may improve the health of homeless people but fail to address their homelessness. Healthcare and housing should therefore be considered as important parts of the equation.

   There does not exist a great deal of research on purely biomedical interventions using a rigorous control design. Instead there area lots of studies on mental illness and substance abuse. In one instance studies have confirmed the effectiveness of Assertive Community Treatment (ACT), which involves a team of psychiatrists, nurses and social workers, following a small caseload of clients in the community and providing high-intensity treatment and case management.

B. Educational and Behavioural strategies: This cluster of strategies seeks to prevent homelessness or improve the health status of homeless people through educational programs and behavioural change. Educational programs may focus on homeless people, individuals at risk of homelessness. or the general public. Efforts to promote behavioural change in the homeless include harm reduction programs, counseling and referral services. Educational programs on homeless for healthcare, shelter workers and service providers are also included

in this strategy. Ontario's Urban Aboriginal homelessness strategy includes culturally appropriate programs such as cultural counseling, programs, and employment services.

Examples of programs targeting homeless or at risk individuals include tenants' rights organizations' eviction prevention services. Educational awareness programs should include a public awareness campaign on how to treat the homeless. Efforts of tenants and advocacy groups, such as the Centre for Equality Rights in Accommodation and the Homelessness and Housing Network in Toronto, seek to influence government policies on homelessness.

C. Environmental strategies: These are the attempts to alter the social, economic or physical environment in a specific setting to create a supportive environment that enables and facilitates behavior change. This approach recognizes that the environment or context in which homelessness occurs may be altered to enhance desired behaviors or limit undesirable actions. Such alterations of environments could include supportive housing sites, outreach programs, a specific neighbourhood or an entire city province or country.

   One such environmental strategy was Street City in Toronto, that provided an environment, which was intended to simulate living on the streets, but was sheltered with staff to monitor homeless people. This experiment was not at all successful, but could be tried again with differences, bearing in mind learnings from mistakes in that venture. On the macro level, funding from the Supportive Community Partnership Initiatives seeks to promote cooperation and coordination at a local level, in response to homelessness in various communities. Research in this area has been mainly community-based, where researchers have looked at homelessness in Toronto to outline lessons learned while conducting this research.

D. Policy and Legislative Strategies: These strategies include efforts to reduce homelessness through policies and legislation related to poverty and its amelioration, social housing, public health, immigration and law enforcement. Recognizing that such policy has an enormous impact on homelessness and its management, these strategies focus on the creation of "healthy public policies." Some of these are safe injection programs, primary healthcare walk-in clinics to serve homeless people; funds for drop in centers throughout the city of Toronto for homeless women. These policies are foundational as there is an absence of a strong policy-legislative approach to homelessness that will seriously limit and undermine efforts in other areas.

Three strategic priorities to reduce homelessness and improve the health of homeless people were suggested, these were:

1. Consensus definition of homelessness and indicators of its extent.
2. A priority should be set to define and measure the health status and use of health and social services by homeless people, as well as the links between homelessness and other factors that determine health such as income.
3. The development of a research infrastructure.

XVII. Barriers to Healthcare for Homeless Women

In “Health Status for Homeless Women: An Inventory of Issues” (2002) it was noted that homeless women suffer from a wide range of physical and mental health problems, yet they experience difficulties in obtaining the healthcare they require. External or systemic barriers restrict or prevent access to the healthcare system, resulting in care that is neither sensitive nor responsive to their needs. These barriers have been identified:

a. Systemic Barriers

There are few regular healthcare providers for the homeless women; they access services mainly through an emergency situation. Their health records are often scattered among various healthcare providers; as a result, follow up services on their medical history are quite impossible in many instances.

