

HEALTH STATUS OF HOMELESS WOMEN

AN INVENTORY OF ISSUES

ONTARIO WOMEN'S HEALTH COUNCIL
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EXECUTIVE SUMMARY

The term “homeless” refers to those individuals who are absolutely, periodically, or temporarily without shelter, as well as those who are at substantial risk of being on the street in the immediate future.

Homelessness has always been a significant social problem. However, as the number of unhoused people has grown dramatically in recent years, some have declared homelessness to be a “national disaster.” Equally disturbing is the rapidly changing face of those who are homeless. Families, single mothers, and children are among the fastest growing segments of the homeless population.

Data from shelters and other service-providing agencies document the extensiveness and severity of the homeless crisis among women and children in Toronto, Canada’s wealthiest urban centre:

- Single women and women with children together compose 29% of shelter users.
- There was a 78% increase in shelter use among single women between 1992 and 1998.
- Young women are at great risk of homelessness, as almost a quarter of shelter users are between the ages of 15 and 24.
- Approximately 300 babies are born to homeless women in Toronto annually, one-third to teenagers.
- Families comprise the fastest growing group of shelter users, with single mothers entering the system at twice the rate of couples with children.
- There was a 130% increase in the number of children in shelters between 1989 and 1999.

While homeless women and men experience similar health problems, the former have distinct characteristics, vulnerabilities, and treatment needs. For instance, they may have a history of physical, sexual, or emotional abuse. Homeless women may also be

pregnant or have young children in their custody. Some of the health issues of particular significance to women include family planning, prenatal care, breast and cervical cancer screening, and sexually transmitted infections. As well, homeless women are disproportionately represented among those with mental health problems and substance abuse disorders.

When it comes to accessing health care services, homeless women are confronted with a myriad of formidable barriers, including unavailable or fragmented health care services; biases and misconceptions held by health care professionals; and competing priorities, such as securing food and shelter, which force health care to assume a relatively low level of importance.

The complex relationship between women’s health and homelessness was identified by the Ontario Women’s Health Council as a key priority in its 2001/2002 Plan of Action. The Council commissioned Consulting Matrix Inc. to conduct a review of current literature and to speak with field experts in order to generate an inventory of health-related issues affecting homeless women. A summary of this inventory then served as a foundation for discussion at a Council-sponsored think tank held in November of 2001. One of the recommendations emerging from the think tank was to distribute this inventory widely in order to educate both health care and social service providers about the health issues that homeless women face.

The inventory of health-related issues affecting homeless women presented in this report illustrates the demographic features of homeless women in Ontario, their unique health issues, and obstacles they encounter in accessing acute, preventative, and other kinds of health care service.

INTRODUCTION

Homeless women comprise a growing population that is at high risk for chronic and infectious diseases and premature death (Plumb, 2000). While homeless women suffer from many of the same health concerns as homeless men, they also face a number of unique challenges. Homeless women often have young children in their custody; some are pregnant; and many have experienced physical, sexual, and emotional violence and are at great risk of violence on the streets and in shelters. As well, mental illness is much more prevalent among homeless women compared to homeless men (Ambrosio, Baker, Crowe, & Hardill, 1992; Burroughs, Bouma, O'Connor, & Smith, 1990; Bassuk, Rubin, & Lauriat, 1984; Breakey et al., 1989; Burt, 1992; City of Toronto, 1999; Glasser & Bridgman, 1999).

The relationship between homelessness and women's health is complex. For some women, pre-existing health problems contribute to their homelessness. For almost all, illness will occur and often become aggravated by homelessness (Raising the Roof, 1999). Homeless women are also confronted with a number of barriers when it comes to accessing health care services. Narrowly conceived services and interventions, most of which have evolved to serve homeless men, are inappropriate for homeless women and their children.

The following, which summarizes some of the key findings of this report, illustrates that homelessness is a major health issue for women:

- Sexual victimization, engaging in prostitution as a means of economic survival, unavailability of contraception, uncertain fertility, and the desire for intimacy may all result in unplanned pregnancy among homeless women.
- Homeless women who are pregnant risk complications because of lack of prenatal care, poor nutrition, and exposure to violence.
- Homeless women are at extreme risk of violence on the streets, which can lead to post-traumatic stress disorder, clinical depression, anxiety disorders, and substance abuse disorders.
- Homeless women are at increased risk for HIV/AIDS and other sexually transmitted infections.
- Gynaecological symptoms, ranging from abnormal vaginal discharge, severe pelvic pain, and skipped periods to breast lumps and burning during urination are experienced by the majority of homeless women.
- Homeless women encounter systemic and personal barriers which impede their access to preventative and acute health care services.

PURPOSE

The negative impact of poverty on women's health status was identified by the Ontario Women's Health Council¹ (hereinafter the Council) as a key priority in its 2001/2002 Plan of Action. The Council is currently engaged in a variety of initiatives related to the health of low income women in Ontario, with a particular focus on homeless, socially isolated, and/or hard to reach women.

As one of its initiatives in this area, the Council commissioned Consulting Matrix Inc. to conduct a review of the literature and an environmental scan of some of the resources and services related to low income, homeless, and socially isolated women in Ontario and to generate an inventory of health-related issues. A summary of highlights from this inventory then served as a foundation for discussion at a Council-sponsored think tank of key players and experts who work with these women, with a view to identifying best practices and health solutions for women. One of the recommendations emerging from the think tank, held in November of 2001, was to distribute the inventory widely in order to educate both health care professionals and social service providers about the health issues that homeless women face.

While not intended to be an exhaustive examination or analysis of the literature and existing services, the inventory of health-related issues affecting homeless women presented here highlights some of the current key issues. The inventory is divided into three sections:

- I. Background information, including a profile of homeless women in Ontario
- II. Health challenges faced by homeless women in Ontario
- III. Systemic and personal barriers homeless women face in trying to access health care services

¹ See Appendix I for information about the Ontario Women's Health Council.

I. BACKGROUND

1.1 WORKING DEFINITIONS

POVERTY

Although there is no official measure of poverty in Canada, the Statistics Canada Low Income Cut-Offs (LICOs) is probably the best known and most widely used measure. According to the LICOs, individuals and families who spend disproportionate amounts of money on food, shelter, and clothing are considered to be living in financially difficult or strained circumstances (Statistics Canada, 2000). Using 1992 as the base year, people who spent more than 54.7% of their income on these items were classified as having incomes under the LICOs (Statistics Canada, 2000). In Ontario, a greater proportion of women than men fall below the LICOs (17% versus 15%; Statistics Canada, 2000).

Low-income rates are more prevalent among certain subgroups of women. Aboriginal and visible minority women are nearly twice as likely as non-visible minority women in Canada to have low incomes. Compared to two-parent families, lone mothers are almost five times more likely to have incomes which fall below the LICOs (Statistics Canada, 2000). The low-income situation of Aboriginal lone mothers is particularly grave. Among this group, 73% live below the LICOs (Statistics Canada, 2000). As well, over two-thirds of women aged 15–24 and about half of unattached women 65 and older have low incomes (Statistics Canada, 2000).

