



Black Health Alliance

How Do Scarborough's Black Youth Access the Health Care System?

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Executive Summary

This document reports the findings from a study of black youths' access to primary health care services in Scarborough. The study examines the experiences of black youth living in low-income neighbourhoods in Scarborough because of growing concerns about the quality of life of youth of colour in marginalized neighbourhoods and the impact of inadequate health services in Toronto's inner-suburban region.

Our findings represent an exploratory first-step towards evaluating the health status of black youth in Toronto. Based on focus group discussions, several striking findings warn us to further examine the impact of violence and social exclusion on health-seeking behaviours of black youth, as well as current methods of outreach and health promotion.

Below are some of the findings:

- ❖ Black males were deeply cynical of the health care system—many may not have a regular primary health care provider.
- ❖ While females tended to have a regular provider more often, in both cases, walk-in clinics were the primary type of health service used.
- ❖ Walk-in clinics were criticized by youth because they offered little time to understand and question their health provider.
- ❖ Black males considered violence their sole health risk; consequently some do not use health care services. Males demonstrated poor knowledge of relevant health risks.
- ❖ Printed materials are largely ignored; some are poorly translated (i.e. Somali language translations).
- ❖ Males and females gather health information differently: males may learn health information 'passively', while females expressed an active interest in health concerns
- ❖ Health information and resources are not well publicized to youth; immigrant youth are especially uninformed

Based on these findings we suggest some areas in need of response. Firstly, community workers and health professionals are urged to promote regular health care in the black community. More can be done to ensure that all black youth have regular and suitable health information and services. Furthermore, person-to-person health promotion is needed to increase the 'visibility' of health issues of black youth. Our study also suggests the need for culturally-appropriate translations. Translations should be done by health professionals who understand the significance of the health information being translated. Furthermore, hospitals and other health care providers should recognize the need for hiring health care providers who reflect and understand the issues of their client community. The absence of East African health staff, may heighten the sense of isolation from health care among this segment of the black community. Another barrier in need of response is the lack of community-based health services in high-population communities, such as Malvern and Kingston-Galloway. Advocacy is needed to raise awareness in government about the inequity of health resources in Toronto. The results strongly suggest the need for a comprehensive examination of health status among the black population. Such a study would add specific details about health risks that could be highlighted in health promotion efforts.

Introduction

This study examines the health care access of Black youth in Scarborough, a suburban area of the City of Toronto with a large and fast growing Black population¹. The overall purpose is to better understand the conditions through which Black youth use the health care system, their health information networks, and the barriers they face when accessing health care. Addressing two unacceptable gaps in Canadian health research—the lack of information about the health access issues of Blacks and for youth—this report details the findings from five focus group discussions done with Black youth in three areas of Scarborough—Malvern, Teesdale/Crescent Town, and Kingston and Galloway.

The experiences of Black youth are examined because this group has not yet received attention in Canadian research; and this group is considered “at-risk” of poor health in population studies (CCMA, 2000; Issac, 1991). Currently, the health access of Black youth is not well-known, but there is evidence that Black people experience considerable challenges to their health because of the lack of culturally appropriate services, and a lack of attention to their specific health risks such as sickle cell anemia, diabetes, heart disease, breast and prostate cancer among health providers, and in the national policy (CCMA, 2000).

This gap is part of a wider problem of a missing agenda on the health conditions of ethnic groups in Canada (Canadian Center of Minority Affairs, 2000). Canadian governments have only recently turned their attention to specific health needs of Canadians, according to ethnic diversity (Health Canada, 2000). Although a small literature has developed in response to growing criticism for the lack of culturally appropriate services, and demonstrated health disparities experienced by immigrants (Raphael, 2000; Doyle and Livy, 1987), it has so far been unable to affect health policy of Canadian governments. This study contributes to the small literature on group health in Canada by examining a group with no previous representation in the health literature.

In this study, our interest is two-fold: we want to know what is the nature of access to health services for Black youth living Scarborough, and we want to examine the nature of barriers they may face that influence the quantity and quality of their health utilization. The findings of this study emphasize the need to sensitively understand the diversity of the Black community in Toronto. Scarborough is a place with a diverse community of Black people, and the diversity of Black youth must be placed in the foreground of health promotion and research in order to promote equitable access to health care. Through community-based focus group discussions, the present study reveals there are various ways in which Black youth acquire health information, make health use decisions and think about their health.

Literature review

Generally, the health status of Canadians is high, relative to other countries including the United States (Roos and Mustard, 1997). But recent attention has found evidence that certain groups (such as Native-Canadians, low income families, and immigrants) experience poorer health, less utilization of services, and fewer regular connections to

¹ In 2001, Scarborough had almost 60,000 Black resident, over 10 percent of the population (Statistics Canada, 2001). This was an increase of over 5% since the previous census in 1996.

health care providers than is evident in the health record of the country taken as a whole (Raphael, 2000). Unfortunately, the study of the health of low-income and immigrant groups has not moved beyond these wide categories. This has limited our understanding of how ethnicity, culture, “race”, age, and gender interact and influence poorer health conditions in these populations. But more importantly, this omission places health care providers at a disadvantage because they have less knowledge of their service populations. Specific health risks affecting certain populations may not be acknowledged appropriately by either health care providers or those at-risk. Health providers may lack knowledge of social, economic and cultural conditions that influence the quality and frequency of care for their clients; and strategies to confront barriers may be misplaced for the community’s health care needs because groups are being inappropriately generalized.

On the whole, few studies have focused on racial and ethnic health disparities in Canada, and there are presently no studies on Black youth and health. Consequently, this research draws on the larger U.S. literature as well as a range of material related, but not specific, to the subject area by Canadian researchers². The purpose of this review is to chart a course for future research on the subject of Black health in Canada and define the key concepts and framework used in the study.

‘Race’ and Health Disparities

Health disparity is a complex issue. Differences in health status, access and use of services are influenced by many social, economic, cultural, biological, environmental and behavioural factors. A person’s income, overall and medical literacy, social linkages, and trust in the health care system may affect how, when and why they use health care services. Understanding the interaction of these various identities and conditions is, therefore, essential to our understanding of health disparities and to establish an equitable health care system (Weinick, 2003).

A key problem of this focus of research, however, is that it is difficult, if not impossible, to distinguish the independent role of one’s access to health care information, income, time resources, as well as the biological fortunes of health and environment to their health (Weinick, 2003). Because health is determined through a variety of factors, there is disagreement concerning what factors are central and what factors are ‘epiphenomenal’ (Mayberry *et al.*, 2000). For example, in the U.S., where studies have considered the role of race (particularly disparities between African-Americans and Whites) some have argued that racial differences are really differences of socio-economic status, and therefore looking at racial differences is misplaced (Guendelan and Schwalbe, 1986). But this criticism does not acknowledge the importance of cultural differences and their role in diet, health visits, sense of health, and information networks; nor does it acknowledge real genetic differences in the population that affect the quality of treatments (Weinick, 2003).

