BRIDGING HEALTH DIVIDES

A COLLABORATIVE STUDY ON ADDRESSING HEALTHCARE DISPARITIES IN RACIALIZED COMMUNITIES

RACIALIZED HEALTH WORKING GROUP

Public Health Agency of Canada
Agence de la santé publique du Canada

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LAND ACKNOWLEDGEMENTS

We are grateful for the opportunity to contribute to this work on land that has been home to generations of Indigenous peoples long before other nation groups arrived. Our efforts take place on the traditional territories of the Huron-Wendat, Haudenosaunee, and the Mississaugas of the Credit. These lands are part of the Dish with One Spoon Treaty, an agreement among the Anishinaabeg, Haudenosaunee, and allied nations to share and protect the resources around the Great Lakes. This territory is also covered by the Upper Canada Treaties.

Today, Tsi Tkaronto, the traditional Mohawk name for this area, meaning "trees in the water," and its surrounding regions continue to be home to Indigenous peoples. As settlers, we honor the generations of First Nations, Métis, and Inuit communities who have maintained a deep connection to these lands since time immemorial, and whose stewardship continues to shape and guide us today.

We acknowledge that the histories of colonization, land theft, and broken treaties have caused profound harm to Indigenous communities. These actions have disrupted traditional ways of life, marginalized Indigenous voices, and led to systemic inequities that persist today. As settlers on this land, it is our responsibility to reflect on these histories and recognize our role in Truth & Reconciliation.

While we focus on the care and contributions of Indigenous peoples, we also recognize the interconnected histories of other oppressed communities. The transatlantic slave trade forcibly displaced millions of Africans, creating enduring legacies of inequity for Black-African-Caribbean (BAC) peoples. Colonization has likewise shaped the experiences of racialized communities globally, compounding systemic injustices that must be addressed.

This acknowledgment calls us to meaningful action. We commit to listening to Indigenous voices, supporting their leadership, and standing in solidarity to uphold their rights and sovereignty. By reflecting on these histories and learning from them, we strive to honor the land and its peoples through our work toward justice and equity for all, including Indigenous, BAC, and racialized communities who continue to face systemic inequities.

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EXECUTIVE SUMMARY

The Racialized Health Working Group conducted a study examining healthcare disparities among racialized communities in Ontario. This research highlights systemic inequities, barriers to healthcare access, and the disproportionate impact of the COVID-19 pandemic on marginalized groups. Using a mixed-methods approach, the study collected qualitative and quantitative data from South Asian, Black-African-Caribbean, LatinX Hispanic, Middle Eastern and North African, and East Asian communities.

Findings reveal that while each community faces unique challenges, several common barriers exist, including language barriers, systemic racism, long wait times, financial constraints, and inadequate culturally competent care. The lack of race-based disaggregated data hinders the development of targeted policies. Many communities report higher rates of chronic illnesses such as diabetes, hypertension, and cardiovascular diseases, exacerbated by social determinants of health, including precarious employment, housing instability, and food insecurity. The COVID-19 pandemic deepened these inequities as racialized communities faced greater exposure risks due to limited remote work options, lack of paid sick leave, and reliance on public transportation. Mistrust in healthcare systems and misinformation led to lower vaccine uptake. Mental health challenges surged, particularly in East Asian and Black communities, where an increase in racial discrimination contributed to higher rates of anxiety and depression. Many racialized individuals delay seeking medical attention due to financial constraints, long wait times, and language barriers. The shortage of healthcare providers who speak their language or understand their cultural needs further discourages engagement, leading to poorer health outcomes.

This report calls for systemic reforms and community-driven interventions to create a more equitable healthcare system. Addressing cultural and linguistic barriers is essential, requiring healthcare providers to undergo anti-racism and cultural sensitivity training while also expanding multilingual services and translated health materials. Ensuring that race-based disaggregated data is collected and used effectively will allow for more informed policies that respond to the specific needs of racialized communities. Equally important is expanding healthcare access through increased funding for community health centers and mobile clinics, as well as financial support for uninsured individuals, will help mitigate disparities in care. Mental health services must also be strengthened through culturally competent therapy, increased accessibility, and awareness campaigns to reduce stigma. Finally, fostering strong partnerships between healthcare institutions and community organizations is key to building trust and ensuring healthcare services are both inclusive and responsive to the diverse needs of Ontario's racialized communities.

By implementing these measures, Ontario can move toward a more equitable healthcare system where all racialized populations have access to high-quality, culturally competent care. Achieving health equity is essential for improving the well-being and health outcomes of all individuals in the province.