HOMELESSNESS

While there is no one definition of homelessness agreeable to all, this report uses the definition provided by Gerald Daly (1996) and adopted by the City of Toronto (1999) in the publication released by the Mayor's Homelessness Action Task Force titled, "Taking Responsibility for Homelessness² :"

Homeless people include those who are absolutely, periodically, or temporarily without shelter, as well as those who are at substantial risk of being on the street in the immediate future. (Daly, 1996, p. 26)

Included in this broad definition are the "absolute homeless," or those who are living on the street, in the bush, or in emergency shelters or transition houses. Also included are the "relative homeless," or those who are living in spaces that do not meet the basic international housing standards, including personal safety, security of tenure, protection from the elements, and affordability (United Nations Committee on Economic, Social, and Cultural Rights, 1991).

SOCIAL ISOLATION

There are very few definitions of social isolation available. Of those that do exist, most refer to the state of being excluded from communication or cooperation with others. The social environment in which a person lives, including their social support network, is a recognized determinant of health status. Without the involvement of significant others and community supports during periods of personal or financial crisis, women are at increased risk of becoming homeless. A plethora of factors can contribute to a woman's social isolation, including being a single parent, immigrant/refugee, or senior; living in an abusive relationship or in a remote area; or having a mental, developmental, and/or physical illness or disability.

1.2 CHARACTERISTICS OF THE HOMELESS POPULATION IN ONTARIO

Homelessness has always been a significant social problem. In recent years, however, homelessness has been declared a "national disaster" as the number of unhoused people has grown dramatically (Toronto Disaster Relief Committee, 1998). For instance, homelessness in Toronto increased by 40% between 1988 and 1999 (City of Toronto,

Between 1988 and 1999, homelessness in Toronto increased by 40%.

(City of Toronto, 1999)

²Also referred to as the "Golden Report," as Dr. Anne Golden acted as the Chair of the Task Force.

1999). The composition of the homeless population has also changed. While once considered a problem exclusive to men (Canadian Mortgage and Housing Corporation, n.d.), there is a greater proportion of youth, single women, and lone-parent families headed by women among today's visible homeless (City of Toronto, 1999).

Homelessness tends to be characterized as a primarily urban phenomenon. Homelessness is, however, a growing issue in rural areas (Lewington, 2002), but many homeless people migrate to large metropolitan centres from rural areas in search of economic and educational opportunities, to be closer to health and other support services, and to escape from violence and abuse. Nearly half of all shelter users in Toronto come from outside the city and 14% come from outside the country (City of Toronto, 1999).

1.3 A PROFILE OF HOMELESS WOMEN IN ONTARIO

In large urban centres like Toronto, single women account for a quarter of the homeless population (Goering, Tolomiczenko, Wasylenki, Boydell, & Halman, 1997). Homeless women comprise a large and diverse population, encompassing many sub-groups, including teenagers, lone parents, single women, abused women, Aboriginal women, immigrant and refugee women, and senior women. Among the population of homeless women are also those with severe and persistent mental illness as well as those with chronic and infectious diseases. Homeless women, however, do share a number of common features, of which poverty and social isolation are central.

Not all of Ontario's homeless women are "visible." While many access emergency shelters and transition houses, there is evidence that women are more likely than men to make use of alternative forms of accommodation, such as staying with friends and

relatives (Lenon, 2000). Statistics on homelessness are based on data collected predominantly from shelters and, accordingly, underestimate the extent of women's homelessness.

It has been difficult to create an accurate demographic profile of homeless women in Ontario given the dearth of reliable data sources. Enumerating the homeless population has typically been an arduous task due to the transient nature of this group (Peressini, McDonald, & Hulchanski, 1995). To date, there are no consistent national or provincial measures of the homeless (National Housing and Homelessness Network, 2001). Information gathered from shelters or other service-provider organizations (e.g., Out-of-the-Cold programs, help-lines, food banks) has typically been used as the best way of estimating the number of homeless people in a community. This method runs the risk of double-counting people who use more than one service and fails to capture those who do not access such services.

Not only are statistics on homelessness plagued by methodological problems, they also tend to be collected from a single geographical location (e.g., Toronto) and exclude important information, such as age and first language spoken. They also use a narrow definition of homelessness, thereby excluding women who live in overcrowded, unsafe, inadequate, unaffordable, or temporary housing or who are otherwise at high risk of becoming homeless.

At best, the statistics outlined in this report provide a crude estimation of the magnitude of women's homelessness within Ontario and, as such, should be interpreted with caution.

WOMEN AND HOMELESSNESS IN URBAN AREAS

The following information, derived largely from shelter users in Toronto, documents the extensiveness and severity of the homeless crisis among women and their families:

- Single women and women with children together compose 29% of shelter users (City of Toronto, 1999).

**Single women
account for
one in four
homeless
persons in
Toronto.**

(Goering et al., 1997)

- There was a 78% increase in shelter use among single women between 1992 and 1998 (City of Toronto, 1999).
- Young women are at great risk of homelessness as almost a quarter of shelter users are between the ages of 15 and 24 (City of Toronto, 1999).
- Families comprise the fastest growing segment of shelter users, with single mothers entering the system at twice the rate of couples with children (City of Toronto, 1999).
- The number of women with children using shelters increased from 24% in 1988 to 37% in 1996 (City of Toronto, 1999).
- There was a 130% increase in the number of children in shelters between 1989 and 1999 (City of Toronto, 1999).
- Approximately 300 babies are born to homeless women in Toronto annually, one-third to teenagers (Berstein & Lee, 1998).
- One-third of shelter users are reported to have a significant mental illness and this proportion increases to three-quarters for single homeless women (City of Toronto, 1999).

GENDER DIFFERENCES IN SHELTER USE

Women tend to stay in shelters for longer periods of time compared to men (median seven days for women versus two to three days for men; City of Toronto, 2000). This may be because women often seek refuge in transition houses and shelters for abused women (City of Toronto, 2000). These facilities provide temporary accommodation and support to abused women and their children for periods ranging anywhere from a couple of days to several months. In addition, they offer food, clothing, counselling, transportation, and information on legal aid, social assistance, education, job training, and community resources and referrals (Health Canada, 1999a).

When the Report of the Mayor's Homelessness Action Task Force was released, there were 12 shelters available in Toronto for abused women with a total capacity of 385 beds (City of Toronto, 1999). Because of the dearth of beds, abused women are often referred to the general hostel system. In fact, between 1988 and 1996, more than half of abused women used shelter services other than those specifically designed to meet their needs (City of Toronto, 1999). The lack of affordable housing in Toronto not only contributes to the shortage of available beds, but also forces women to remain in shelters for longer periods of time (City of Toronto, 1999). Another reason for women's longer-term use of the shelter system is that, compared to their male counterparts, they often present with more complex mental and physical health needs and require more extensive treatment and intervention (City of Toronto, 1999).