Assessing racial differences in health is an important task. American studies have found that, despite controlling for socio-economic status, there are frequently racial differences

² While there are few studies on health access for Blacks in Canada, there are some studies on social services needs for racially and ethnically distinct groups in Canada (Doyle and Livy, 1987), racial disparities of quality of life in Canada (Darden, 2004), and variations in health use by income (Roos and Mustard, 1997) and immigrant groups (Blais and Maiga, 1999).

in health status, utilization and access among Americans (Mayberry *et al.*, 2000). African-American and Latino groups frequently have poorer health than other groups in their economic class. It is also important to note real bio-physical differences among the population have implications for the health of a specific group, such as sick cell anemia disease that affects 1 in 400 hundred Black children. In sum, there are several health conditions that affect African-Americans—as a group—at disproportionate rates. As noted vividly by Walker and Singleton (1999):

Race matters because African Americans are more likely than people of other races to die a premature death. There is an 8.5-year difference in the median survival rate between white and Black males and 5.9-year gap between white and Black females (Walker and Singleton, p.3).

However “racial” differences must be acknowledged as socially and politically constructed. Health disparities between Blacks and Whites in the U.S. are created by economic and social marginalization in segmented labour markets, it is created through the legacy of slavery and the impacts of racism on the Black family, it is articulated through distinctive cultural differences created in the social and spatial segregation of Blacks, and racialized assumptions of health practices. Although Canada has a much different history of racism and racial discrimination than experienced in the United States, we cannot assume that the Canadian experience does not create racial impacts in health. Furthermore, the growth of the Black population in Canada has largely occurred through immigration. Therefore, Black health in Canada may relate to the immigrant experience, and more precisely to the distinct process of racialization of Blacks' experience in Canada (Mensah, 2005).

Therefore, it is important to develop, and fairly distribute, measurable data about Black health in Canada that can be compared for changes over time. In the United States the availability of this resource has permitted clear signs that Black health status is getting worse relative to other groups (Walker and Singleton, 1999); furthermore, this information allows various stakeholders to develop health protocols and strategies to combat poor population health.

Health Disparities among Black Youth in Canada: A Missing Agenda?

In 2000, one of the first comprehensive studies on Black health in Canada was done. *Health Promotion and Population Outreach in the Black and Caribbean Canadian Community* was based on health issues found among Blacks in Nova Scotia and Ontario but was regarded as a break-through for addressing Black health issues in Canada. There had been earlier studies (Fraser, 1997; Issac, 1991; Doyle and Livy, 1987), but this study was the first federally-commissioned and geographically broad-based study of Black health in Canada. The study was comprehensive: it identified specific health issues of Blacks such as prostate cancer, hypertension, diabetes, and sickle-cell anemia, as well as systemic issues such as racism, barriers to health access, health status indicators and risk factors, access to health care, and certain over-riding issues such as women's health, men's health, research priorities, funding, cultural determinants, socio-economic status, and participation and capacity building.

Because of the lack of previous studies on the subject in Canada, *Health Promotion and Population Outreach* drew information from various studies. Studies on cultural and ethnic conditions of addiction, cultural awareness issues within health management and

services, and barriers for disabled minorities were used to formulate a set of future research objectives. It found that “access to adequate care and good health and health promotion, and the existing chronic poor health of many in the Black and Caribbean community is very directly a function of socio-economic status and levels of literacy” (CCMA, p.17). It went on to argue:

Optimum health is shaped by cultural imperatives that influence the individual’s interface with the health care system (how and if the person approaches health practitioners, their attitudes to the formal health care system, their ongoing follow-up to medical advice, their care of family members, and the health care system’s understanding of the particular health issues, concerns, socio-economic status, literacy—both actual and medical, and cultural beliefs and attitudes, the health care system’s ability to deliver appropriate care in appropriate language, and racism in allocation of funding for research and in service delivery and design (CCMA, p.17).

In conclusion, the report expressed that health care for the Black and Caribbean community in Canada is very much affected by systemic racism across the sector; that there are very specific health issues for women, as well as for men, and that these relate not only to specific diseases, but to culturally imposed attitudes and behaviours that affect good health. It reported that health determinants are very much amplified by the stress faced by the individual, both in terms of the physical and mental violence they experience in the family and from racism in society. The report stressed that no approach to improved health care for the Black and Caribbean population in Canada can be effective without approaching it in a holistic manner that integrates all these factors, underlined by a commitment to social justice (CCMA, 2000).

Criticizing the lack of Canadian research, CCMA called for research on the specific health determinants, health status, and cultural competency issues affecting Black health (CCMA, 2000). More research was recommended on the physical and community-specific conditions of the Black and Caribbean Canadian community, and it advocated for several improvements to health policy such as a cohesive policy approach to the health needs of this community, as well as capacity development of the sector to deliver culturally appropriate services and the community to develop partnerships with health care providers and researchers. Appealing to government, the report asserted the responsibility of governments to provide assistance to organizations undertaking local, regional, and national projects towards the improvement of Black health in Canada.

But much of its recommendation that research be done to assess the Black populations’ health status has been restricted by the lack of data on race and health in the Canadian context. Therefore, studies have been bound to primary data collection, and have been, as a consequence, few and far between because of the financial costs. Furthermore, because of the costs and difficulties of producing random samples, the research on Black health in Canada has yet to produce a generalizable account of health status, utilization or access.

Areas of Health Disparity Research

Three main areas of focus are defined in the literature on health disparity. Studies distinguish between differences in health status, health utilization, and health access.

Health status is the level of health of the individual, group or population as subjectively assessed by the individual, or through more objective measures (Mayberry *et al.*, 2000). Health status, especially between groups, is studied to highlight differences that may offer insight into causes of health inequality.

Health utilization is defined according to “a number of characteristics, including the volume of services used, the site of utilization and the type of services” (Blais and Maiga, p.1238). Health utilization disparities are studied to assess differences in the rate and nature of health care usage among groups (Blais and Maiga, 1999). Once again, use can be self-assessed, but according to Weinick (2003), where the data permits, it is best to use health records to ensure accuracy and commensurability. Table 1 indicates Health Canada’s figures on health service use in Canada with reported difficulties accessing services.

Table 1: Access to Selected Health Care Services, 2001, Health Canada

Type of service	Accessed services	Reported difficulty
Routine visits	91.2	11.1
Health information or advice	45.7	13.1
Immediate care for a minor health problem	33.9	18.8
At least one of these above first contact services	93.7	18.4

Compared with the United States, a very high percentage of Canadians make regular health care visits, with a sizable proportion also using informational resources and immediate care services (Blais and Maiga, 1999). Generally, Canadians report the most difficulty accessing immediate care services, and this is confirmed by the recent public discourse regarding the problem of long wait times at emergency services.

Health access refers to material and perceptual factors of health care use, in addition to health care use (Seils and Schulman, 2004). This area is studied to assess and understand how the many behavioural, social, economic, cultural, biological, and environmental factors interact to influence individual and group abilities to attain health care (Mayberry *et al.*, 2000). Mayberry *et al.* (2000) reviewing the U.S. literature, note that the interaction of these factors on health status are “poorly understood for the general population and even less so for minorities” (Mayberry *et al.*, p.109).

Some have asserted that factors affecting health disparities can be grouped into two broad categories, ‘material’ factors, such as health care coverage, social economic status, literacy levels, travel times and locational conditions, and the language and cultural knowledge of service providers, and ‘perceptual’ factors, such as social norms, values and attitudes to health. These categories are useful for acknowledging the depth of conditions that affect one’s access to health, but it abstracts from the depth of inter-relationship among social and physical factors.

