Poverty and the Social

By Kathy Hardill

Street Health est une organisation communautaire qui fournit des services de santé aux femmes et aux hommes sans-abri ou vivant dans des logements marginaux au centre-ville de Toronto. Street Health est une initiative de la communauté pour pallier à l'incapacité du système officiel de santé à tenir compte du contexte social dans lequel vivent ces personnes. Dans le présent article, l'auteure, une infirmière œuvrant auprès de Street Health, décrit une initiative visant à faire valoir les besoins de ce groupe.

The connections between poverty and poor health have been well known and well documented for many years. However, actually internalizing those connections in a way which meaningfully places health care within the social context of poverty rarely happens. This results in two consequences: 1) the failure to address the root causes of illness; and 2) the provision of inappropriate and often ineffective health care.

Street Health is a community-based organization which has been providing health services since 1986 to women and men who are homeless or marginally-housed in the downtown core of Toronto. It originated as a grassroots response to the failure of the mainstream health care system to place health care for this group of people in the social context in which they live.

A group of homeless women and men who were concerned about health care issues came together with a small number of community workers and developed Street Health as a response to those same issues. Many individuals reported having experienced encounters with mainstream health services which had been unsatisfying either because they had felt humiliated or discriminated against because they were poor and homeless, and perhaps unkempt or dirty, or because they had been given instructions or treatments that were impossible to carry out due to living circumstances. Street Health was thus created to begin dealing with the problems of health care for homeless people. Street Health's mandate is three-fold:

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1) to provide hands-on nursing care to clients in an environment which is familiar to them;

2) to assist clients to gain access to appropriate care in the mainstream health care system; and

3) to lobby the existing health care system to become responsive to the needs of homeless people.

Street Health operates nursing clinics in drop-in centres and shelters and is managed by a 12-person board of directors, one half of whom must be people who are homeless or who have experienced homelessness in the past. The organization is staffed by nurses and two AIDS street workers.

Over the years, Street Health has been advocating on behalf of our clients and for equal and fair access to the health and social service system with limited effect. Early in 1991, we decided that we wanted to begin comprehensively documenting the health problems and barriers to services (structural and attitudinal) frequently encountered by the people we work with. We decided to complete a health survey which would be written by us, useful to the homeless community and their advocates, and reflective of their experiences and problems with the health care system. Homeless people have largely been excluded from general population-based health surveys which depend on people having an address or a telephone number to facilitate random selection, neither of which this population has.

We believed that a rigorously executed research project could prevent the marginalization of our findings and add strength to our lobby efforts. We developed a lengthy questionnaire which was administered to over 450 homeless women and men in 25 different locations, either overnight shelters or soup kitchens. Each interview took approximately one hour to complete. With the assistance of York University's Institute for Social Research, we developed an innovative methodology allowing us to randomly select a sample which would be representative of homeless people across the City of Toronto.

Interviewing took place during December 1992 and January 1992. The results were summarized in *The Street Health Report*, which was released in May 1992. Information was gathered on two broad areas of concern: health status and access to health care.

Context of Health

Health status findings

Homeless women and men do not have health problems that are different from those of the general population. What does differ is the way their living and economic circumstances affect the severity of their health conditions, and their ability to cope with health problems.

Not surprisingly, our research found much higher prevalences in the homeless sample of a number of chronic conditions. For example, respiratory conditions such as emphysema and chronic bronchitis had a prevalence over four times greater than that reported in the general Toronto population (comparisons were made with the Toronto Community Health Survey, 1988). Asthma was more than twice as prevalent.

An interesting finding which we had not anticipated was that 4.5 per cent of our sample reported having suffered a brain injury in the past, despite the fact that we did not ask respondents any direct questions about this. Some people reported having had lengthy periods of unconsciousness, which is indicative of severe injury usually resulting in permanent damage, such as diminished memory span, reduced concentration, difficulty with abstract thinking, behavioural changes, and physical deficits.

Had we specifically asked about past brain injury, it is likely that a greater incidence would have been discovered in our sample, as many people with a history of brain injury do not consider that it may be currently affecting their lives. Although we cannot support a correlation between brain injury and homelessness, we do know that the health care system falls short in the lack of follow-up for those surviving traumatic brain injuries. Hospital-based trauma services receive vast amounts of provincial health care dollars in Ontario to resuscitate accident victims. However, the Ontario Ministry of Health does not sufficiently fund prevention education, rehabilitation services, family support care or supportive housing for those suffering from head injuries.

Violence in many forms profoundly influences the health of women and men who are homeless. For women, being homeless is particularly dangerous. Forty three per cent reported having been sexually harassed.

We also asked no questions about HIV infection. However, five individuals (1.1 per cent of the sample) volunteered that they were HIV-infected or had AIDS. Three of these were women. It is quite possible that more than these five respondents were HIV-infected but either were not aware of their HIV status or chose not to reveal this information to the interviewers. Being homeless and HIV-positive is a potentially devastating combination, given that HIV infection compromises one's immune system as does homelessness itself through poor nutrition, fatigue, and exposure to a multiplicity of communicable respiratory infections in crowded spaces such as hostels.

As well as ongoing chronic health conditions, we found that violence in many forms profoundly influences the health of women and men who are homeless. Over 40 per cent of all respondents had been physically assaulted at least one time in the past year. One quarter of these assaults were perpetrated by members of the police force.