About 385 beds are available in Toronto shelters for abused women. When no space is available, women must turn to other emergency shelters. At least as many assaulted women and their children stay in emergency shelters as in shelters for abused women.

(City of Toronto, 1999)

SLEEPING ROUGH ON THE STREETS³

People who sleep rough on the streets form the core population of the homeless (Raising the Roof, 2002). While it is very difficult to estimate the number of homeless who sleep rough on the streets, street outreach programs in Toronto suggest that the proportion is on the rise. For instance, in addition to those who use year-round emergency shelters in Toronto, approximately 450 people are housed each night by "Out-of-the-Cold" emergency shelters that operate only during the winter months (City of Toronto, 1999). Women are believed to comprise

³ "Sleeping rough on the streets" is a phrase referring to individuals who reside on the street, in public places, or in any other place not meant for human habitation (Raising the Roof, 2002).

about one-quarter of the homeless who reside in non-sheltered environments. Many of these women are not only confronting homelessness, but are also pregnant (Killion, 1995). There continues to be a disproportionate number of Aboriginal people and people with mental disorders and addictions living in unsheltered conditions (City of Toronto, 2000).

WOMEN AND HOMELESSNESS IN RURAL AREAS

Since Canadian research into homelessness has been conducted predominantly in large metropolitan areas, there is very little Canadian literature on homelessness in rural communities. Homelessness is underreported in these settings and there is generally a scarcity of housing, emergency shelters, and other resources (S. Trujillo, Chair of the Rural Health Working Group, personal communication, October, 2001), which together contribute to the migration trend identified previously.

A recent article in the Toronto *Globe and Mail* suggests that, while not as visible as in the major centres, homelessness is a real and growing problem in smaller communities (“Homeless woe,” 2002). The scarcity of emergency and other housing options in small cities often means that people move from one temporary housing arrangement to another.

First and Toomey (n.d.) found that women made up a large proportion of the homeless population in rural Ohio and approximately 50% had children with them. Close to half of these women lived with family or friends, two-fifths in shelters or missions, and 15% in cars, abandoned buildings, and other unsheltered locations.

1.4 WHY ARE SOME POOR WOMEN HOMELESS?

Poverty is the primary cause of homelessness (City of Toronto, 1999). Research shows that women are overrepresented among the poor, a phenomenon often referred to as the “feminization of poverty” (Belle, 1990). The feminization of poverty is largely

explained by the rise of lone-parent families headed by women, women’s relegation to low-status and low-paying jobs, the unavailability of decent and affordable childcare, and restrictions and cutbacks to income security programs such as welfare and Employment Insurance (City of Toronto, 1999).

Not all women living in low-income situations become homeless. Some subgroups are at heightened risk, including women with mental illness and those whose lives have been characterized by violence and abuse.

MENTAL ILLNESS

Women with mental illnesses are overrepresented among the homeless. As many as three-quarters of single homeless women in Toronto suffer from mental illness (City of Toronto, 1999). The

most common diagnoses among this population are clinical depression, post-traumatic stress disorder, and substance use disorders (Bassuk, Buckner, Perloff, & Bassuk, 1998).

The increased prevalence of mental illness among the homeless has been linked to deinstitutionalization (Bachrach, 1984). The last 40 years have witnessed a dramatic change in the delivery of services to individuals with mental illness. The Canadian mental health system has shifted from a centralized, hospital-based model to a decentralized, community-based model (Wasylenki, Goering, & Macnaughton 1992). Since 1960, the number of available psychiatric beds in the Greater Toronto Area has fallen by 80% (City of Toronto, 1999). At the same time, it has been suggested that there are insufficient psychiatric and medical services and programs available in the community, particularly for individuals with severe and chronic mental illness (City of Toronto, 1999). These individuals, who are often socially isolated and reliant on social assistance, are at an increased risk of becoming homeless.

75% of homeless single women suffer from mental illness.

(City of Toronto, 2001)

VIOLENCE AGAINST WOMEN

Violence against women is intricately related to homelessness among women (Canadian Mortgage and Housing Corporation, n.d.). Women whose lives are marked by violence and abuse often use homelessness as a strategy to maintain their safety (Canadian Mortgage and Housing Corporation, n.d.). Domestic violence was reported by 27% of

Almost three in ten women in the shelter system reported domestic violence as the primary reason for their homelessness.

(City of Toronto, 1999)

women in the Toronto shelter system as the primary reason for their homelessness (City of Toronto, 1999). As well, sexual and physical abuse accounted for approximately 70% of youth homelessness (City of Toronto, 1999). The problem of violence may be intensified in rural

areas because of geographical separation from friends and family, inadequate public transportation, few job opportunities, poverty and economic dependence, and distance from shelters, health care facilities, and other support and protective services (Cohen & Ansara, in press).

Lack of adequate health, social, and community services, a shortage of affordable housing in the community, family breakdown, refugee status, eviction, and being new to a city are other factors which may contribute to a woman becoming homeless (Bhugra, 1996; Novac, 1996; Raising the Roof, 2002).

II. HOMELESS WOMEN'S HEALTH CHALLENGES

2.1 HEALTH ISSUES AFFECTING THE HOMELESS POPULATION GENERALLY

The overall physical health status of homeless people is poor as they exhibit a wide range of health problems and are at high risk of premature death. While the types of illnesses they experience do not differ substantially from the general population, they tend to be more severe and chronic in nature due to factors such as crowded and unstable living conditions, sleep deprivation, stress, exposure to extreme temperatures, inadequate medical care, poor nutrition, and violence (for a review, see Hwang, 2001).

A 1991 survey of the health status of a representative sample of 458 homeless women and men in Toronto found the following chronic health conditions to be much more prevalent than among the general population: allergies/hay fever, angina, arthritis/rheumatism, asthma, diabetes, emphysema/chronic bronchitis, epilepsy, head injury, heart attack, hypertension, gastrointestinal problems, muscular-skeletal disorders, neurological disorders, and stroke (Ambrosio et al., 1992). There is some evidence that individuals who reside in non-sheltered environments have a health status that is even worse than those in shelters (Gelberg & Linn, 1989).

The following provides further detail about some of the more common health issues affecting the general population of homeless persons in Canada:

SLEEP DEPRIVATION AND EXHAUSTION

It is often difficult for homeless people living on the street or in crowded shelters to get adequate sleep. The survey of Toronto's homeless population found that almost 50% slept less than six hours per night (Ambrosio et al., 1992).

NUTRITIONAL DEFICIENCIES

Access to adequate amounts of nutritious food is an ongoing challenge for the homeless. Bunston and Breton (1990) compared the daily food intake of single homeless women using hostels and drop-in centres to Canada's Food Guide and found that the average number of servings in each of the four food groups was below the recommended number. Even when they have sufficient food available to them, homeless women and their dependants often have diets that contain high levels of saturated fats and lack sufficient vitamins and minerals. This is because the most affordable food is often the least healthy (Silver & Panares, 2000).