In terms of health care access, material factors include the roles of, and interrelationships between income, time and information resources, services locations, literacy levels of clients, language diversity and the use of medical jargon, as well as biologically and socially determined risks. Access to services also involves ‘perceptual’

cultural and psychological values and attitudes. Cultural and social values influence how people perceive the health care system, health risks, and their own health status. Furthermore, people's relationships with the health care system (i.e. frequency of use, and levels of trust and engagement) relate to their personal experiences as well as socially transferred knowledge.

Each of these three areas, health status, health utilization and health access, are related in complex ways, but it is a reasonable assumption that a person's health status—one's actual or perceived health condition, is determined to some degree by their access and use of the health care system. However, as asserted in the conference summary from CCMA, it is not certain that more access equates with better health status—the quality of this access is fundamental to its importance. This makes the study of health care accessibility critical to our understanding of health and, therefore, the development of good health policy.

Health Care Access

In the United States, income and literacy have been the dominant issues examined in racial disparities among youth. Income is highlighted because health care in the U.S. is not guaranteed to citizens; rather, health insurance is granted to some workers, and to some degree those on social assistance. Despite the frequent finding that income affects access according to its role in health insurance coverage, even where studies are controlled for health insurance, incomes are found to be important because of its impact on key factors of access, such as transportation, time, information, and educational levels. Literacy (or the inadequate literacy) is considered a barrier because both deficiencies of 'actual' and medical literacy can exclude people from knowing relevant health matters, and their own health condition. Furthermore, insufficient literacy can create feelings of distance and mistrust between health workers and clients. Finally, this literature calls for increased education for both youth and health workers to 'bridge the gap' by increasing the 'actual' and medical literacy level of youth, while recommending health workers find new ways to communicate health matters. The point is to both *popularize health language, while increasing the use of popular language in health.*

One of the key issues about health access disparities is that they occur in the local context. Although racial disparities in health are found at the national level (in the U.S.), they vary according to state and city scales of investigation (Waidman and Rajan, 2000; Fisher *et al.*, 1994). The reasons given suggest the importance of place in the attainment of health services. For example, Seils and Schulman (2004) concluded that "efforts to eliminate disparities in access to quality healthcare may need to be tailored to the specific needs" of the area (p.351). Moreover, they suggested that "strategies for one racial or ethnic group in one location will not necessarily be successful for other racial and ethnic groups in other location...experiences with, and demands on the healthcare system also vary" (Seils and Schulman, p.351).

Although the health care disparity literature is characteristically interested in differences, there is growing attention paid to a *normative* rather than *comparative* assessment of health access (Mayberry *et al.*, 2000). A normative approach compares the quality of health access to an ideal or acceptable norm. Generally, health care access is held up to expectations of equity; for example, fair and accessible health care is said to be: "care that recognizes and responds to health-related beliefs and cultural values, disease incidence and prevalence and treatment efficacy" of the whole population (CCMA, p.4).

This means health care that does not ostracize, exclude or estrange users because of their identities. Increasingly discussions about equitable access have underlined the concept of cultural competency. Cultural competency refers to an understanding and commitment to the cultural views of health held by health care seekers: recognizing the diversity of values people have, health care providers are better equipped to engage and serve their clients.

Research Framework

The nature of a person's health information, income, social networks, as well as their 'chance' biological traits affects their quality of health. But where and when groups of individuals experience recognizable differences in their health compared to others, it must be acknowledge that they are experiencing a common determinant affecting their health.

For Black youth in Canada, disparities in health status are experienced two-fold. On the one hand, Black youth are over-represented in poor families and poor neighbourhoods, and low-incomes are one of the strong determinants of poor health acknowledged in the literature (United Way, 2004; Roos and Mustard, 1997); and, secondly, Black youth have distinctive health concerns (such as sickle cell anemia), cultural conditions of their health utilization, and the experience of racism, which is gaining exposure as a determinant of health (CCMA, 2000). Over-arching these broad issues however are the personal and social factors that make-up Black youths' experiences of health access, such as their time resources, past experiences, the type of services they are forced to used, and their continuously developing perceptions of health and health care.

Health status is strongly tied to health access, utilization and lifestyle (Mayberry *et al.*, 2000). So in this study, we observe the stories of youth about why and how they use health services. Our aim is to gain a better understanding of the factors that may influence their health. Using knowledge of social determinants of health derived from the large U.S. literature, and recent efforts in Canada, we pose questions that speak to several factors of health access. These include: knowledge of the health care system and information networks; the role of parents, educators, and health care providers; travel times and the influence of distance; the influence of the type of health care service used; initiators of health care needs and use factors; and issues of language, literacy, and cultural competency.

Methodology

The literature review reveals that in the few Canadian studies on the issue of Black health, the issues of language ability, culturally appropriate services, and access to health information are cited as key factors of health care access (CCMA, 2000; Raphael, 2000; Doyle and Livy, 1987). In contrast to the U.S., where poverty impacts health access through exclusionary forms of health insurance, and stark contrasts in the many tiers of the health care system (Bulatao and Anderson, 2004), in Canada disparities relate to poverty through disparate information and less frequent visits based on barriers such as time and travel resources (Roos and Mustard, 1997). In Canada, it is also apparent that individual choices and group choices—related to cultural values, and perceptions and experiences of discrimination—affect how and when people use health services.

Much of the preceding work on the subject of health access has used qualitative methods for good reason. Qualitative approaches allow rich information to emerge that not only “explain” social conditions, but also allow the researcher to “understand” phenomena (Curtis *et al*, 2000). Increasingly qualitative approaches are being recognized for their usefulness in health research; and the focus group method has had a leading role. The participatory nature of focus groups is seen as a powerful tool for exploring health behaviours, barriers to access, and other complex forms of health practice, while developing community capacity about health issues. Therefore, this method complements generalizable reports on health status by offering insight into reasons for health disparities (Curtis *et al*, 2000).

Focus groups are useful in exploratory research because they allow for relatively free interaction among participants that may enrich discussion and lead the research into “uncharted” territories (Krueger and Casey, 2000). By encouraging discussions around broad themes, and sometimes very specific issues, focus groups may elicit unexpected responses and lead to new questions posed by participants (Krueger and Casey, 2000). Unfortunately the strengths of focus groups may be their weaknesses as well. In focus groups, there is always a risk that the conversation will lead outside the research question and produce information not immediately useful (Krueger and Casey, 2000). Focus groups ideally create an atmosphere that allows free discussion and friendly disagreements to emerge. . To avoid this possibility, considerable effort should be made to put everyone at groups can be challenging and, therefore, they require a sensitive understanding of how emergent responses relate to the research question. Also, focus groups may encourage consensus rather than the expression of diverse opinions (Krueger and Casey, 2000)³.