With no fixed address or telephone number, it is difficult for homeless women to schedule healthcare appointments and for healthcare professionals to notify them of their lab results for follow up care, referrals and support services (City of Toronto. 1999).

b. Discharge Issues

Women have no place to go “home” to, once they leave hospitals after serious illnesses. They also need some sort of care to recover fully; there is no place to provide this, as hostels and shelters do not give personal care to homeless women who are sick.

c. Health Insurance Documentation

Homeless women often lose all of their documents pertaining to birth, medical histories and health insurance. With these documents missing, there is no way to access medical care easily, and women in need of care stay away from medical facilities for this reason.

d. Lack of Transportation

Poor health conditions and distance may prevent women from accessing medical care, due to lack of funds to take public transportation. In urban areas this does not pose a serious problem, however in many instances, a homeless woman secures transportation too late to prevent critical situations, should she need immediate care from a doctor.

e. Discomfort with the Health System

Many homeless women are uncomfortable with hospitals, also with going to clinics for medical check ups, and those with mental illness often refuse to seek help due to distrust of male doctors. This often creates a dilemma, as homeless women are not willing to seek medical attention based on their perceived status.

f. Misconception and Lack of Understanding By Professionals

Homeless women have reported facing discrimination and stigmatization from healthcare providers. Some have reported that they have been denied treatment altogether while others are given clear indications that they care they are receiving is

being given reluctantly. Healthcare professionals are not equipped to accommodate the complexities presented by homeless women and may lack knowledge and sensitivity around the circumstances and special needs of the population.

g. Preventative Healthcare

This is often elusive to women who are homeless, as they struggle to obtain the basic necessities of life such as food and shelter, healthcare presents a low level of importance. Management of health problems in these circum stances can be extremely difficult.

XVIII. Environmental Scan: Sections of Toronto

Barbara Miles, MES, the Author, and Karen Hawn, an Inclusion Researcher, conducted the Environmental Scan. The Scan provides comparison data for downtown east Toronto with other areas in the city to document differences in demographics, labour, immigration and income. The facts in this data have been derived from the www.torontohealthprofiles.ca website. The data from the Environmental Scan appears in Appendix 1.

General Information on Format for Presentation of the Data

Data collected for information throughout the charts took place in three five-year spans: 1991, 1996 and 2001. In keeping with this pattern, data should again be collected in 2006. It would therefore be safe to say that patterns might have changed considerably over the past five years. However, this is the most up to date information available in the city on facts and figures that are of interest to our research.
.
Group #1 represents the Study Area of the research project.

Group #2 applies to areas outside of the Study Area of the research, used to provide comparative data on all topics.

The topic you are reading about appears on the left hand top corner of each page.

Figures in the left hand column represent the overall situation in the GTA, regarding each sub-topic.

Figures in the other columns represent only the areas under each heading.

Analytical information for each sector appears on the page after the charts for easy reading and comprehension purposes.

XIX. Conclusion

The Literature Review became an important part of our “way of working.” The Working Group realized that the project was breaking new ground in community-based research, moving it forward to Inclusion Research. This meant that the Literature Review had a direct and continuous relationship with the field, as ideas emerged from the literature and entered our thinking in developing the line of questioning for the Focus Groups, in

analyzing the data from the Focus Groups, and in proposing courses of action to flow from the research. The Review became a dynamic part of our approach, placing our findings in the context of what was in the literature and what was not in the literature.

The two streams in the Literature Review – the social and health contexts of homelessness research – tend to be embedded in their respective disciplines. The social approach tends towards policy adjustments and the health approach tends towards risk reduction. The Inclusion Researchers, familiar with these streams from the Review, began to reject their conceptual orientation in favor of their findings, which came from the voices of their peers in the study area. The voices talked about a harsh reality, with no easy paths of opportunity, and a continuous clash with seemingly indifferent providers of health, social, legal, financial, housing, etc. services. The voices talked about the need to change and the need to change through action.

As evidenced in the final report of the project, the Inclusion Researchers began to lead the Working Group to propose concrete actions based on their findings in the Focus Groups, not more research or more study or more reports. However, they also realized the power of this new research methodology to give a voice to the previously voiceless.

Count Us In! has taught us to listen to the voices of the marginalized in our society, frame solutions that they articulate, and take action, together, to change the world for women.