INTRODUCTION

2.1 ABOUT THE RACIALIZED HEALTH WORKING GROUP

Racialized populations in Ontario are among the fastest-growing demographic groups, yet they continue to experience significant health disparities that place a considerable strain on the province's health and social services. The COVID-19 pandemic has only deepened these inequities, highlighting the urgent need for comprehensive systemic reforms to address the long-standing barriers these communities face within Ontario’s healthcare system.

The Racialized Health Working Group (RHWG), funded by the Public Health Agency of Canada, is committed to addressing these disparities and driving transformative change in healthcare. The coalition was originally formed in 2019 with seven core partners, including the Council of Agencies Serving South Asians, Sickle Cell Awareness Group of Ontario, Roots Community Services, Black Health Alliance, Punjabi Community Health Services, Chinese Canadian National Council Toronto, and the Hispanic Development Council.

The COVID-19 pandemic prompted the RHWG to reassess its approach, leading to a revised proposal that focuses on the immediate needs of racialized communities disproportionately impacted by the pandemic. The newly updated RHWG is made up of five core partners, each committed to addressing health disparities and advocating for systemic change.

- **Council of Agencies Serving South Asians (CASSA)**: CASSA is a social justice organization representing over 120 agencies, groups, and individuals committed to empowering South Asian and racialized communities. They envision a Canada free from discrimination, where all communities shape the nation’s political, economic, social, and cultural landscape. Their strategic priorities include advancing health equity, supporting immigration and settlement, promoting economic empowerment, combating racism and oppression, advocating for gender equity, and addressing online hate and hate crimes. They work in partnership with their members and other social justice organizations across the nation to achieve these goals.
- **Roots Community Services (RootsCS)**: RootsCS provides culturally relevant programs and services to empower individuals, primarily from the Black, African, and Caribbean communities, to make positive changes in their lives and communities. Their strategic goals focus on managing growth, ensuring financial stability and sustainability, enhancing stakeholder and community engagement, upholding strong governance, and advocating for policies that promote equity and inclusion. They aim to build strong relationships with stakeholders and lead the charge in advocating for social transformation.
- **Hispanic Development Council (HDC)**: HDC works to ensure the full participation of the LatinX Hispanic community in Canada by promoting inclusion and pluralism across social, economic, cultural, and political spheres. They focus on building community capacity, advocating for equitable access to services, and advancing youth issues, from schooling to justice. Their mission is to ensure that every member of the LatinX Hispanic community has the necessary support to achieve a sustainable quality of life and reach their full potential within Canadian society.

- **Canadian Arab Institute (CAI)**: CAI is a national non-partisan organization dedicated to advancing the interests of the Canadian Arab community through research, policy, programming, and community engagement. They celebrate and promote Arab Canadians' contributions across all aspects of Canadian society, striving for an empowered and engaged community thriving socially, politically, culturally, and economically. Their strategic priorities include informing society on key issues, celebrating achievements, fostering engagement, and supporting integration and professional development within the community.
- **Chinese Canadian National Council – Toronto Chapter (CCNC-TO)**: Established in 1985, CCNC-TO is a non-profit organization representing Chinese Canadians in the Greater Toronto Area. As a chapter of the Chinese Canadian National Council (CCNC), they are committed to advancing the rights and full participation of Chinese Canadians in Canadian society. Their work focuses on promoting equity, social justice, and inclusion, while fostering understanding and cooperation between communities. Through community engagement, advocacy, and education, they empower Chinese Canadians to actively contribute to the social, political, and cultural landscape of Canada.

The original proposal by the RHWG in 2020 called for the creation of an Office of Racialized Health within Ontario's Ministry of Health to monitor health outcomes, foster partnerships, and ensure the delivery of culturally competent services. While the establishment of the Office remains a long-term goal, dependent on the collection of sufficient data, the current shift focuses on addressing the immediate needs of racialized communities. This project pieces together actionable steps to shape a clear path to systemic change, with key goals outlined below.

Foster Community Engagement
Actively engage racialized communities represented within the RHWG to gather insights and co-develop culturally relevant, population-specific health equity strategies and policies.

Revise Policy Proposal
Update the proposal to the Ministry of Health by integrating community feedback and the most recent race-based data, including COVID-19 and vaccination statistics from Ontario’s public health units.

Raise Awareness
Increase community awareness about the importance of targeted health equity initiatives for racialized populations and advocate for the systematic collection of race-based, disaggregated data.

Advocate for Policy Change
Increase community awareness about the importance of targeted health equity initiatives for racialized populations and advocate for the systematic collection of race-based, disaggregated data.