Focus Groups

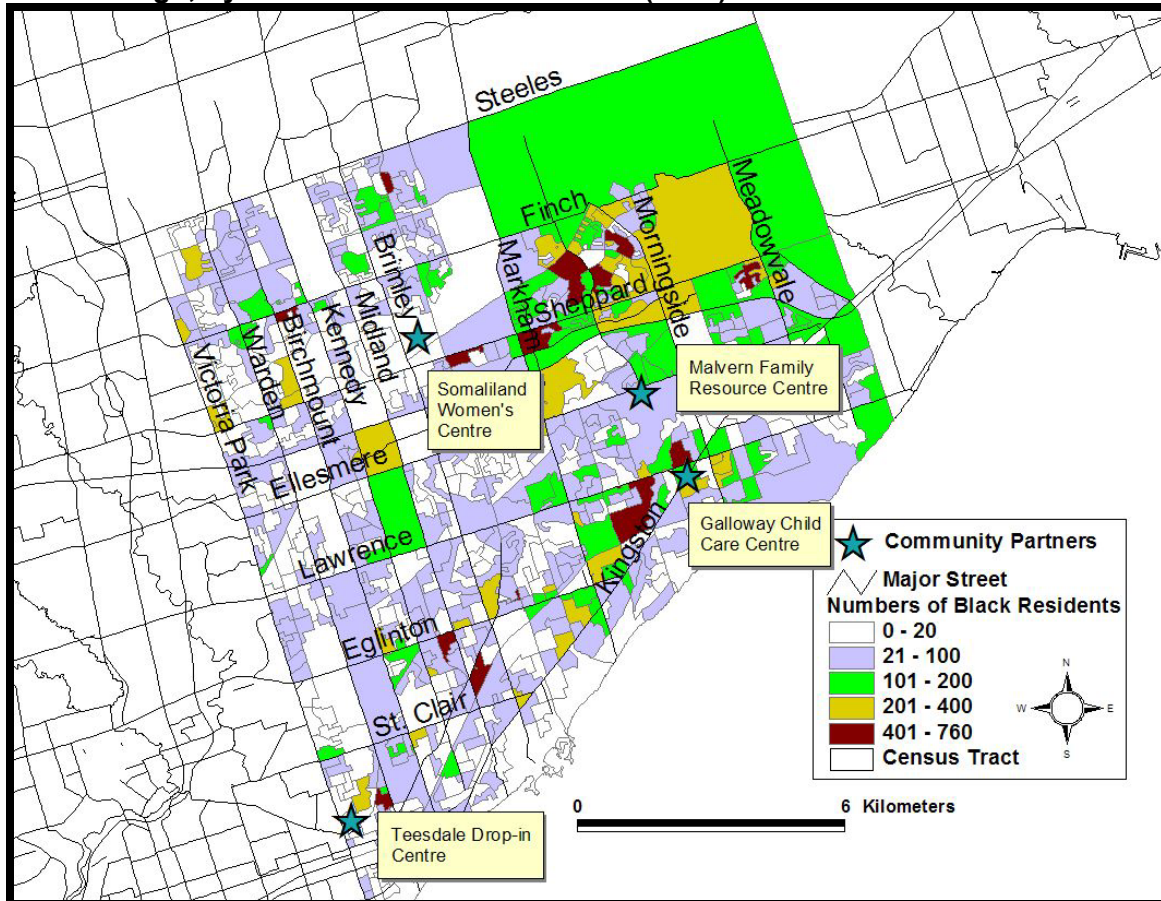
In this study, focus groups are the main instrument used to examine the access issues of Black youth. In the research process, youth were encouraged to offer their own questions and bring up their own experiences and perceptions of the health care system, in general, and accessibility more specifically. Therefore, answers include a variety of perspectives. The focus group method was also chosen because of our efforts to encourage group discussion of health issues in the Black community, share useful information and introduce the Black Health Alliance to young members of the community. In short, the focus groups were meant as a learning experience for all involved—rather than strictly for gathering data according to the research topic.

Because of the literature’s recognition that health access is a complex social and personal issue, with effects found in cultural diversity, we aimed to explore the diversity *within* the Black youth group. With limited resources we set an agenda with the purpose to include Black youth living in so-called “at-risk” communities of Scarborough. This choice was made because of our awareness of the disparities and inequalities

³ Another possible remedy to this problem is for the moderator to pose alternative responses as the discussion develops. This may signal acceptance for alternative views and help to identify the reasons behind views expressed in the discussion. Although it is still debated whether the moderator should take an active role in the discussion because of their power and influence in the discussion, participatory and feminist theorists argue convincingly that there are no ‘objective’ positions in social research, and therefore the research should represent their values in the work.

experienced by Blacks in Toronto's low-income communities (for example, Jane-Finch, Regent Park). Furthermore, recognizing the frequent omission of Scarborough neighbourhoods from discussions about social inequity, and no previous attention in health research, we set out to include neighbourhoods in Scarborough with large concentrations of Blacks (Figure 1).

Figure 1: Map of Community Partners and the Locations of Black Residents in Scarborough, by Census Dissemination Area (2001)



Source: Census of Canada, 2001 Profile Data

Using the literature and the first-hand knowledge of health matters within the Black Health Alliance's network of health workers, activists and researchers, we added to our agenda, concern for the health access of young parents, recent immigrants and refugees, and specific ethnic groups in the Black youth population; as well as attention to gender differences.

Exploration of the situation of young parents was determined because of the large number of teenaged parents in the Black community; this led to our questions and concerns about the reproduction of health care behaviours as well as material barriers to health care related to daycare, time resources, poverty, and social supports. The large and growing communities of recent immigrants in Scarborough, many of whom are entering Canada as refugees with even fewer resources than non-refugee immigrants, determined our interest in the experiences of recent immigrants and refugees. Furthermore, the fact that immigrants are increasingly coming from non-English-

speaking countries, with significantly different cultural practices, values, and health experiences calls for a major re-assessment of community health needs (see Doyle and Livy, 1987).

With this broad agenda, the focus groups were not wholly pre-specified; instead selection was sequential and emergent—the themes of focus groups developed with the research process, especially as we partnered with community agencies. In the end, five focus groups were held with: (1) an all-male group living in the Malvern community; (2) an all-female group living in Malvern; (3) young parents, many of them living in the Kingston-Galloway community; (4) a multi-ethnic group of recent immigrants and refugees, many of them living in the Teesdale community (Victoria Park and Danforth); an a focus group with Somali-born females, coming from various locations in Scarborough.

The Sample

This research is not based on a representative sample, but on *purposive* or *theoretical sampling* criteria⁴. Sample selection was conceptually driven, by both the theoretical framework, which underpins the research question, and through the emerging findings, which were derived as the research proceeded. Participants were recruited with the help of community-based agencies in Scarborough. This was done, initially, by making contact with executive directors of a number of agencies, either located in areas with large number of Black residents, or with organizational mandates associated with sub-groups of the Black youth population. In the end, four agencies offered their space as meeting places for the focus groups. They were the Malvern Family Resource Centre, Somaliland Women's Organization of Toronto, Teesdale Drop-in Centre, and Galloway Child Care Centre. Below is a list of the focus group samples as well as the community agencies that enabled recruitment.

Table 2: Focus Group Participants

Focus Group	Community Partner	Number of Participants	Gender Composition	Median Age
All Male	Malvern Family Resource Centre	10	All male	17
All Female	Malvern Family Resource Centre	7	All female	17
Recent immigrants	Teesdale Drop-in Centre	7	3 males, 4 females	18
Young Parents	Galloway Child Care Centre	8	7 females, 1 male	18
Somali youth	Somaliland Women's Organization	8	All female	18

⁴ According to this approach, samples are small, but drawn with a purpose or key informant insights; they “are studied intensively, and each one typically generates a large amount of information”. The samples were designed, “to make possible *analytic* generalizations (applied to wider theory on the basis of how selected cases ‘fit’ with general constructs), but not *statistical* generalizations (applied to wider populations on the basis of representative statistical samples)” (Curtis *et al.*, p.1002).