Malnutrition has negative health implications, including increased risk for chronic diseases and a weakened immune system. Homeless women with children are at particular risk of malnutrition as they may go without food in order to feed their children (Canadian Institute of Child Health, n.d.).

DIABETES, HYPERTENSION, AND ANAEMIA

Diabetes, hypertension, and anaemia tend to remain undiagnosed and untreated for extended periods among the homeless because of barriers that impair access to health care services. Poor nutrition, delays in seeking care, unaffordable prescription drugs, stress, and difficulty following treatment protocols, make these conditions difficult to manage in the homeless population (Daly, 1996; Hwang & Bugeja, 2000).

SKIN AND FOOT CONDITIONS

Skin problems, including cellulitis, impetigo, venous stasis disease, scabies, and body lice, are common among the homeless population (Hwang, 2001). Common foot conditions among the homeless include onychomycosis, tinea pedis, corns and calluses, and immersion foot (Hwang, 2001). These

are caused or exacerbated by inadequate footwear, prolonged exposure to moisture, long periods of walking or standing, and unavailability of shower or laundry facilities (Hwang, 2001).

COMMON ILLNESSES

Influenza and colds, easily treatable in the general population, often become serious problems among the homeless due to stress, exposure to extreme temperatures, and lack of timely and ongoing health care (Silver & Panares, 2000).

RESPIRATORY DISEASES

Respiratory diseases, including tuberculosis, are also common among the homeless. Treatment is complicated by late diagnosis/prolonged infection, non-adherence to treatment, and drug resistant strains (Hwang, 2001). The risk of contracting infectious diseases is heightened by the crowded conditions that tend to be found in shelters (Hwang, 2001).

2.2 HEALTH ISSUES SPECIFIC TO HOMELESS WOMEN

While studies have not found a significant difference in the overall physical health status of homeless women and men (Bhugra, 1996; Novac, 1996), homeless women have distinct characteristics, vulnerabilities, and treatment needs. The following represent some of the health concerns specific to homeless women.

FAMILY PLANNING

Homeless women may have little control over the timing and circumstances surrounding conception. Sexual victimization, engaging in prostitution as a means of economic survival, unavailability of contraception, uncertain fertility, and the desire for intimacy may all result in unplanned pregnancy (Silver & Panares, 2000).

Approximately 13% of the Toronto homeless women surveyed by Ambrosio and colleagues (1992) indicated that they were pregnant. In 1998, a study by several public health agencies in Toronto

estimated that 300 babies are born to homeless women annually (Berstein & Lee, 1998). Statistics from the US have shown that as many as one in four homeless women are currently pregnant or have had a completed pregnancy during the past year (Wenzel, Andersen, Gifford, & Gelberg, 2001). Pregnancy is linked to a whole host of health issues for homeless women. Risks for pregnancy complications due to lack of prenatal care, poor nutrition, stress, and exposure to violence are common. A study by

Between 13% and 25% of homeless women are pregnant.

(Ambrosio et al., 1992; Wenzel et al., 2001)

Street Health, a Toronto-based organization, found that while most of the pregnant homeless women were receiving prenatal care, a sizeable proportion were not eating enough to sustain adequate health (Ambrosio et al., 1992). As well, a third of those who had delivered their last baby in the hospital had nowhere to go after discharge (Ambrosio et al., 1992).

Three in ten homeless women who delivered their last baby in a hospital reported having nowhere to go after discharge.

(Ambrosio et al., 1992)

Despite being at risk for unplanned pregnancy, homeless women may be unable to use birth control because their desired method may not be readily available to them. Limited access to health care facilities and benefits may force them to rely on birth control methods that do not require a prescription (e.g., condoms). Even when contraceptives are available, barriers such as unwilling partners, memory loss, and theft may limit their successful utilization. Physicians may be reluctant to suggest other methods (e.g., intrauterine devices, Norplant, Depo-Provera) because of the unreliability of follow-up (Burroughs et al., 1990).

SEXUALLY TRANSMITTED INFECTIONS AND GYNAECOLOGICAL SYMPTOMS

Sexually transmitted infections (STIs) are high among homeless women. Gelberg and colleagues (2001) estimate that as many as six in ten homeless women have had an STI. A review of the medical records of homeless women who had presented to a mobile women's health unit in Chicago indicated that 30% of Pap smears were abnormal (Johnstone, Tornabene, & Marcinak, 1993). The proportion of women with chlamydia, gonorrhoea, and trichomoniasis was 3%, 6%, and 26%, respectively. These findings highlight the importance of providing homeless women with routine gynaecological care.

Homeless women are also at increased risk for HIV/AIDS. Unprotected heterosexual contact and injection drug use are the two primary methods through which women become infected with HIV/AIDS (Health Canada, 2001). Kilbourne, Herndon, Andersen, Wenzel, and Gelberg (2002), who interviewed homeless women in the US regarding HIV risk behaviours, found that 64% engaged in unprotected sex, 22% were involved in the sex trade, and 8% used injection drugs. Sexual victimization on the streets and in shelters may place homeless women at even greater risk for HIV/AIDS.

Gynaecological symptoms, including abnormal vaginal discharge, bleeding between periods, severe pelvic pain, skipped periods, burning during urination, and itching, swelling, and redness in the vaginal area are also common among this population (Wenzel et al., 2001).

BREAST AND CERVICAL CANCER

Breast cancer is the most frequently diagnosed cancer in Canadian women and incidence rates have increased steadily since the early 1980s (Health Canada, 1999b). While the incidence of cervical cancer has declined in recent years, early age of first intercourse, multiple sex partners, infection with human papillomavirus (HPV), smoking, and low socio-economic status make women more susceptible to the disease (Health Canada, 1998). At present, the only proven strategy to reduce the incidence and mortality of breast and cervical cancer is early detection

through mammography screening and Pap tests, respectively (Health Canada, 1999b; Health Canada, 1998). While research focusing exclusively on homeless women is absent, there is evidence to suggest that women with lower incomes and less education are among the group least likely to undergo regular screening for breast and cervical cancer (Katz & Hofer, 1994).

VIOLENCE AGAINST WOMEN

Some of the most serious health issues for homeless women relate to their experience of violence. Violence is often a precursor to homelessness for women and, once homeless, violence against women continues and intensifies. Thus, violence is a constant threat to the health of homeless women.

More than one in five homeless Toronto women are sexually assaulted per year.

(Ambrosio et al., 1992)

Almost half (46%) of women surveyed in Toronto had been physically assaulted in the past year, 21% had been sexually assaulted, and 43% had been physically and/or sexually assaulted more than five times (Ambrosio et al., 1992). Beyond the immediate painful physical injuries, the consequences of violence include social isolation, post-traumatic stress disorder, clinical depression, generalized anxiety disorders, and substance abuse disorders. As well, many women report anger, fear, and becoming more cautious and less trusting, all of which can act as barriers to accessing health care services (Statistics Canada, 1993).