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City of Toronto Group #1.A Population Demographics	Church-Yonge Corridor	Cabbagetown South St. Jamestown	Regent Park	Moss Park	North St. Jamestown
2001: 2,481,560	21,860	10,580	11,280	13,100	18,570
1996	20,229	11,090	10,675	11,700	17,498
1991	16,645	11,570	10,615	10,870	15,550
Percentages					
19 & Under					
2001: 23.3%	7.2	10.0	38.2	12.7	21.9
1996	7.9	11.3	38.4	13.5	21.0
1991	6.8	11.8	38.0	11.2	15.6
65 & over					
2001 : 13.6%	8.8	13.3	4.1	8.0	7.4
1996	8.9	12.7	5.9	10.3	8.9
1991	8.4	11.9	7.3	12.8	10.9
65 & Over living alone					
2001: 26.6	52.8	53.7	39.3	59.5	40.3
1996	55.7	55.9	45.6	67.5	46.9
1991	53.7	47.7	46.4	60.7	54.1
Lone Parent Families					
2001: 19.7	17.0	19.2	37.6	32.5	26.7
1996	17.8	19.5	42.2	32.6	26.5
1991	15.1	19.3	48.2	27.3	29.8

1-A. Population Demographics: Between the years 1991 – 2001.

The area with the largest overall population growth was the Church Yonge corridor – 31.3%.
This was followed by Moss Park – 20.5%
North St. Jamestown – 19.4%
Regent Park was 6.3%
Cabbage Town South- St. Jamestown had a decrease of 8.6%

Increases in certain areas of downtown Toronto east were due to the expansion of condominiums in the city. Notably, is the Church Yonge St. Corridor, where new buildings have been constructed and this section also marks the expansion and legitimacy of the gay/lesbian district.

On doing some research, Cabbage Town, south St. Jamestown, with the decrease has experienced large houses being built with an influx of businesses coming into the area which resulted in an overall decrease in population growth.

The remaining statistics represent a breakdown of the percentages of people in various categories.

An important point to note is that the Regent Park, where the largest amount of social housing exists, was the area with the largest amount of lone parent families. The ratio of male of female-headed households was not discernable from the figures presented.
65 and over living alone has decreased in each area, this could be due to death, moving into homes in the suburbs, or to live with families.
65 and over has decreased in general, which shows that the demographics has changed to that of a younger age, more lone parent families, as well as an increase in same sex couples and individuals.

We can deduce from these figures that the majority of the population falls between 22-65 years of age, as Regent Park has the highest levels of under 19's but also the smallest population group of all the designated areas on the chart.

City of Toronto **Group #1.B** **Socio-Economic Status**	Church-Yonge Corridor	Cabbagetown South St. Jamestown	Regent Park	Moss Park	North St. Jamestown
2001:$ 69,194 -Average	56,829	68,514	30,162	31,246	32,539
1996	41,666	53,545	22,351	30,337	26,118
1991	43,726	52,296	22,496	32,206	29,5337
Percentages					
Low income families					
2001: 19.4	20.4	14.4	67.8	48.7	41.0
1996	28.2	21.6	71.7	48.9	51.8
1991	15.7	20.4	63.4	43.1	40.0
Low Income Individuals					
2001: 22.5%	27.8	22.2	70.2	56.9	46.3
1996	35.1	29.4	73.4	58.3	54.6
1991	22.2	24.4	64.8	48.3	41.3
Rented dwellings					
2001: 49.2%	78.0	58.6	91.4	88.4	98.5
1996	86.2	65.5	95.5	88.7	98.5
1991	87.6	69.9	94.8	85.5	98.8
Unemployment					
2001: 7.0%	6.9	6.6	19.4	12.5	10.0
1996	9.5	6.9	28.0	19.4	12.5
1991	8.2	9.5	22.7	15.5	13.8
Not in Labour Force					
15 and over	23.5	27.8	44.7	39.2	34.7
2001: 34.7%	26.0	27.9	51.3	41.5	38.9
1996	18.0	24.2	51.1	39.4	29.9
1991					
Less than High School					
2001: 28.4 %	10.0	15.3	38.8	25.3	24.3
1996	13.5	17.4	51.9	33.1	28.7
1991	14.2	23.0	61.9	38.9	34.4
University Degree					
2001: 25.3%	43.5	39.2	15.6	27.7	24.6
1996	35.1	36.2	8.2	20.6	19.5
1991	33.3	32.9	6.2	19.4	15.4

1-B. Socio-Economic Status: Between the years 1991-2001.