A Description of the Research Process

The research process for this study was approved by York University's ethics protocol. All participants were made aware of their ethical right to withdraw from the survey at any time before, during or after the focus group, as well as the risks of the survey—which, for this study, is negligible. All participation was done anonymously and everyone was made aware that the discussion would be recorded. At no time during the process did anyone object to the nature of questions, or remove them-self from the discussion.

On average, the meetings lasted approximately one hour, and included several different activities. Each meeting began with a brief group introduction, and explanation of the research purpose. Then the ethics statement was made, and any questions about the nature of the study, the qualifications of the researcher, and the mandate of the Black Health Alliance were answered.

Following their consent, a discussion began about their knowledge of health risks. In order to gauge the awareness of the participants about health risks, and to ultimately share information, three questions were asked about health risks: (1) What are the health risks for Black males? (2) What are the health risks of Black females? And (3) what are the health risks for Black youth?

With these questions and concepts introduced, it was easier to engage participants about more standard health access questions⁵, such as: What experiences have you had using, or trying to access, health care services? How do you get health (and health care) information? Is it difficult to make health appointments? Is it difficult to travel to health services? How are your parents involved in your health matters? How can the health care system become better? How do you feel in the presence of medical providers? Do you ever feel intimidated by health care providers? These questions, generally, engaged a good level of response: but it was apparent as the research progressed that males—generally—were not as communicative as females. Males also showed less concern for the issues, and a few were occasionally disruptive⁶.

As the research progressed, some themes emerged that were examined through specific questions. We became increasingly interested in the role of parents, and consequently, asked questions about their role in the 'control' of young people's health cards. Another emergent question was regarding their family and associative connections to the health work sector. With knowledge of the high proportion of health care workers with Afro-Caribbean backgrounds, we wished to question the hypothesis that potential networks of health information capacity-building were not be used to their fullest potential, specifically in the Afro-Caribbean community.

In addition, questions were asked about their trust in the health care system; use of emergency services; routine visits to health services; and their opinions about the identities and qualifications of health providers. Using a semi-unstructured framework, questions were asked as new ideas emerged in the meeting environment; a checklist was followed to ensure all the research questions were examined. Each discussion ended with an open period where participants were given time to question the "moderator". An honorarium of \$20 was paid to each participant for his or her time and effort in the study. Below I detail the observations of each of the focus groups.

Findings

Focus group 1: Male youth in Malvern

A lasting image of the responses by male youth living in the Malvern area occurred with the end of the focus group meeting. One of the participants, a fifteen-year old, mentioned to me as I was leaving that he did not think the issue of health mattered because ‘the “real” risks were from gun violence’. His comments, which were made with an assured tone, echoed several comments made earlier and underlined a possible source of the apathy found in their treatment of health issues by his peers during the discussion.

Preliminary questions about health risks in the Black population initiated what would be the recurring identification of violence as the primary health risk for Black males. In addition to violence, the participants noted “crack cocaine” and AIDS (and other sexually transmitted infections) as life-threatening health risks. Only one participant identified other health risks. He noted diabetes and cancer, and mentioned stress (identified as a health condition). Despite their lack of knowledge about the breadth of health risks affecting their community, when I began to list various health risks they did not mention, there was not great interest. In fact, one participant seemed to perceive these risks as “jokes” and not worth attention. Overall, I was left with the sense that they were fatalistic; an attitude perhaps drawn out of their sense of powerlessness. This may be concluded in the words of one 15 year-old participant who said matter-of-factly: “we [Black males] are born to die”.

Almost all of the participants had a regular family doctor, some did not; nevertheless, several mentioned that they had not been to a physician in over a year. One participant stated, almost with pride: “I can’t remember the last time I went to a doctor”. While the majority had a regular primary care provider, they also occasionally used emergency services for immediate health concerns.

They travelled various distances to their health services, usually outside of their neighbourhood. Consequently, they were dissatisfied with the number of services in their neighbourhood, and when one participant mentioned that Malvern “should have its own hospital”, others agreed. Despite their unhappiness with the lack of services nearby, some of the respondents did not feel this to be a major barrier. For example, one respondent who traveled to his family doctor’s office, on Eglinton West, explained that his mother wanted him to maintain this service because of his long history with the physician; and that he also thought it was a good idea because his doctor knew his “file”.

Experiences offered by this group were mainly regarding slow service; but they offered other reasons for their distrust in the health care system as well⁸. One respondent mentioned the long wait-times for using emergency services, and suggested that this was the result of doctor’s disregard for patient well-being. Another reported that he did not trust the health care system because “doctors mistreat their patients”. Generally, their opinions regarding the quality of health care centered on the expectations of unfair treatment based on racism. Other sources of mistrust included one respondent’s remark that he did not always answer his doctor’s questions honestly, because “his was too nosey”. For some of the respondents, the “racial” identity of their doctor was a key issue that mattered to their access. For example, one respondent preferred a “Chinese

doctor” rather than any other doctor; and his least preferred being a white person⁵. There was some consensus around this statement, but one respondent disagreed strongly saying that each doctor was different and therefore one could not assume who is racist by what they look like.

Language was a key issues brought up in this discussion. The participants criticized doctors who did not speak “good English” by suggesting that they would therefore receive poor quality service, and mistakes could be made. Also, they criticized doctors for using medical language that they did not understand, and making the process too difficult. Yet, when asked if they felt intimidated by their health care provider, most remarked that they did not.

Parents played a mixed role in the health access of the respondents. On the one hand, parents held their health cards, and for some, scheduled their health appointments, and, on the other hand, parents infrequently discussed their health issues with them. Furthermore, it was suggested sexual health was a touchy issue that they avoided talking about with their parents⁶. Most of the participants, for example, acquired their health information from their physical education teacher, or through the Internet; later they admitted that schools offered insufficient health resources, and perhaps this explains their lack of knowledge of health risks and apathetic health behaviours. They offered, upon questioning, that health care could be improved if there were better services in schools and in their community.

Focus group 2: Female youth in Malvern

The female discussion, occurring in the same neighbourhood and community space as the male focus group, offered starkly different insights. The female participants, generally, showed a rich understanding of their health risks, and identified risks affecting Black males as well, such as prostate cancer. They visited physicians more regularly, and held them in greater trust. In short, the health awareness of the female participants who, incidentally, were primarily of Afro-Caribbean heritage, translated well into routine health visits, attention to health information, and the recognition of health as a relevant youth issue. However, the female group also traveled outside their home communities for health services, and voiced dissatisfaction with the services available locally. They did not feel that the ‘racial’ or ethnic identity of their health care provider was a critical issue; but they did cite that talking to a male physician about certain health issues was awkward, and some of the discussants admitted holding back information or concerns because of social uneasiness with their doctors. Overall, they expressed preference for a female physician (for primary care), and some desired a person from their background.

Like the male group, they found the health care system to be exclusionary; particularly because of the divides created by medical language and culture. Also like their male counterparts, they did not acquire much health information directly from their parents, or other family member despite the fact that several of them had health care workers in their family¹¹; instead receiving much of their information from television programming

⁵ His reasoning was that Chinese doctors exercise traditional knowledge that was better than Western medicine; and secondly, that white doctors could not be trusted because, in his estimation, they were racist against Blacks.

⁶ In the words of one participant, “I don’t talk about those things with my mom!” To which others laughed and showed agreement.

and books; the latter of which they shared with their friends.