For women, being homeless is particularly dangerous. Almost one half of the women we interviewed had been assaulted at least once in the past year. Of all of the women we spoke to, 43.3 per cent reported having been sexually harassed, having experienced unwelcome sexual advances or having been grabbed or touched when they did not want to be. Thirteen women stated that this happened to them so frequently that they could not count the number of times. More than one in five women reported having been raped in the past year.

Another finding we had not specifically anticipated was that childhood abuse was a common theme in the lives of many women we interviewed. Of the women we surveyed, 8.5 per cent reported being physically or sexually abused (including incest) during childhood. This figure is based on the women who voluntarily mentioned this information during the course of the interview. We did not ask questions about this.

When added to the realization that violence against women is a frequent cause of their homelessness, it is even more appalling to find evidence that once homeless, violence continues and intensifies.

Despite the stereotypes about mental illness and homelessness, we found that the most prominent mental health prob-

lem cited by our sample was lack of self-esteem or the depression that accompanies homelessness. Thirty per cent of all the women and men in our sample told us that this was the single most difficult part of trying to stay healthy when homeless. Almost eight per cent of the entire sample had attempted suicide in the past year. An alarming 29 per cent of the women had attempted suicide in the same time period. Overall, the survey revealed women and men feeling the severe psychological effects of coping with extreme adversity on an ongoing basis.

Access to health care

Despite the sometimes smug attitudes of Canadians about our health care system/social safety net, we found that universal access to care is not the case if one is poor and homeless. We found that most respondents had had some contact with the health care system. For example, 66 per cent had seen a general practitioner in the past year. However, having used services is not equivalent to having received good care. A number of barriers were identified which prevented either receiving care at all, or which resulted in frustration or dissatisfaction with health care.

Almost seven per cent of our entire sample had been refused health care at some time because they did not have an Ontario Health Card. (This card demonstrates eligibility for Ontario provincial health insurance. All Ontario residents are entitled to it.) Most often this occurred in hospital emergency departments. This is not supposed to happen and is completely unacceptable.

One-quarter of all the people we interviewed had, in the past year, been given instructions by a health worker which they had been unable to follow because of their living circumstances. Examples include being prescribed bed rest but being unable to follow through because hostels close during the day, or being told to buy supplies (such as bandages, crutches, or over-the-counter medications) and being unable to afford them.

Other obstructive barriers were the incidents of attitudinal discrimination by health workers reported by over 40 per cent of all of the women and men we interviewed. These respondents cited at least one experience in which they had felt unhappy or frustrated with the kind of health care they had received or in which they had felt badly treated by a health care worker.

Most commonly specified were problems such as not having been taken seriously by a health worker, not having one's problem investigated thoroughly, and not being listened to by a health worker. Many respondents specifically related these problems to having been negatively judged by health care staff—because they did not have an address or a place of work to give to a receptionist, or because they may have looked dirty or dishevelled.

Significantly more women than men reported such episodes (50.9 per cent of women as compared to 36.7 per cent of men). This is no doubt partly related to the fact that more women than men had used the health care system in the past year. However, it is undoubtedly also related to the institutionalized sexism upon which the health care system is founded.

In terms of preventive care or routine health maintenance activities, we also found unequal access in our sample, coupled with a failure of mainstream health policymakers to prioritize this group of women and men. For example, almost two out of three respondents had not been offered a vaccination against influenza, despite the fact that this population is clearly vulnerable to such infections and qualifies under a number of the Canadian criteria for receiving this vaccine.

As well, our sample was almost twice as likely as the general Toronto population not to have received dental care in the past year. Most commonly-cited reasons for not having seen a dentist were economic barriers such as lacking dental benefits coverage or limitations on the coverage available. These figures will only worsen with the elimination of all dental services, except emergency care, to social assistance recipients in Toronto.

Another example of the difficulty of gaining access to even the most fundamental health maintenance supplies is that of obtaining or storing menstrual supplies. Many of the women we spoke to reported experiencing the following problems: 1) pads or tampons are unaffordable; 2) shelters only provide one or two at a time; 3) supplies are not available at shelters or drop-in centres; and 4) there is nowhere to store one's supplies. It is difficult for most people to imagine experiencing these problems on an ongoing basis, but these barriers are simply part of the lives of many street women.

Homelessness is a stark reminder of the inadequacies of our health and social service systems. Given the current climate of erosion of health and social service programmes, it is crucial that those most vulnerable be prioritized. *The Street Health Report* contains over 40 recommendations for change targeting ten different government bodies and institutions, including the Toronto Public Health Department, the Ontario Ministry of Health, and a number of inner city hospitals. Recommendations include, for example, that the Toronto Department of Public Health acknowledge violence as a public health issue and specifically recognize that the level of violence experienced by homeless women and men is unacceptably high, and that programming reflect a commitment to solutions. The report also urges Metropolitan Toronto Council to ensure the provision of training enabling hostel and drop-in centre staff to support survivors of adult and childhood physical and sexual violence.

The Street Health Report is our attempt to give voice to a group of women and men who are largely silenced and to begin documenting the substantial difficulties of trying to stay healthy when one is homeless. Very few of the recommendations require large economic expenditures. Many involve shifting priorities around poverty and changing attitudes towards people with low incomes. The authors of the report recognize that attitudinal change is not easy, but believe strongly that the impact of attitudinal barriers is as serious as those related to structural or systemic barriers. The changes required to ensure "health for all" are thoroughly possible, if there is the political will to accomplish them. In the words of one respondent we interviewed in a soup kitchen, "There should be universality of health care, regardless of who you are."

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