MENTAL ILLNESS

Women with mental illness, particularly depression, are overrepresented among the homeless population. Studies have shown that as many as 75% of single homeless women in Toronto are suffering from mental illness (City of Toronto, 1999). Further, two-thirds report having attempted suicide at some point during their lifetime and another 29% report attempting suicide in the past year (Ambrosio et al., 1992).

Two-thirds of homeless women attempted suicide at some point during their lifetime and 29% attempted suicide in the last year.

(Ambrosio et al., 1992)

Compared to the general homeless population, homeless women with mental health problems often face an additional set of challenges. For instance, these women:

- Often have histories of sexual, physical, and/or emotional abuse (Ambrosio et al., 1992; Ontario Medical Association, 1996);
- Remain homeless for longer periods of time (Ontario Medical Association, 1996);
- Tend to have undiagnosed physical illnesses in addition to their mental health problems (Burroughs et al., 1990);
- Are harder to reach in terms of health care service delivery (Burroughs et al., 1990);
- Underutilize psychiatric services (Padgett & Struening, 1992);
- Frequently exhibit paranoid- and avoidance-type behaviour, further reducing their likelihood of seeking treatment (Ontario Medical Association, 1996);
- Have fewer social supports to assist them in accessing health care services (Hatton, 2001).

SUBSTANCE ABUSE

Evidence suggests that between 16% and 67% of homeless women have substance abuse disorders (Silver & Panares, 2000). Substance abuse in early adult life, along with other adverse life events, including unstable housing, sexual and physical victimization, and parental mental illness and substance abuse, have been found to be correlated with homelessness (Goering et al., 1997; Nyamathi, Bayley, Anderson, Keenan, & Leeke, 1999).

CONCURRENT DISORDERS

It is common for homeless people to have substance abuse problems in combination with mental illnesses. In fact, homeless women may use alcohol and drugs to temporarily alleviate symptoms of their mental illness (Silver & Panares, 2000). *Pathways to Homelessness*, a comprehensive study examining the prevalence of alcohol dependence and abuse among shelter users in Toronto, found that three-quarters of

**75%
of shelter
users with
mental illnesses
also have
addiction problems.**

(Goering et al., 1997)

those with a lifetime diagnosis of mental illness also had a diagnosis of substance abuse (Goering et al., 1997).

Research in the US has shown disparities in the prevalence of mental illness and substance abuse among subgroups of women. Specifically, single

homeless women are more likely to have mental illness without any accompanying substance abuse problems (Fischer & Breakey, 1991). Compared to the general homeless population, women who are lone parents have lower rates of both mental illness and substance abuse (Shinn et al., 1998).

III. BARRIERS TO ACCESSING HEALTH CARE SERVICES

Although homeless women suffer from a wide range of physical and mental health problems, they often experience difficulties obtaining the health care they require. External or systemic barriers restrict or prevent access to the health care system, result in care that is neither sensitive nor responsive to the needs of homeless women, and discourage health care professionals from providing necessary care. There also exist a number of personal or lifestyle challenges that make it difficult for homeless women to access or accept care.

3.1 SYSTEMIC BARRIERS TO ACCESSING HEALTH CARE SERVICES

The conventional health care system operates on the assumption that patients have a stable address, access to a telephone, and a network of friends and family to support them when they need assistance. This system presents formidable barriers to accessing health care for homeless women.

NO REGULAR HEALTH CARE PROVIDER

Few homeless women have a regular source of health care; instead, they access services only in an emergency situation and often rely solely on emergency services. Ambrosio and colleagues (1992) reported that 54% of the homeless people they surveyed had used an emergency department at least once in the past year; almost one in five used emergency care more than any other form of care. As a result, their health records are often scattered among various health care providers, with no one having a complete medical history (Ambrosio et al., 1992).

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(Ambrosio et al., 1992)

ADMINISTRATION AND COMMUNICATION BARRIERS

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

DISCHARGE ISSUES

Hospitalization is reserved for more serious medical conditions and patients are discharged more quickly now than in the past. Patients are typically given a detailed treatment plan which they are instructed to follow at “home.” This, of course, assumes that patients have homes and that they have social supports in place to assist in following the treatment plan. However, according to the 1999 Report of the [Toronto] Mayor’s Homelessness Action Task Force, institutions regularly discharge clients with no fixed address to a hostel or even to the street. Hostel operators have limited resources available to help them provide adequate supports and services for these individuals (City of Toronto, 1999). Homeless people are, therefore, often left with no other alternative than to recuperate on the streets (Ambrosio et al., 1992). This extends the convalescent period and compromises complete recovery (Ambrosio et al., 1992).

Nearly eight in ten homeless patients were discharged from hospital with no assistance to find a place to go.

(Ambrosio et al., 1992)

Ambrosio and colleagues’ (1992) study of Toronto’s homeless population found that 79% of those surveyed had been discharged from hospital with no assistance in finding a place to recuperate. More than 38% went onto the streets or into a shelter after leaving the hospital. The presentation of these individuals at a shelter can pose a significant challenge to staff, who often lack adequate training, resources, or facilities to provide the appropriate care.

HEALTH INSURANCE DOCUMENTATION

Members of the general population often take it for granted that they can access health care services as needed with relatively few barriers. This is not the case for the majority of homeless persons. Even though Canada has universal health insurance and access to health care, many homeless people lack

proof of their health coverage (Hwang, 2001). In the Toronto survey, almost 40% of respondents reported not having a valid health insurance card (Ambrosio et al., 1992). This may be because it was stolen or misplaced. It is difficult and time consuming to get a replacement card, particularly if other identification has been lost or stolen as well. The cost of obtaining replacement identification is high and the bureaucratic process is daunting.

Almost four in ten homeless people do not have a valid health card.

(Ambrosio et al., 1992)

Not having a health card and other identification presents a significant barrier to accessing health care. Hwang, Windrim, Svoboda, & Sullivan (2000) found that 7% of respondents were refused health services because they did not present with a valid health card. Almost half were refused care at an emergency department. Even in those health care facilities that do not require a health card, the absence of a card precludes access to medical tests, lab work, and referrals to specialists (Hoey, 1996). As well, many homeless people do not have drug insurance benefits and cannot afford to fill prescriptions (Hwang & Gottlieb, 1999).

DISINCENTIVES FOR PHYSICIANS

Provision of health care for homeless people under the conventional payment model also has financial disincentives for physicians (Hwang et al., 2000). Without a valid health card, physicians, lab technicians, and specialists do not get paid. Physicians providing care to homeless persons in downtown Toronto on average received payment from only 54% of patients (Hwang et al., 2000). In addition to the high proportion of patients without a health card, the amount of time spent with homeless women is often longer than average because of the complexity of their physical and mental health problems (Hwang et al., 2000). Physicians cannot make extra billings for the longer appointments.

LACK OF TRANSPORTATION

Homeless people are sometimes unable to access services due to the absence of affordable public transportation. Health conditions and distance may rule out the option of walking to services. This situation is exacerbated in rural areas, where distances are greater and public transportation is limited or non-existent (Fitchen, 1992; S. Trujillo, personal communication, October, 2001).