A striking issue brought up by the group, and one that received much affirmation in their responses, was regarding their parents' treatment of pregnancy and sexuality. They, generally, asserted that their parents would scold them to not "bring home a baby"; but only a few of them noted that their parents went beyond this advice by discussing sexual issues more openly. Unlike the males, who seem to have ignored the neglect of sexual health advice from their parents, the females sought health information in response to their families' silence on the subject.

While the general narrative of the discussion was that their concern for appropriate health information led them to initiate their own resources for their health care, there were comments that criticized the nature of the health care system. For example, one respondent felt that many of procedures followed in check-ups did not take into account ethnic or racial differences. In addition she felt that available health information in libraries, and through her doctor's office, did not match her lifestyle or likely risks.

Focus group 3: Young parents in Kingston-Galloway

Focusing on a group of young parents, who use a subsidized childcare service in the Kingston and Galloway community, brought to the foreground the interplay of various factors that bar one's health access. The group of mostly female respondents had several comments to make about how their health has been affected by their parenthood, as well as insights into the challenges they experienced visiting doctors, and getting good health information.

All of the respondents had a regular 'family doctor', but the use of this service was barred by factors such as distance and travel, time resources, and social disruptions. Each of the participants noted that getting to the doctors, or traveling in general, was difficult: Either they had to bring their child, which presented challenges, such as using transit, and especially in the winter, or they had to use the daycare which was costly because "it added up". Besides these costs, respondents cited the expensive cost of medicine for children, as well as for themselves. Their concern for the well-being of their children, gave them more incentive to learn health information, and on the whole, they were well-informed. That said, much of this knowledge was developed by their own assertion and search for reading materials that described medical issues of child birth and natal care. Some of the respondents suggested that the "government did not give them" information.

Although two of the respondents were no longer in school, the rest were. One of those in school suggested that the health education in school should be improved by including health as a course. She suggested further that this would give people an opportunity to "find work in the health profession", or at least, improve people "consciousness". Criticizing the current state of health services in schools, one said: "There's a health nurse at my school but she's never there", followed by the assertion that the presence of a health provider "once a week is not enough". Another agreed by saying: "In my whole school I have never seen the nurse once, they are never there". It was also mentioned that there is only room for one person to be sick at once, because of the lack of space for people who are sick.

Parents were an important source of health information, and social supports. In each case, a continuing dependence on parents for financial and moral supports showed the

vulnerability of young parents, especially on account of the financial and time-resource costs of parenting. Finding time to do school work, and finding employment were compromised by their responsibilities. It was suggested that parents provided a 'safety valve' to relieve the pressures of parenting. At the same time, however, many of the respondents held their own health cards, made their own health appointment, and sought their own information.

Personal details about their spousal relationships were raised by the discussants but never probed in the research. However, it was apparent in tone and comment that stress arose from difficulties in their personal relationships. For example, one respondent noted that her child's father was in-and-out of their lives and that during the pregnancy he created a lot of stress and "drama". Studies support the claim that experiences of social disruption, because of financial and personal stress, have numerous implications on the health of the pregnant mothers (in terms of mental health, diet, and body image), as well as for the unborn and newborn child.

Focus group 4: Recent immigrants and refugee youth

One of the first agencies approached by the researcher was the Teesdale Drop-in Centre, a satellite site of Warden Woods Community Centre. The Teesdale community located in the Victoria Park and Danforth area is a diverse neighbourhood with a variety of different immigrant groups, including large numbers of African and Caribbean youth. The focus group sample was selected through outreach in the community by approaching youth in the area and describing the project. The focus group consisted of seven participants, three of West Indian origin (two Guyanese, and one Jamaican), three born in Eritrea, and one person of Ethiopian origin.

According to government definition, a recent immigrant is a person who has arrived in Canada in the last 3 years. But there is criticism of this bureaucratic category, and it is now suggested that the adjustment of immigrants to Canadian society lasts well beyond the first three years. The respondents had been in Canada no longer than six years. The majority of them entered the country through family sponsorship, but the Eritrean respondents were refugees.

The lasting impression of the discussion with the group was that immigrant youth may have difficulty finding a family doctor because they do not have the appropriate information about the health care system. The health care system was reported to be a 'maze-like' obstacle that was not well introduced to newcomers. A suggestion was supported that 'real people' should promote health services, since printed materials are easily ignored or may be poorly circulated.

The issue of 'real people providing services' was highlighted regarding their experiences at health services as well. They felt that the experience at walk-ins was too mechanistic: one said, for example, "I think [doctors] tell everyone the same thing". When this response was probed, he offered a statement of distrust concerning the medical prescriptions of health care providers. In his words: "the medicine is not good" because it is given to "everyone" despite their different medical needs⁷. Other respondents agreed with someone's claim that the medicine and health care system in Canada offered few cures for illnesses but many 'quick fixes' that did not necessarily improve the long-term

⁷ Although a specific medicine was not identified, he might have been speaking about penicillin.

health of patients. Another important perception was that death in Canada was likely from several diseases that could be prevented using other forms of health care (proper diets, exercise and non-western medical approaches). A female Jamaican-born respondent suggested that (Bio-medically-trained) doctors “kill you”; and that using herbal medicine and maintaining a good diet (“with lots of fish and vegetables”) would “save your life”.

Use of English was not seen as a major barrier, even for the Ethiopian/Eritrea respondents, but the use of medical language, without good explanation was identified as a barrier. The interview left the impression that the ‘secrecy’ through which medical information was discussed by doctors contributed to the respondents distrust of the medical advice and prescriptions offered by their doctors. Another factor, though, was their lack of regular relationships with doctors. Only one of the respondents had a primary health care provider.

Parents had a mixed role in the health practices of the group. Most of the respondents did not keep their own health card, or make their own appointments; but almost all of them were “told to visit the doctor” on occasion by their parents, and then they usually did. Travel was not considered a major barrier but one person did suggest that the cost of travel, in addition to the cost of medicine, made his visits to the doctors another economic burden he had to recover from. Others in the group shared this last sentiment and observed “drugs cost too much”. They did not voice concern about the quality of health information in schools, but mentioned that they did not get much out of it. Instead, health information was derived from their social relationships, where informal discussions about health contributed to their views of health and well-being. Although it is difficult to assess the repercussions of this avoidance of “official” knowledge sources, their identification of health risks affecting Blacks was mixed. The group identified diabetes and heart disease, as well as cancers (one male Eritrean respondent identified colon cancer as the result of “fast foods”); but failed to note sickle cell anemia, strokes or mental health concerns.

Focus group 5: Female Somalian youth

Early on, the research team decided that the specific case of a particular ethnic group should be highlighted. Because of the demographic predominance of Caribbean-background youth in Malvern, where the first focus groups were held, we thought it would be important to focus on a non-Caribbean group that is rapidly growing in Scarborough. With our growing ties in the community, an opportunity arose with the Somaliland Women’s Organization—an Ethno-specific agency located in the McCowan and Sheppard area.