Through the collaboration of these five core partners, the RHWG aims to create a healthcare system that better serves all Ontarians, especially those who have been historically underserved. The project will ensure that the voices of racialized communities are included in policy discussions and that transformative, systemic changes are made to foster equitable health outcomes.

2.2 RESEARCH PURPOSE AND OBJECTIVES

The purpose of this research is to conduct a thorough assessment of Ontario's healthcare system, with a specific focus on the health disparities that racialized communities have long faced. These disparities, which were sharply exacerbated by the COVID-19 pandemic, continue to affect racialized populations in profound ways, often influencing their access to quality care and overall health outcomes. This study aims to gain a deeper understanding of the ongoing challenges racialized groups encounter in accessing healthcare services, and to identify pathways for creating lasting, data-informed policy changes that address these inequities. By shedding light on how these disparities have evolved in the post-pandemic era, this research seeks to inform strategies that not only reduce health inequities but also foster a more inclusive and responsive healthcare system.

Assess the Impact of COVID-19 on Health Disparities

To evaluate how the COVID-19 pandemic exacerbated existing health disparities within racialized communities, and to examine how these disparities have evolved since the pandemic's onset. This will involve a closer look at the differential impact of the pandemic on various racialized groups, including the factors contributing to disproportionate outcomes.

Analyze Systemic Barriers to Healthcare Access

To identify and assess the systemic barriers that continue to affect healthcare access for racialized populations. This includes barriers related to cultural competency, service availability, and experiences of discrimination within healthcare settings, as well as the long-term consequences of the pandemic on healthcare accessibility.

Examine the Impact of Social Determinants of Health

To explore how the social determinants of health, such as employment, housing, and education, have contributed to health disparities, particularly in the context of the pandemic. The research will assess how these factors have evolved and their ongoing impact on the health outcomes of racialized communities.

Investigate the Need for Race-Based Disaggregated Data

To advocate for the systematic collection and use of race-based, disaggregated data in healthcare, which is crucial for identifying health disparities and informing policies that address the unique needs of racialized populations. This objective will emphasize the importance of race-based data in improving the responsiveness and equity of the healthcare system.

Engage Racialized Communities in Healthcare Policy Development

To involve racialized communities in the research process through interviews, surveys, and focus groups, ensuring that their perspectives are integral to the development of health equity strategies. The research will prioritize the inclusion of community-driven insights to inform policy decisions and improve healthcare outcomes.

Raise Awareness and Advocate for Change

To increase awareness among healthcare providers, policymakers, and the public about the persistent health disparities faced by racialized communities and the need for targeted health equity initiatives. This will also involve advocating for changes in healthcare delivery, including policy reforms and the inclusion of health equity in medical education and practice.

Provide Actionable Recommendations for Policy Reform

Based on the research findings, the study will provide evidence-based recommendations to inform policy reforms aimed at addressing ongoing health disparities. These recommendations will be directed at Ontario's Ministry of Health and other key stakeholders to support the creation of a more equitable healthcare system.

Through these objectives, this research intends to offer a detailed and evidence-driven assessment of Ontario's healthcare landscape, with an emphasis on the persistent and evolving disparities impacting racialized communities. In addition to identifying key barriers and challenges, the research will provide actionable, community-informed recommendations to guide the development of policies aimed at reducing health inequities. By engaging with diverse communities and using robust data, the study will advocate for systemic reforms that will improve access to healthcare, reduce discrimination, and ultimately create a more equitable system for all Ontarians. These reforms will be crucial in ensuring that health outcomes are no longer determined by race, socioeconomic status, or immigration background, but by the quality of care and resources available to everyone, regardless of their identity or circumstances.

2.3 OVERVIEW OF RACIALIZED COMMUNITIES EXAMINED

Racialized communities are integral to Canada's demographic makeup, constituting a significant and growing portion of the population. In 2021, 16.1% of the national population identified as belonging to a racialized group, with the largest populations being South Asian (7.1%), Chinese (4.7%), or Black (4.3%) (Statistics Canada, 2022a). Other notable groups include Filipinos (2.6%), Arabs (1.9%), and LatinX Hispanics (1.6%) (Statistics Canada, 2022a). Ontario, one of the most culturally diverse regions in the world, reflects this diversity, with 34.3% of its population identifying as racialized (Statistics Canada, 2022b). The largest racialized communities in the province are South Asian (8.6%), East Asian (6.5%), and Black (4.7%), followed by Middle Eastern (2.7%) and LatinX Hispanic (1.5%) populations (Statistics Canada, 2022b).