LACK OF COMFORTABLE AND SAFE ENVIRONMENT FOR CARE

Many homeless women report feeling uncomfortable in the institutional atmosphere of a hospital and are reluctant to travel to an unfamiliar lab or clinic for tests or follow-up care (Ambrosio et al., 1992). This is especially true of women with mental illness and physical and sexual abuse histories. As well, many homeless women are uncomfortable in co-ed facilities where they have to walk past groups of homeless men to access health care services (Kinnon & Hanvey, 1996).

MISCONCEPTIONS AND LACK OF UNDERSTANDING BY HEALTH CARE PROFESSIONALS

Many homeless women have reported facing discrimination and stigmatization from health care providers (Plumb, 2000). Some report being denied treatment altogether while others are given clear indication that the care they are receiving is being provided reluctantly (Ambrosio et al., 1992; Fisher & Lohin, 1997; Novac, 1996). Health care professionals may not be equipped to accommodate the complexities presented by homeless women, may lack knowledge and sensitivity around the circumstances and special needs of this population, and may inadvertently provide ineffective care. For instance, some may assume that routine screening and preventative care are not feasible interventions given the instability of homeless life (Burroughs et al., 1990).

FRAGMENTED AND POORLY COORDINATED SYSTEM OF SERVICES

Lack of Awareness of Available Services: Many organizations that provide services to homeless women have limited budgets and rely heavily on

volunteer labour. Furthermore, poor coordination among different service sectors is quite common. For instance, health care services are not often linked to one another and health care providers have limited knowledge of the full range of health, housing, and social services required by women who are homeless and, therefore, fail to make appropriate referrals (Plumb, 2000).

Incomplete Medical Records: As noted above, few homeless women have a regular source of health care, instead accessing services only in an emergency situation or when directed by someone else. As a result, their health records will often be scattered among various health care providers, with no one having a complete medical history (Ambrosio et al., 1992).

Lack of Consistency of Service Provision: Rules of access to service and standards of care may vary from organization to organization (Ambrosio et al., 1992). Women moving across service organizations, therefore, are often required to reiterate their stories and health care needs in lengthy intake processes and in some cases are not eligible for services.

Dental Care Inaccessibility: A scarcity of affordable dental care means that homeless women will only access such services if they have been injured or are experiencing acute discomfort (Ambrosio et al., 1992; Breakey et al., 1989).

SHORTAGE OF SERVICES FOR MENTAL ILLNESS AND ADDICTIONS

Mental Health Problems: Limited community resources to support individuals with mental illness results in access issues for homeless women, as over three-quarters of single homeless women experience mental health problems (City of Toronto, 1999).

Substance Abuse Problems: Homeless women who have substance abuse problems may be doubly disadvantaged. Not only do they experience stigmatization and discrimination when attempting to access health care services due to their homelessness, but they may also be refused care if they do not abstain from substance use (Silver & Panares, 2000).

Concurrent Disorders: Homeless women with mental illnesses who also have substance abuse issues are a

particularly vulnerable and hard to reach population. Mental health services are often not equipped to address the substance abuse needs of the patient and may in fact deny service to patients unable to abstain while in care. As well, health care providers at substance abuse treatment centres may lack the knowledge, experience, and resources to appropriately address the specific needs of homeless women with mental illness (Fisher & Lohin, 1997; Racine, 1994).

3.2 INDIVIDUAL BARRIERS TO ACCESSING HEALTH CARE SERVICES

GENERAL LIFESTYLE CHALLENGES

As homeless women struggle to obtain the basic necessities of life, such as food and shelter, competing priorities may force health care to assume a relatively low level of importance (Gelberg, Gallager, Andersen, & Koegel, 1997). This is particularly true in relation to preventative care and asymptomatic chronic conditions. Management of a health problem in these circumstances can be extremely difficult, as illustrated in the example below:

Diabetes is a condition that requires careful management of diet and medication to avoid serious consequences such as blindness. In Toronto, most homeless adults with diabetes report difficulties managing the disease. People reported difficulties with diet (type of food in shelters and inability to make dietary choices) and scheduling and logistics (inability to get insulin and diabetic supplies when needed, and inability to coordinate medication with meals). Many shelters forbid the possession of needles, making it necessary for individuals to sneak their medication or risk losing housing. Generally they have no place to store their needles or monitoring devices, so they must constantly guard against the risk of theft.

(Hwang & Bugeja, 2000)

DIFFICULTY COMPLYING WITH TREATMENT PROTOCOLS

With limited finances and no stable place to stay, many homeless women have difficulty complying with treatment protocols. They cannot fill prescriptions, have no place to rest, and do not have access to affordable and nutritious foods (Ambrosio et al., 1992).

DIFFICULTY ACCESSING PREVENTATIVE CARE

Personal health beliefs and previous experiences may also act as obstacles to accessing certain health care services, such as gynaecological and breast cancer screening. Some women may believe that such screening is unnecessary or that it is inappropriate. Homeless women are among the group of women least likely to request preventative health care interventions, such as a routine Pap smear and mammography (Burroughs et al., 1990).

LACK OF SUPPORT SYSTEM / SOCIAL ISOLATION

Most homeless women do not have family and friends to provide emotional and financial support during periods of illness. This is especially true of women who have fled from violent relationships or who have migrated from remote areas. This social isolation further reduces their connection to available services (City of Toronto, 1999; Novac, 1996; Silver & Panares, 2000).

3.3 PSYCHOLOGICAL / MENTAL HEALTH BARRIERS

SELF ESTEEM

Low self-efficacy, feelings of worthlessness, and limited control over one's life are common among homeless persons (Ambrosio et al., 1992). Not only do these factors negatively impact on mental health, they also present significant personal barriers to accessing health care services and engaging in healthy behaviours (Ambrosio et al., 1992).

LACK OF TRUST

Many homeless women delay seeking health care or avoid it altogether because of previous negative encounters with and/or lack of trust in health care providers. For many homeless women, a gynaecological or dental appointment may trigger memories of abuse and, as such, is a source of great fear and anxiety (Usatine, Gelberg, Smith, & Lesser, et al., 1994).

CONCLUSION

While homeless women are a heterogeneous group, they do share a number of similar features that may contribute to their overall poor health status. These include low income, unemployment, low levels of education, insufficient material resources (i.e., telephone, transportation, permanent and proper housing), fear and mistrust of the health care system and of health care providers, and limited social support.

Receiving appropriate and timely health care can enable homeless women to take control of their lives and plan for their futures. Once their immediate physical and mental health care needs have been attended to, case management and appropriate linkages to community supports can lead to stable housing, recovery from substance abuse, participation in job training and life skill development programs, and employment.

There is an urgent need for new and innovative strategies that will address the barriers to health care that homeless women face. Identifying and evaluating promising models and practices in service integration and coordination for women who are homeless or at risk of homelessness is one approach that might be used to improve access (Council Think Tank on the Health of Homeless and Socially Isolated Women, November, 2001).