The majority of the discussants lived in the Victoria Park and Finch area, but some came from other parts of Scarborough⁸. Suggesting the impact of the devastating civil war experienced in Somalia, arising out of Italian, British, French and Ethiopian imperial interventions, two of the participants were born outside of Somalia, in surrounding

⁸ Although it is often observed that many Somali immigrants have settled in Etobicoke, people who identify with Somaliland, the northern region of Somalia often live in eastern parts of the city. Therefore, more than representing Somalis, the focus group highlights the voices of a specific part of the Somalian immigrant community—another basis for the study’s call for greater understanding of cultural diversity in the Black community.

states, Italy and Saudi Arabia. The remaining participants were born in Somalia, but sought refuge in Canada as a result of the political crisis in Somalia.

The participants demonstrated good knowledge of health risks affecting Blacks, in general, and suggested Somali adults were at high risk of diabetes and heart disease. For youth, diabetes was cited as problem affecting both Black males and females. No risks were identified for Somali youth, specifically.

Several problems with the health care system were cited in the conversation. Many of the participants did not have a primary health provider, and one of the participants asserted this put them at a disadvantage because their health interactions were contingent and usually occurred without the important context of previous medical history. One respondent, using a walk-in clinic, had been misdiagnosed in the past; another had visited a walk-in clinic intensively for a week because of a mysterious ailment that was never identified by the physician.

As a result of their experiences with walk-in clinics—the slow wait times and alleged ineffectiveness—one respondent concluded that youth were “on their own” when it came to their health. Furthermore, all of the walk-in clinic users attested to avoiding health services for ‘minor’ health concerns, some suggesting that even if they were experiencing an “new” illness with symptoms not experienced in the past, they would “wait it out” or “sleep it off”, or “let it go on its own”; one respondent, in contrast, would immediately seek health services, or use the health information line. This sort of avoidance was also reported about the use of emergency services, where it was suggested the level of disorganization, and long wait times were major disincentives to its use. Travel times, however, were not considered a major barrier.

The respondents, like previous discussants, felt some intimidation when communicating their health concerns and interests with their health providers. In the words of one youth: “‘half the time’ I don’t know what they are talking [about]”. Another agreed saying: “I just sit there and nod my head, whatever medicine they give me I say: ‘yeah twice a day’ and just take it”. Even more telling, youth responded: “They don’t really explain anything at all, they just say ‘take this medicine, okay?, here you go’”. Furthermore, they noted that health care providers did not give them enough time to talk about their health, and therefore neglected their interest to learn more about their health concerns. Interestingly, the only disagreement with these assessment was from a person with a family doctor, who suggested that her doctor had good knowledge of her, through her routine visits, and therefore offered insights into her health questions.

Although the doctor-patient privilege was known to all of the respondents, they expressed concern about their personal health information getting back to their parents. They were apprehensive about having health care providers from their background because of the tight social ties in their community. That said, they all observed the need for greater health awareness in their community, citing that young Somali males neglected their health concerns, and that Somali patients in hospitals experienced some level of loneliness as a result of their linguistic absence in the health care profession.

Several of the respondents used health line information services, or the Internet to get their health information; one respondent found her health information from the library. Their health knowledge was frequently discussed in their friendships, but family members rarely discussed health issues, and they felt the schools did a poor job of

health education.

They offered compelling ideas about how to make health care services better and more accessible to their community. One suggestion was for a community-based health organization, such as the Black Health Alliance, to produce an information site on the Internet that would allow interaction by posting comments and experiences⁹. Another suggestion was to increase the number or frequency of school nurse presence: currently they considered this service infrequent and difficult to access—in fact they considered this service “a joke”. Following up on prior knowledge about the inappropriate types of translation occurring with English to Somali translations, there was immediate consensus that the problem with the translations was that “they tried to find Somali words that fit, but it doesn’t always work”.

Discussion

The findings from the group discussions present several insights. There were several differences among the groups that suggest the diversity of views, values, and situations of Black youth. Gathering together a variety of perspective within and between focus groups, there was a large amount of data collected. In order to analyze what were often mixed results a theme-based approach was taken. The data was analyzed both according to the question-response dynamics of the meetings as well as for the broad issues and concerns raised by the participants. Therefore, responses were thought of in the context of their individual discussions, with consideration of their meaning for group health. In the following discussion, I compare the focus group outcomes, and attempt to map patterns and prevailing issues that contribute to the health experiences of Black youth. The study finds gender and ethnic identities to be important factors that shape the health access. In addition, there are strong indications that structural and social characteristics of health care, family structure/values, and economic and time resources are influential.

Gender differences regarding Black youths’ health access are the most obvious factor revealed in the study. Males demonstrated less understanding of their own or general health risks affecting the community. Furthermore, their informational networks were confined to the health information they received in school. Compared with the more “active” role females took to learn health information, it could be said that the males were “passive” regarding their health knowledge. That said, males—despite their overall lack of enthusiasm about health issues—identified some important risks, and recognized that the short and infrequent health information offered in the classroom was inadequate. Overall, it was troubling to see some males’ attitudes to health, which included apathy, a lack of seriousness, and a sense of hopelessness.

Males in the study were less likely to handle their health cards or make health appointments. In the study, female parents were the most independent when it came to acquiring health identification and making health-decisions, nevertheless, their parents continued a supportive role. Another gendered difference was that females desired female health care providers, because this gave them more ease to discuss health matters, and an empathic ear for their concerns. Males did not suggest a gender preference for their physician.

⁹ In response, one person mentioned that she personally preferred speaking with a person, such as with the health info phone services.

Young parents face several challenges from traveling to health services and finding health care for their children. The financial and time expenses of travel create challenges, and the cost of daycare presents a further burden. In the other focus groups, travel was not seen as a major obstacle, but youth were concerned with the lack of health services in their communities, and some did admit it was a disincentive to regular visits.

Many of the respondents throughout the study, used walk-in clinics—some because they could not find a family doctor. This is unfortunate because there are doctors taking patients, but many are unaware of the ways to find one. The majority of walk-in clinic users reported dissatisfaction with the quality of care, particularly the shortness and superficiality of the visits; the lack of long-term relationships; and the failure to acquire health services on their own terms. It was also noted that ‘formal’ health care services were exclusionary because of their inappropriate language use. In the sample, there were several participants who expressed satisfaction with their health care; these respondents were mainly those with a regular service provider. Many of the respondents used emergency services in the past year, and reported dissatisfaction with the quality of services, and primarily the number of health care workers versus the overcrowded wait rooms.

The experiences of immigrants highlight the general problem of ineffective health promotion and the lack of long-term health care relationships between health providers and users. Among many of the respondents who were born outside of Canada, it was reported that the health care system is confusing, and that finding appropriate health information is difficult. Dissatisfaction with their relationships with doctors contributed to mistrust in health providers, which may have exacerbated their mistrust in the philosophy and function of the Canadian health care system more generally.

Attesting to the peculiar migration-settlement history of Caribbean-Canadians, and to their gendered labour market experiences in Canada, many of the Caribbean respondents had relatives who worked in health professions. This was in contrast to the Somali, Ethiopian and Eritrean respondents who generally did not have family working in the health care system. Yet, Caribbean-origin respondents reported that health was rarely a topic of discussion in the home. These findings emphasize the need to promote health and health discussion at both the individual and household levels, as well at the community level.

Conclusion: Policy Recommendations and a Plan for Action

The findings of this study reveal several grounds for action, as well as a future research agenda (see appendix for table of findings and recommendations). The relative abstinence of males from health services use, as well as their lack of health knowledge shows the need to promote health issues to this group. Health risks affecting Black males need to be publicized using appropriate concepts. For example, relying on published materials and doctor-patient relationships (which may often occur in walk-in clinics) to transmit health information will not succeed with this population; instead we recommend more direct—person-to-person—health promotion, perhaps best done by role models in their communities.