The growing presence of racialized communities in Canada underscores the urgent need to address systemic health inequities. These disparities became especially evident during the COVID-19 pandemic, which disproportionately impacted racialized groups. Higher rates of infection, hospitalization, and mortality were driven by long-standing structural barriers, including limited healthcare access, systemic racism, and broader social determinants of health such as income inequality, occupational exposure, and inadequate housing.

This study examines health disparities among five racialized communities—South Asian, Black-African-Caribbean (BAC), LatinX Hispanic, Middle Eastern and North African (MENA), and East Asian. It explores how these inequities manifest in each group's healthcare experiences and outcomes, shedding light on the structural challenges they face and the need for targeted policy interventions.

SOUTH ASIAN COMMUNITIES

According to the 2021 Census, 7.1% of the Canadian population identified as South Asian, including individuals with origins from India, Pakistan, Sri Lanka, Bangladesh, and the Indo-Caribbean (Statistics Canada, 2022a). In Ontario, however, South Asians make up 8.6% of the population but accounted for over 16% of cumulative COVID-19 cases during the pandemic (McKenzie, Dube, & Petersen, 2021). The health impact on South Asian communities was disproportionately severe, with infection rates 6.7 times higher, hospitalization rates 5.6 times higher, ICU admissions 6.2 times higher, and mortality rates 4.0 times higher than those of White Ontarians (McKenzie et al., 2021). Several intersecting factors heightened these risks, including overrepresentation in essential industries, overcrowded housing, lower income levels, and a higher prevalence of multigenerational households. Barriers such as limited access to culturally competent healthcare, language difficulties, underemployment, and social isolation further exacerbated health disparities, leading to disproportionately high infection and mortality rates.

BLACK-AFRICAN-CARIBBEAN COMMUNITIES

In 2021, 4.3% of Canadians identified as BAC, representing diverse backgrounds from countries such as Nigeria, Ethiopia, the Democratic Republic of the Congo, Ghana, Somalia, Jamaica, Trinidad, Barbados, and Haiti (Statistics Canada, 2022a). In Ontario, BAC individuals made up 4.7% of the population but accounted for 5.9% of cumulative COVID-19 cases (McKenzie et al., 2021). Despite their relatively small population share, they faced disproportionately severe health impacts, with infection rates 4.6 times higher, hospitalization rates 6.3 times higher, ICU admissions 6.1 times higher, and mortality rates 4.6 times higher than White Ontarians (McKenzie et al., 2021).A significant factor in these disparities was the high proportion of BAC individuals employed in frontline essential roles, which increased their risk of exposure and exacerbated preexisting health inequities (Olanlesi-Aliu et al., 2024). These challenges are rooted in long-standing systemic barriers, including socioeconomic disadvantage, overcrowded housing, limited access to healthcare, medical distrust, and a reduced sense of belonging. Additionally, ongoing experiences of racial discrimination—particularly anti-Black racism—have further deepened these inequities, highlighting the urgent need for targeted health and social interventions (Olanlesi-Aliu et al., 2024).

LATINX HISPANIC COMMUNITIES

In the 2021 Census, 1.6% of Canadians identified as LatinX Hispanic, with most born in South America, Central America, or the Caribbean (Statistics Canada, 2022a). LatinX Hispanic individuals, comprising only 1.5% of Ontario’s population, were particularly hard hit by the pandemic, representing 3.1% of all COVID-19 cases (McKenzie et al., 2021). They experienced some of the highest disparities among racialized groups, with infection rates 7.1 times higher, hospitalization rates 9.1 times higher, ICU admissions 10.4 times higher, and mortality rates 7.6 times higher than those of White Ontarians (McKenzie et al., 2021). LatinX Hispanic immigrants also had the second-highest mortality rate among immigrant communities in Canada and reported a sharp decline in self-rated mental health during the pandemic, dropping from 68% to 43% (Molina et al., 2023). In Ontario, migrant agricultural workers from Mexico, the Caribbean, and Central America faced heightened risks due to poor healthcare monitoring, inadequate quarantine and isolation conditions, and limited medical access (Molina et al., 2023). Overall, disparities were exacerbated by lack of services available in Spanish, uninsured and those with precarious status, limited access to online health and mental health services, and challenges with increased caregiving responsibilities (Molina et al., 2023).