Another strategy is to ensure that health care professionals are receiving appropriate education and training in regards to the needs and issues of homeless women (Council Think Tank on the Health of Homeless and Socially Isolated Women, November, 2001). This could be achieved through the development of a comprehensive common core curriculum for all health care professionals who will be working with poor populations, a significant group of which are homeless or at risk of homelessness. This curriculum could have a focus beyond homelessness to include poverty and the interaction between poverty and gender as determinants of health.

Finally, efforts can be made to build networks of knowledge and expertise across health care and social service providers, as well as policy- and decision-makers in government and key institutions, to ensure that the unique health care needs of homeless women are known and taken into account.

REFERENCES

- Ambrosio, E., Baker, D., Crowe, C., & Hardill, K. (1992). *The Street Health Report: A study of health status and barriers to health care of homeless women and men in the City of Toronto*. Toronto: Street Health.
- Bachrach, L.L. (1984). Deinstitutionalization and women. *American Psychologist*, *10*, 1171–7.
- Bassuk, E.L., Buckner, J.C., Perloff, J.N., & Bassuk, S.S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry*, *155* (11), 1561–4.
- Bassuk, E.L., Rubin, L., & Lauriat, A. (1984). Is homelessness a mental health problem? *American Journal of Psychiatry*, *141*, 1546–9.
- Belle, D. (1990). Poverty and women's mental health. *American Psychologist*, *45*, 385–9.
- Berstein, J. & Lee, J. (1998). *Young parents: No fixed address*. Toronto: Public Health Department. Report to City Council.
- Bhugra, D. (1996). *Homelessness and mental health*. New York: Cambridge University Press.
- Breakey, W.R., Fischer, P.J., Kramer, M., Nestadt, G., Romanoski, A.J., Ross, A., Royall, R.M., & Stine, O.C. (1989). Health and mental health problems of homeless men and women in Baltimore. *JAMA*, *262*, 1352–7.
- Bunston, T. & Breton, M. (1990). The eating patterns and problems of homeless women. *Women and Health* *16*, 43–62.
- Burroughs, J., Bouma, P., O'Connor, E., & Smith, D. (1990). Health concerns of homeless women. In P.W. Brickner, L.K. Scharer, B.A. Conanan, M. Savarese, & B.C. Scanlan (eds.). *Under the safety net: The health and social welfare of the homeless in the United States*. New York: W.W. Norton.
- Burt, M. (1992). *Over the edge: The growth of homelessness in the 1980s*. New York: Russell Sage Foundation.
- Canadian Institute of Child Health. (n.d.). *Families in crisis*. Retrieved May 2, 2002, from <http://www.cich.ca/famcrisis.htm>.
- Canadian Mortgage and Housing Corporation. (n.d.). *No room of her own: A literature review on women and homelessness*. Ottawa: Canada Mortgage and Housing Corporation. Retrieved April 19, 2002, from http://www.cmhc-schl.gc.ca/en/imquaf/ho/ho_015.cfm.
- City of Toronto. (2000). *The Toronto report card on homelessness, 2000*. City of Toronto: Toronto.
- City of Toronto. (1999). *Taking responsibility for homelessness: An action plan for Toronto*. Toronto: City of Toronto.
- Cohen, M.M. & Ansara, D. (in press). Sexual assault and intimate partner violence. In D.E. Stewart, A. Cheung, L. Ferris, I. Hyman, M. Cohen, & I.J. Williams (eds.) *Ontario Women's Health Status Report*. Toronto: Ontario Women's Health Council.
- Daly, G. (1996). *Homeless: Policies, strategies and lives on the street*. London: Routledge.
- First, R.J. & Toomey, B.G. (n.d.). *Rural demographics*. Retrieved October 23, 2001, from <http://www.seorf.ohiou.edu/~xx085/rural.html>.
- Fischer, P.J. & Breakey, W.R. (1991). The epidemiology of alcohol, drug, and mental disorders among homeless persons. *American Psychologist*, *46*, 1115–28.
- Fisher, M. & Lohin, R. (1997). *Beyond survival: Homelessness in Metro Toronto*. Toronto: United Way of Greater Toronto.
- Fitchen, J. (1992). On the edge of homelessness: Rural poverty and housing insecurity. *Rural Sociology*, *57*, 173–93.
- Gelberg, L., Gallagher, T.C., Andersen, R.M., & Koegel, P. (1997). Competing priorities as a barrier to medical care among homeless adults in Los Angeles. *American Journal of Public Health*, *87*, 217–20.

- Gelberg, L., Leake, B.D., Lu, M.C., Andersen, R.M., Wenzel, S.L., Morgenstern, H., Koegel, P., & Browner, C.H. (2001). Use of contraceptive methods among homeless women for protection against unwanted pregnancies and sexually transmitted diseases: Prior use and willingness to use in the future. *Contraception*, 63(5), 277–81.
- Gelberg, L. & Linn, L.S. (1989). Assessing the physical health of homeless adults. *Journal of the American Medical Association*, 262(14), 1973–9.
- Glasser, I. & Bridgman, R. (1999). *Braving the street: The anthropology of homelessness*. New York: Berghahn Books.
- Goering, P., Tolomiczenko, G., Wasylenki, D., Boydell, K., & Halman, M. (1997). Pathways to homelessness: *The role of substance abuse*. Toronto: Health Systems Research Unit, Clarke Division, Centre for Addiction and Mental Health.
- Hatton, D.C. (2001). Homeless women's access to health services: A study of social networks and managed care in the US. *Women & Health*, 33(3–4), 149–62.
- Health Canada. (2001). *HIV and AIDS among women in Canada*. Bureau of HIV/AIDS, STD and TB Update Series. Retrieved May 3, 2002, from http://www.hc-sc.gc.ca/hpb/lcdc/bah/epi/women_e.html.
- Health Canada. (1999a). *Transition houses and shelters for abused women in Canada*. Ottawa: Minister of Public Works and Government Services.
- Health Canada. (1999b). *Breast cancer in Canada*. Retrieved May 3, 2002, from http://www.hc-sc.gc.ca/hpb/lcdc/bc/updates/breast_e.html.
- Health Canada. (1998). *Cervical cancer in Canada*. Retrieved May 3, 2002, from http://www.hc-sc.gc.ca/hpb/lcdc/bc/updates/cervix_e.html
- Hoey, J. (1996). It takes patience to treat the homeless. *Canadian Medical Association Journal*, 155(12). Retrieved April 19, 2002, from www.cma.ca/cmaj/vol_155/issue-12/1737sid1.htm.
- Hwang, S. (2001). Homelessness and health. *Canadian Medical Association Journal*, 164(2), 229–33.
- Hwang, S. & Bugeja, A. (2000). Barriers to appropriate diabetes management among homeless people in Toronto. *Canadian Medical Association Journal*, 163(2), 161–5.
- Hwang, S. & Gottlieb, J.L. (1999). Drug access among homeless men in Toronto. *Canadian Medical Association Journal*, 160(7), 1021.
- Hwang, S., Windrim, P., Svoboda, T., & Sullivan, W. (2000). Physician payment for the care of homeless people. *Canadian Medical Association Journal*, 163(2), 170–1.
- Johnstone, H., Tornabene, M., & Marcinak, J. (1993). Incidence of sexually transmitted diseases and Pap smear results in female homeless clients from Chicago Health Outreach Project. *Health Care for Women International*, 14(3), 293–9.
- Katz, S.J. & Hofer, T.P. (1994). Socioeconomic disparities in preventative care persist despite universal coverage. Breast and cervical cancer screening in Ontario and the United States. *JAMA*, 272, 530–4.
- Kilbourne, A.M., Herndon, B., Andersen, R.M., Wenzel, S.L., & Gelberg, L. (2002). Psychiatric symptoms, health services, and HIV risk factors among homeless women. *Journal of the Poor and Underserved*, 13(1), 49–65.
- Killion, C.M. (1995). Special health care needs of homeless pregnant women. *Advanced Nursing Science*, 18(2), 44–56.
- Kinnon, D. & Hanvey, L. (1996). *Health aspects of violence against women: A Canadian perspective*. Canada-U.S.A. Women's Health Forum Commissioned Papers. Retrieved April 19, 2002, from www.hc-sc.gc.ca/canusa/papers/canada/english/advocate.htm.
- Lenon, S. (2000). Living on the edge: Women, poverty, and homelessness in Canada. *Canadian Woman's Studies*, 20(3), 125.