A key barrier to Black males’ health access, unfortunately, is apathy; but this condition is

the result of a lack of effective promotion and a social environment in which violence precedes other concerns. Therefore health promotion should emphasize the interconnections of social exclusion, poverty, violence and health. Another potential remedy is to focus on empowering males to become more assertive about their health care needs. For Caribbean-background males, the already-existing health network of family members and co-ethnics working in the health care system is a potential resource that may be useful in community-centered health promotion. To initiate this, greater communication and organization is needed among Caribbean health care workers. Ideally, this group could take a lead in challenging harmful taboos such as the silence around sexual health towards improving the decision-making conditions of Black youth.

The female population—while having relatively better knowledge of their health risks, and reporting more frequent and routine use of health services—also report some issues that demand response. They underline the general issues of insufficient health services in their schools, and emphasize that finding a family doctor is difficult. Therefore, it is necessary to supply information about how to find a family doctor to this population. For young parents (and the majority of the young parents we spoke with were female), problems of access include difficulties of traveling to health care services and the costs of daycare.

For new immigrant populations, particularly for youth that do not speak English as their first language, the quality of current translated materials is inappropriate. Somalian females reported unanimously that materials translated into Somali frequently used inappropriate language. The absence of non-Caribbean African groups in the health care profession may explain the inappropriate translations of materials, which might be better made by translators with working knowledge of the health concepts being translated. Non-Caribbean African-origin groups should be sought in health care employment drives; furthermore, it is important to outreach to groups, such as Somali youth, about health care careers, and to provide immediate opportunities (perhaps allowing youth to translate for adults) for these youth in the health care sector.

More generally, new Canadians report a difficult time finding regular health services, and note that time and financial problems make using health services and purchasing medications difficult. They are also distrustful of the nature of health care, which they cite as secretive. Throughout the study it is evident that more explanation of health diagnosis is needed between doctors and their patients. The study suggests the possibility that the level of distrust among youth of the health care system is associated with the lack of appropriate explanation between health provider and youth, racialization of Black youth in the health care experience, and issues of assertiveness, and the broader realities of violence, marginalization, and stigmatization of youth (particularly among males).

The study also suggest that is important we respond to the silences *in the home* regarding health issues. To open discussion between guardians and youth about health risks and their health practices, we recommend a commitment to normalizing issues of sex and sickness, both currently seen as off-limits topics and areas of vulnerability in the relationship of adults and youth in the Black community. Secondly, a focus on assertiveness training and social and political empowerment of youth is needed to ensure that youth always feel that they can respond to the quality of treatment they receive.

Because of the scope of this work, there are several areas of future research that may

be identified. This report suggests the diversity within the Black youth population by looking at five groups, more case studies of individual and group values about health would strengthen our understanding of these differences so that programs and community-based policy will be inclusive to all members of the community. Related to this, outreach is needed to increase the visibility of community organizations developing our health infrastructure and to create broad partnerships that amplify community concerns and support new initiatives. Part of this outreach would be to list health care providers, particularly medical doctors, in our communities to emphasize their presence. Another important goal is to get more young people to seek a regular doctor, rather than to continue their dependence on often overcrowded and under-resourced walk-in clinics. In addition to the focus group findings, the findings from the literature show the need for future research done with a representative sample in order to assess both the health status of Black youth as well as their access and use of health services.

Appendix

Table 3: Findings and Identified Health Access Factors

Finding	Factor	Implication	Response
Black youth in Scarborough typically travel outside their communities for health services Some youth lack family doctors; and avoid routine visits	Lack of health services in many communities in Scarborough Need for more community health promotion Information “breakdown” regarding doctors taking new patients	May discourage regular health visits; Decreases the visibility of health care as a community issue Risk of poorer health; “Multiplier effects” for information sharing and community health	Pressure government to locate services equitably Promote Ontario College of Physicians and Surgeons “find a doctor” website ¹⁶ ; Promotional drives to get people signed-up with regular doctors; Encourage youth and their families to seek regular doctor-patient relationships
Lack of confidence and trust in doctor-patient relationship	Cultural, racial and gender divides create barriers to free and open conversation between black youth and their doctors; Intimidation	Youth may not receive early warnings about important health information; Doctors may misdiagnose patients because of incomplete information	Work towards empowering youth through assertiveness training; Promote awareness of the doctor-patient privilege and its limits
Male youth appear more “passive” about health care decisions	Apathy and fatalism; “Externalization of health care issues”	Risk of poorer health from preventable illness; Multiplier effects	Publicize relevant health risks for Black youth and the Black population; Work towards improving the assertiveness of youth in spaces of “power” such as government institutions
Recent immigrants may lack knowledge of health care system; may be less likely to have a family doctor	Recent immigrants experience difficulty accessing health information	May heighten risk of avoidable illnesses Multiplier effects	Target health counselling in new immigrant communities; Publicize existing materials and resources; Person-to-person health promotion
Males consider violence their primary health risk	Reality of violence in the black community; Lack of socio-health promotion and services that connect issues of violence with racism, economic marginalization, and “lifestyle”	Youth are developing poor health attitudes and practices early in their life course that may impact health status now, in the future, and for their peer groups; The issue of violence is	Increase crisis response counseling in communities struck by violence; Engage youth to discuss the reality of violence and think about its many impacts; Greater outreach and health promotion to

Finding	Factor	Implication	Response
Printed materials are being ignored	Apathy among youth; Lack of engaging materials	“overshadowing” other health risks and issues; “Externalization” of many health risks Youth are not getting important health information	males More face-to-face health promotion; Recognition of how family structure, economic needs, and time resources challenge “simple” document promotion; Promote health in social spaces of youth, and their parents, Increase presence of Somalis in health professions; Employ co-ethnic health professionals to translate materials rather than laypeople; Create translations in group meetings rather than privately
Poor translation of Somali language materials; some instances of misdiagnosis	Misuse of concepts and lack of cultural awareness	Risk of preventable disease; Creation of disengagement and distrust	Outreach to parents with message that sexuality is a normal part of life that should be discussed openly at home; Promote better sexual health information in public and private youth spaces; Confront unhealthy popular images of sexuality
Sexual health is not being discussed in the home	Sexual topics are taboo between parents and their children	Knowledge about sexual health is not being contextualised in home life; Risk that sexual health is being learned through popular culture rather than holistic/spiritual contexts	Lobby government to return health to schools; Encourage Ministry of Education to include health studies as a mandatory part of curriculum
Inadequate and infrequent health services in schools	Lack of school funding to health services; Cuts to role of school nurses	Bars youth (especially those less-likely to approach health services through travel or other active assertions) from an important local service	

Finding	Factor	Implication	Response
Doctors use inappropriate language, or fail to offer good explanation about their diagnoses to youth	The medical culture creates awkward and 'closed' languages that are not well translated; Doctors (especially in Walk-in clinics) lack time to offer the appropriate explanation for their diagnoses	Youth are excluded from full knowledge of their health; Language exclusion widens the cultural divide between doctors and youth; Language re-inforces disempowerment of youth through increasing intimidation of their voice and interests	Target medical professionals and schools with message that better systems of explanation, translation, and language production are needed to engage young people

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