MIDDLE EASTERN AND NORTH AFRICAN COMMUNITIES

In the 2021 Canadian Census, 1.9% of the population identified as having Arab ancestry, representing individuals from the MENA region, which includes countries such as Lebanon, Iran, Egypt, Morocco, Syria, and Algeria (Statistics Canada, 2022a). Despite making up just 2.7% of Ontario's population, MENA individuals accounted for 4.3% of COVID-19 cases (McKenzie et al., 2021). Their health outcomes were notably worse, with hospitalization rates 7.1 times higher, ICU admissions 8.7 times higher, and mortality rates 5.3 times higher than those of their White counterparts (McKenzie et al., 2021). Contributing factors include overcrowded living conditions, lower income levels, and structural racism, which hindered access to healthcare and protective measures (Sharif et al., 2024). Additionally, MENA individuals are often categorized as White in healthcare data, which leads to their underrepresentation in public health strategies, further exacerbating health disparities and limiting their access to culturally competent care (Sharif et al., 2024).

EAST ASIAN COMMUNITIES

According to the 2021 Census, East Asians make up approximately 5.8% of Canada's total population, which includes individuals of Chinese, Japanese, Korean, and other East Asian backgrounds, with Chinese individuals representing 4.7% (Statistics Canada, 2022a). In Ontario, East Asians comprise 6.5% of the population and experienced comparatively lower infection and hospitalization rates (McKenzie et al., 2021). Their infection rate was 1.2 times higher than that of White Ontarians, and hospitalization rates were 1.7 times higher (McKenzie et al., 2021). However, they still faced significant disparities in severe cases, with ICU admissions 2.1 times higher and mortalities 1.7 times higher than those of White Ontarians (McKenzie et al., 2021). The relatively lower infection rates among East Asians may be attributed to their early adoption of public health measures and protective behaviors. Despite these lower rates, they endured a rise in anti-Asian racism during the pandemic, which had a detrimental impact on their mental health and overall well-being.

BACKGROUND

3.1 HISTORICAL CONTEXT: HEALTH DISPARITIES PRE-PANDEMIC

Before the COVID-19 pandemic, racialized communities in Canada faced persistent health disparities driven by systemic and structural inequities. Key factors contributing to these disparities included, language and cultural barriers, systemic racism and discrimination within healthcare systems, socio-economic challenges such as precarious employment and housing instability, and the stigma surrounding mental health. These inequities not only limited healthcare access but also contributed to a higher prevalence of chronic illnesses and preventable health conditions in these communities. Understanding these historical disparities is essential for addressing the root causes of health inequities, informing effective policy interventions, and assessing how the COVID-19 pandemic further exacerbated these inequities. This section provides an overview of these long-standing disparities, setting the stage for a deeper exploration of the pandemic's impact on healthcare access and outcomes.

CULTURAL, SYSTEMIC, AND STRUCTURAL DETERMINANTS OF HEALTHCARE ACCESS

These historical inequities in access to care laid the foundation for the systemic, cultural, and structural challenges that continue to affect racialized communities today. Racialized communities, particularly immigrants, have long faced language and cultural challenges in accessing healthcare. A 2012 study found that 26% of South Asian and East Asian parents struggled to communicate with healthcare providers in English, while 12% were unable to communicate in English at all (Gulati et al., 2012). These communication difficulties not only hindered their ability to care for their children but also made it challenging to understand medical terminology and navigate healthcare services (Gulati et al., 2012). Additionally, a study on chronic diseases among South Asian immigrants in Toronto found that the lack of culturally tailored care was a significant barrier to follow-up healthcare (Rishworth et al., 2022). Despite seeking community support, parents often encountered services that were culturally homogeneous, which left them feeling isolated and less motivated to pursue necessary care for their children (Rishworth et al., 2022). MENA community members, particularly Muslims, face a similar barrier due to healthcare providers' lack of understanding of religious practices, dietary needs, and fasting requirements (Camargo, Mahamad, Moni, Punjani, Jamalifar, & Gravely, 2023). The shortage of female healthcare providers also often discourages Muslim women from seeking care, especially for sensitive health issues (Camargo et al., 2023).

Beyond language and cultural barriers, racialized communities also contend with systemic racism and discrimination in healthcare, which further exacerbates disparities in access and quality of care. For example, a scoping review on Black health in Canada underscores how prolonged exposure to racism, colonialism, and segregation has left Black Canadians disadvantaged in accessing health services and social support, resulting in poorer health outcomes compared to their White counterparts (Olanlesi-Aliu, Alaazi, & Salami, 2023). Specifically, 14.2% of Black Canadians aged 18 and older rated their health as fair or poor, higher than the 11.3% of White Canadians (Olanlesi-Aliu et al., 2023). Similarly, Muslim patients, particularly those from MENA communities, often experience Islamophobia in healthcare, including stereotyping, assumptions about their beliefs, and microaggressions (Camargo et al., 2023). These can manifest in dismissive attitudes from healthcare providers, lack of understanding of religious practices, and inadequate accommodations (Camargo et al., 2023). Such experiences deepen mistrust and deter individuals from seeking care.