- Lewington, J. (2002, April 25). Homeless woe not confined to big cities. *Globe and Mail*, A8.
- National Housing and Homelessness Network. (2001). State of the crisis: A report on housing and homelessness in Canada. Retrieved May 2, 2002, from <http://www.tao.ca/~tdrc/news/StateofCrisis2001.htm>.
- Novac, S. (1996). *No room of her own: A literature review on women and homelessness*. Ottawa: Canadian Mortgage and Housing Corporation.
- Nyamathi, A., Bayley, L., Anderson, N., Keenan, C., & Leake, B. (1999). Perceived factors influencing the initiation of drug and alcohol use among homeless women and reported consequences of use. *Women & Health*, 29(2), 99–114.
- Ontario Medical Association. (1996). *Exploring the health impact of homelessness*. Retrieved May 2, 2002, from <http://www.oma.org/phealth/homeless.htm>.
- Padgett, D.K. & Struening, E.L. (1992). Victimization and traumatic injuries among the homeless: Associations with alcohol, drug, and mental problems. *American Journal of Orthopsychiatry*, 62(4), 525–34.
- Peressini, T., McDonald, L., & Hulchanski, D. (1995). *Estimating homelessness: Towards a methodology for counting the homeless in Canada*. Retrieved May 2, 2002, from http://www.cmhc-schl.gc.ca/en/imquaf/ho/ho_005.cfm.
- Plumb, J.D. (2000). Homelessness: Reducing health disparities. *Canadian Medical Association Journal*, 163(2), 172–3.
- Racine, G. (1994). Des “cas lourds” aux situations complexes: Étude exploratoire sur le concept des “cas” lourds dans les maisons d’hébergement pour femmes sans abri. Publié par l’auteure.
- Raising the Roof. (1999). *Q & A: 1. What is homelessness? Q & A: 4. Who are the homeless?* Retrieved April 19, 2002, from <http://www.raisingtheroof.org/educate.html>.
- Shinn, M., Weitzman, B.C., Stojanovic, D., Knickman, J.R., Jimenez, L., Dunchon, L., James, S., & Krantz, D.H. (1998). Predictors of homelessness among families in New York City: From shelter request to housing stability. *American Journal of Public Health*, 88, 1651–7.
- Silver, G. & Panares, R. (2000). *The health of homeless women*. Retrieved April 19, 2002, from <http://www.med.jhu.edu/wchpc>.
- Statistics Canada. (1993). The violence against women survey. *The Daily*, November 18.
- Statistics Canada. (2000). *Women in Canada: A gender-based statistical report*. Ottawa: Statistics Canada.
- Toronto Disaster Relief Committee. (1998). *State of emergency declaration: An urgent call for emergency humanitarian relief prevention measures*. Toronto: Toronto Disaster Relief Committee. Retrieved April 19, 2002, from <http://www.tao.ca/~tdrc/>.
- United Nations Committee on Economic, Social, and Cultural Rights. (1991). *The right to adequate housing: United Nations Definition* [General Comment No. 4]. New York: United Nations. Retrieved April 19, 2002, from <http://www.unhcr.ch/tbs/doc.nsf>.
- Usatine, R.P., Gelberg, G., Smith, M.H. & Lesser, J. (1994). Health care for the homeless: A family medicine perspective. *American Family Physician*, 49, 139–46.
- Wasylenki, D., Goering, P., & Macnaughton, E. (1992). Planning mental health services: I. Background and key issues. *Canadian Journal of Psychiatry*, 37, 199–205.
- Wenzel, S.L., Andersen, R.M., Gifford, D.S., & Gelberg, L. (2001). Homeless women’s gynaecological symptoms and use of medical care. *Journal of Health Care for the Poor and Underserved*, 12(3), 323–41.

APPENDIX I: ONTARIO WOMEN'S HEALTH COUNCIL

The Ontario Women's Health Council was established in December 1998 by the Ontario Minister of Health and Long-Term Care. The over-riding goal of the Council is the improvement of women's health at all stages of life.

WOMEN'S HEALTH

Women's health involves women's emotional, social, cultural, spiritual, and physical well-being, and is determined by the social, political, and economic context of women's lives, as well as by biology. It is defined by, and recognizes the validity of, women's perceptions and life experiences of health and illness, the values and knowledge of women, and the role of women both as users and as providers of health care.

Ontario Women's Health Council Working Definition of Women's Health

MEMBERSHIP

The Ontario Women's Health Council is comprised of members who are appointed by the Minister of Health and Long-Term Care. The Council, which is chaired by N. Jane Pepino, provides a wide range of expertise in the areas of treatment, research, public and community health, and consumer issues.

MANDATE

Acting as a catalyst for vital and positive change, the Ontario Women's Health Council has been given a mandate to:

- **Advise, inform, and educate** the public about the unique health needs of women and critical issues affecting women's health;
- **Advocate** strongly for improvements in women's health;
- **Promote, influence, and disseminate research** into women's health issues;
- **Reach out and empower women** across the province to be decision-makers about their own health.

The Council provides well-researched strategic advice to the Minister on matters pertaining to women's health by:

- Identifying health issues affecting women and developing policy advice on selected issues to the Minister and key stakeholders;
- Undertaking research, policy studies, and demonstration projects in areas significant to women's health;
- Communicating policy, research, and project findings to women and other stakeholders in Ontario; and
- Promoting public understanding and awareness to improve women's health.

GUIDING VALUES

The core values that guide the work of the Council are consensus-building, equity, information-sharing, transparency, consultation, and partnership.