In all sectors of downtown East Toronto, the average income falls below that of the overall average in Toronto, which is $69,194.
This is one factor that may have changed since 2001, with the excessive amount of condominium buildings taking place between 2001–2006.

Regent Park stands out as the most socially economic depressed area in East Toronto, and where people have the lowest incomes, and the least amount of education, in every category but one, which is rental units.

The only category in which they were not the lowest denominator as stated was rental, where North St. Jamestown has more rental units than Regent Park.

The depressed situation is in the process of changing drastically in Regent Park, with the new development of mixed housing units taking place.

City of Toronto **Group#1.C** **Diversity** **Population: 2,481,560**	Church-Yonge Corridor	Cabbagetown South St. Jamestown	Regent Park	Moss Park	North St. Jamestown
Percentages **No knowledge of English/French**					
2001: 5.1%	2.2	2.0	5.6	2.4	5.0
1996	2.5	3.6	10.8	4.9	7.7
1991	1.5	3.4	10.5	4.0	6.4
Recent Immigrants – within 5 years					
2001: 11.4	37.8	6.0	16.2	47.3	26.2
1996	37.0	9.0	20.9	40.8	34.2
1991	33.6	-	-	30.7	-
Immigrants within 10 years					
2001 : 21.0%	17.4	11.1	38.0	28.3	43.2
1996	-	-	-	-	-
1991	11.3	12.0	28.8	11.5	28.1
Immigrants					
2001: 49.5%	10.7	34.2	58.4	16.4	63.6
1996	11.0	36.5	56.5	12.7	64.3
1991	-	33.5	48.2	-	51.8
Visible Minorities:					
2001: 42.8%	32.9	25.9	79.4	52.5	72.3
1996	27.8	27.8	70.0	41.4	67.8
1991	-	-	-	-	-
Top 3 countries for people immigrating within last 5 years **China** **India** **Pakistan**	South Korea China United Kingdom	Russian Federation Phillipines China	China Bangladesh Sri Lanka	China Pakistan Bangladesh	Phillipines Sri Lanka China

1-C. Diversity Trends: Between the years 1991-2001

China is the definite winner in all areas, from which immigration has taken place in the past 5 years.

It is interesting to note that the largest amount of immigrants have settled in Regent Park and North St. Jamestown, which represent the two areas with the highest rental units in the city, and the highest amount of visible minorities. 42.8 % of the 49.5% of the immigrants to the city who came to the downtown East Toronto areas were visible minorities.

Moss Park had the most recent immigrants between 2001-2005, which was 47.3%, showing an unemployment level of 12.5%, well above that of the City of Toronto, which in that period was 7%.

The most depressed area – Regent Park has the highest level of visible minorities, 79% proving the argument that racialization of poverty is a reality in Downtown East Toronto.

City of Toronto Group # 2.D Demographics	South Riverdale	Annex Profile	Waterfront Communities & The Island	Rosedale/Moore Park
Population 2,481,560				
2001	26,880	26,700	18,530	19.135
1996	26,105	26,777	14,188	18,412
1991	24,850	26,135	12,625	18,402
Percentages				
19 & under				
2001: 23.3	21.6	10.7	12.6	17.7
1996	22.9	10.5	12.7	16.8
1991	22.3	11.9	13.4	16.5
65 & Over				
2001: 13.6	10.8	14.2	9.1	18.9
1996	10.9	13.4	7.9	18.2
1991	10.0	12.9	6.0	16.9
65 + Living Alone				
2001: 26.6	25.3	38.8	47.7	39.3
1996	24.4	36.3	40.1	38.6
1991	23.1	40.7	37.9	39.7
Lone Parent Families				
2001: 19.7	23.4	14.4	18.5	9.6
1996	23.6	14.6	21.9	10.9
1991	22.4	15.6	21.4	10.9

2.D. Demographics in areas in downtown Toronto: Between the year 1991-2001

The areas chosen in group 2 fall outside of Downtown East Toronto, but are adjacent to areas where our research is being conducted.