These experiences of discrimination are further compounded by structural and circumstantial barriers, including issues related to health system patterns, transportation, geographical distance, availability of health information, variations in institutional practices, and other related factors. For many individuals in racialized communities, healthcare systems are not designed to accommodate their specific needs, creating additional obstacles to access. A cross-sectional study of 2,214 older Chinese immigrants identified transportation as a key barrier, with participants noting the difficulty of reaching healthcare services due to long travel distances and unreliable public transit options (Zhu, Song, Walsh, Ekoh, Qiao, & Xu, 2024). Additionally, participants reported that administrative obstacles, such as long waiting lists, inconvenient office hours, and complicated procedures, further diminished their motivation to seek care (Zhu et.al., 2024).

For many racialized individuals, immigration status adds another layer of complexity, as those without permanent residency face even greater barriers to healthcare access. For example, undocumented LatinX Hispanic migrants in Canada face exclusion from public health insurance, which limits their access to necessary care (Gastaldo & Magalhães, 2007). They also encounter challenges like language barriers, fear of deportation, cultural insensitivity, and administrative issues, such as long wait times and racism (Gastaldo & Magalhães, 2007). While community health centers offer limited support, these services cannot fully address the fragmented and marginalized healthcare access they experience (Gastaldo & Magalhães, 2007). Similarly, international students from South Asian and Chinese communities also face barriers such as lack of awareness of healthcare services, language difficulties, and financial challenges, which delay access to care (Mandell, Phonepraseuth, Borras, & Lam, 2022). Many international students, unfamiliar with the Canadian healthcare system, often delay or forgo medical care due to fears of high costs and insufficient knowledge of their rights and available services (Mandell et al., 2022). This results in health issues being left untreated and a general reluctance to seek help when needed.

SOCIO-ECONOMIC DRIVERS OF HEALTH DISPARITIES

While cultural and systemic barriers play a significant role in healthcare access, socio-economic factors such as income, education, and employment also impact the health outcomes of racialized communities. These factors limit access to essential resources like healthy food, stable housing, and healthcare, leading to poorer health outcomes. According to the Public Health Agency of Canada, racialized Canadians are disproportionately affected by housing instability, with MENA and Black Canadians facing the greatest challenges (Public Health Agency of Canada, 2020). For instance, MENA Canadians are 2.7 times, Black Canadians 2.2 times, LatinX Hispanics 1.9 times, East Asians 2.0 times, and South Asians 1.8 times more likely to experience core housing needs compared to White Canadians (Public Health Agency of Canada, 2020). Furthermore, Black adults are 2.1 times more likely to experience homelessness than White adults (Public Health Agency of Canada, 2020).

Housing instability often intersects with food insecurity, as financial strain forces families to choose between paying rent and affording nutritious food. Food insecurity plays a critical role in health disparities, contributing to poor nutrition and an increased risk of chronic diseases like diabetes, hypertension, and cardiovascular conditions. Black adults experience the highest rates of food insecurity, 2.8 times greater than their White counterparts, followed by LatinX Hispanics at 1.5 times and MENA communities at 1.4 times (Public Health Agency of Canada, 2020). This results in an additional 13 Black adults per 100 people facing food insecurity (Public Health Agency of Canada, 2020). The inequality is even more pronounced among women, with Black women bearing the highest proportion of food insecurity within these groups, exacerbating their vulnerability to poor health outcomes (Public Health Agency of Canada, 2020).

Beyond housing and food security, employment conditions further shape health outcomes, as low-income and precarious jobs limit access to healthcare and workplace benefits. Many racialized individuals are employed in low-wage, temporary, or part-time jobs without access to employer-sponsored healthcare benefits. Immigrants in Canada, particularly from Asia, Latin America, and Africa, are disproportionately employed in precarious or part-time jobs (Cukier et al., 2023). Immigrant women face additional challenges, including lower wages and job insecurity (Cukier et al., 2023). In 2021, immigrants represented 27% of the workforce, yet had a higher unemployment rate (7.7%) compared to Canadian-born residents (6.4%) (Cukier et al., 2023). Recent immigrants (those arriving in the past five years) had the highest unemployment rate at 9.6%, followed by those who arrived 5-10 years ago at 6.2% (Cukier et al., 2023). The combination of precarious employment, lack of health benefits, and lower income significantly limits healthcare access, worsening health disparities within these communities.

CHRONIC ILLNESSES, MENTAL HEALTH, AND HEALTH LITERACY PRECEDING COVID-19

The socio-economic challenges that racialized communities face are not only barriers to accessing healthcare but also contribute directly to higher rates of chronic illness and mental health challenges. Racialized communities in Canada, in particular, face a disproportionate burden of chronic illnesses, exacerbated by systemic barriers. For example, South Asians are 2.3 times more likely to develop Type 2 diabetes compared to White Canadians due to genetic and lifestyle factors (Public Health Agency of Canada, 2020). Meanwhile, heart disease and stroke are leading causes of death, with Black and other racialized populations showing higher risk factors (Olanlesi-Aliu et al., 2023). Additionally, compared to White adults, racialized adults are less likely to report their health as good or excellent (Public Health Agency of Canada, 2020). The disparities are largest for women. Per 100 women, 17 fewer MENA women, 12 fewer South Asian women, 10 fewer East & Southeast Asian women, 8 fewer BAC women, and 8 fewer LatinX Hispanic women feel very positively about their health compared to White women (Public Health Agency of Canada, 2020).

In addition to physical health disparities, racialized communities also face significant mental health challenges, often shaped by systemic barriers and cultural factors. Across Canada, racialized communities typically experience higher exposure to life stressors; however, mental health inequalities may appear smaller in these communities. This may be due to different cultural perceptions of mental health, experiences of stigma, and barriers to mental health services. For example, the Statistics Canada Community Health Survey reveals that South Asian communities have the lowest treatment-seeking rates for depression, followed by Japanese, Chinese, Koreans, and BAC groups (Canadian Public Health Association, 2021). Among those with Major Depressive Episodes, 48.2% of South Asian individuals reported symptoms, with BAC groups reporting the lowest treatment rates (25.1%) (Canadian Public Health Association, 2021). East and Southeast Asian and MENA adults are also less likely to report that their mental health is excellent or good compared to White adults (Public Health Agency of Canada, 2020).

These disparities in both physical and mental health are further compounded by barriers to health literacy, which affect how individuals access, understand, and engage with healthcare services. Limited health knowledge can prevent effective disease management and participation in preventive care, particularly among immigrant communities. For example, among older Chinese immigrant women, lower health literacy leads to a reliance on interpersonal sources like family over written materials (Zhu et al., 2024). While beneficial, this may limit exposure to comprehensive health information and reduce engagement in preventive care, such as cancer screening (Zhu et al., 2024). Consequently, poor health literacy can impede chronic disease management by affecting understanding of diagnoses and adherence to treatment plans (Zhu et al., 2024).

3.2 EXACERBATION OF DISPARITIES: THE COVID-19 PANDEMIC

The COVID-19 pandemic intensified existing social and health inequities, disproportionately impacting racialized and marginalized communities. Many individuals faced heightened vulnerability and exposure to the virus due to frontline and precarious work, overcrowded living conditions, and systemic barriers to healthcare. Limited access to essential health services during the pandemic further deepened disparities, while the mental health toll of prolonged isolation and uncertainty added another layer of hardship. Additionally, vaccine access and hesitancy emerged as significant challenges, influenced by historical mistrust, misinformation, and logistical barriers. This section examines these critical issues, shedding light on how the pandemic exacerbated disparities and what lessons can be learned for future health equity efforts.

INCREASED VULNERABILITY AND EXPOSURE TO COVID-19

Racialized communities in Canada experienced disproportionately high risks of COVID-19 exposure, infection, and mortality, which were compounded by a range of structural and health-related factors. The COVID-19 mortality rate for racialized populations was 31 deaths per 100,000, compared to 22 per 100,000 for non-racialized and non-Indigenous populations (Gupta & Aitken, 2022). BAC individuals had the highest mortality rate (49 per 100,000), followed by South Asians (31 per 100,000), LatinX Hispanics (28 per 100,000), and Chinese communities (22 per 100,000) (Gupta & Aitken, 2022). Additionally, communities with higher proportions of visible minorities or recent immigrants were more likely to test positive for COVID-19 (Thomson et al., 2021). In Ontario, these communities had 10 COVID-19 cases per 100 tested individuals, compared to just 3.2 cases per 100 in less diverse neighborhoods (Thomson et al., 2021).