Between 1991 to 1995 growth was as follows:

Rosedale-Moore Park -	4. 0%
South Riverdale	8.2%
Annex Profile	2.2%
Waterfront Communities	46.8%

The large growth in the Waterfront communities can be attributed to construction in the waterfront area that has been quite phenomenal
Between 1991- 2001 period, and which still continues today. We can safely anticipate an even larger shift in growth in this community.

South Riverdale is the most heavily populated area, except for people 65 years and over. This can be explained by the affordable housing prices in this area, when compared to the rest of Toronto.

Bearing all this in mind, the density of the population in these areas are greater than areas as listed in Chart #1.

There is also less movement in numbers with regard growing populations, except in the Waterfront communities where condominiums are being constructed.

City of Toronto Group # 2.E Socio-Economic Status	South Riverdale	Annex Profile	Waterfront Communities & The Island	Rosedale/Moore Park
Average Household Income in Toronto				
2001: $69,194	55,736	83,080	88,298	236,029
1996	42,827	61,394	58.542	126,925
1991	45,805	58,435	54,998	114,033
Percentages				
Low Income Families				
2001: 19.4	22.5	11.2	14.0	3.5
1996	36.9	15.5	18.4	3.8
1991	25.2	12.5	18.4	3.2
Individual Low Income				
2001: 22.5	27.3	19.3	19.6	5.5
1996	39.5	24.9	22.4	7.4
1991	28.5	20.5	20.4	6.6
Rented Dwellings				
2001: 49.2	45.7	66.5	59.0	47.1
1996	51.1	71.3	73.2	51.2
1991	45.8	69.7	74.8	51.7
Unemployment Rate				
2001: 7.0	7.9	5.8	4.8	3.7
1996	11.9	8.1	6.9	4.5
1991	13.4	8.1	8.7	5.0
Not in Labour Force				
2001: 34.7	31.7	26.0	22.8	31.6
1996	38.2	24.9	22.5	30.1
1991	32.1	23.1	19.8	30.2
Less than High School Education				
2001: 28.4	35.1	12.0	11.6	9.0
1996	44.3	13.9	13.8	9.8
1991	46.6	18.6	14.9	12.0
University Degree				
2001: 25.3	22.2	52.8	43.4	58.7
1996	14.3	47.4	39.8	52.4
1991	15.2	42.8	37.9	49.5

2.E. Socio Economic Status: Between the years 1991-2001

The differences in income status are outstanding in Chart # 1 as compared to Chart #2.

The only area that falls below the average level in Toronto is Riverdale.

The others areas are very much higher in income levels.

Rented dwellings are about the same, however university degrees and high school graduates are greater in number.

Unemployment rates are less than in Chart #1.

People not in the labour force, which would be well to do housewives, women and men living off trust funds was greater in these areas, except for Riverdale, which is comparable to Chart #!.

City of Toronto **Group # 2 .F** **Population: 2,481,560** **Diversity**	South Riverdale	Annex Profile	Waterfront Communities & The Island	Rosedale/Moore Park
Percentages **No knowledge of English/French**				
2001: 5.1%	12.0	2.2	1.7	0.3
1996	18.1	2.1	1.6	0.2
1991	14.7	3.3	2.4	0.2
Recent Immigrants – within 5 years				
2001: 11.4	44.9	5.4	40.0	3.1
1996	46.3	7.2	38.3	4.0
1991	42.6	-	35.4	-
Immigrants within 10 years				
2001: 21.0	18.3	8.9	13.9	5.4
1996	-	-	-	-
1991	20.4	8.5	14.1	4.2
Total Immigrants				
2001: 49.5	9.6	32.8	7.2	25.8
1996	14.2	33.6	8.8	25.5
1991	-	35.1		24.5
Visible Minorities				
2001: 42.8	52.5	22.0	35.2	10.2
1996	52.8	19.5	27.4	7.7
1991	-	-	-	-
Top 3 countries of origin for people immigrating in past 5 yrs	China Philippines Pakistan	China United States Iran	China United Kingdom United States	United States China Philippines

2.F. Diversity Trends: Between the years 1991-2001

With the exception of the Riverdale area, immigration in all other areas in Chart #2 have been very low.

China is still the leading country for immigration in these areas, as is the trend in the rest of the GTA.

Source: (www.torontohealthprofiles.ca) website.