Racialized populations also faced heightened risks during the pandemic due to their overrepresentation in frontline and low-wage jobs with limited protections, increasing both their exposure to the virus and economic insecurity. Many worked in healthcare support, manufacturing, and food services, where remote work was not an option, and these jobs often lacked paid sick leave and benefits (Thomson et al., 2021; McKenzie, Dube, & Petersen, 2021). In healthcare alone, visible minorities made up about one-third of nurse aides, orderlies, and patient service associates, with BAC, Filipino, and South Asian workers disproportionately represented (Thomson et al., 2021). Unemployment rates were also significantly higher among MENA (17.9%), BAC (17.6%), Southeast Asian (16.6%), and South Asian (14.9%) populations. While Southeast Asian (32.0%), BAC (24.9%), and MENA (21.4%) workers were more likely to be in low-wage positions compared to Chinese (17.4%) and non-racialized workers (15.9%) (Public Health Agency of Canada, 2021).

Compounding these risks, racialized communities often lived in high-density or multigenerational households, making isolation infected individuals more difficult. Research by Gupta and Aitken (2022) found that people living in apartments had twice the odds of dying from COVID-19 compared to those in other types of housing, even after accounting for income and other factors. In Toronto, it was reported that people living in households of 5 or more people comprised 26% of cases, compared to 20% of Toronto's population (Public Health Agency of Canada, 2021). This housing disparity was particularly stark for Black Canadians, with nearly 21% living in overcrowded or unsuitable conditions—almost three times the rate of White Canadians (7.7%) (Gupta & Aitken, 2022).

Moreover, chronic health conditions such as diabetes and cardiovascular disease; prevalent among certain racialized groups, heightening the severity of COVID-19 outcomes. In 2020, 44% of Canadian adults had at least one chronic disease, and among hospitalized COVID-19 cases, 86% had an underlying condition—most commonly hypertension (64%), cardiac illness (32%), or diabetes (30%). Nearly all (98%) who died in hospital had at least one preexisting condition (Public Health Agency of Canada, 2021). These risks are even more pronounced in certain racialized groups. South Asians, for example, experience disproportionately high rates of diabetes and cardiovascular disease compared to White Canadians (Thobani & Butt, 2022). Alongside these physical health disparities, mental health conditions such as depression and anxiety—often worsened by socioeconomic stressors such as substandard living, poor working conditions, and financial barriers to mental healthcare— were also more prevalent in racialized communities and have been linked to poorer COVID-19 outcomes (Thomson et al., 2021). These intersecting factors not only increase the severity of COVID-19 but also reinforce long-standing health inequities, highlighting the urgent need for targeted interventions.

HEALTHCARE ACCESS DURING THE PANDEMIC

Despite Canada's commitment to universal healthcare, many racialized populations faced substantial challenges in accessing both outpatient and inpatient care, which contributed to their disproportionate burden of COVID-19 infections (Public Health Agency of Canada, 2021). In some regions, racialized groups accounted for over 80% of reported COVID-19 cases in 2020, despite comprising just over half of the local population (Public Health Agency of Canada, 2021). These groups included MENA, BAC, LatinX Hispanic, South Asian, and Southeast Asian communities (Public Health Agency of Canada, 2021).

One of the primary factors driving these disparities was the financial and logistical barriers that many racialized individuals faced when accessing care. Many worked in precarious, low-wage jobs without paid sick leave, making it difficult to take time off for medical appointments, testing, or treatment (Public Health Agency of Canada, 2021). This financial strain, coupled with transportation challenges such as reliance on public transit and limited healthcare facilities in racialized neighborhoods, further restricted access to care (Public Health Agency of Canada, 2021).

In addition to these practical obstacles, language and cultural barriers also played a significant role in hindering access to healthcare. Limited language proficiency prevented individuals from fully understanding public health guidelines, risk communication, and treatment options (Public Health Agency of Canada, 2021). The shortage of culturally competent healthcare providers and interpreters led to miscommunication, often resulting in inadequate care (Public Health Agency of Canada, 2021). This highlighted the importance of taking more proactive steps to identify access disparities, such as enhancing digital education and training, providing language interpretation services, collecting data on virtual service usage, and expanding access to affordable broadband (Public Health Agency of Canada, 2021).

Quality of care was another critical concern. Racialized patients often faced implicit and explicit biases within the healthcare system, which led to their symptoms being dismissed or taken less seriously. This resulted in delayed diagnoses and inadequate treatment (Public Health Agency of Canada, 2021). Beyond this, stigma and discrimination rooted in historical and social determinants of health reinforced mistrust in the healthcare system, deterring some individuals from seeking care (Public Health Agency of Canada, 2021).

Further complicating efforts to address these disparities was the lack of race-based health data, which hindered the development of targeted interventions. McKenzie, Dube, and Petersen (2021) highlighted that 43% of COVID-19 cases in Ontario lacked racial data, complicating the development of targeted interventions. Without comprehensive race-based data, public health officials and policymakers struggled to allocate resources effectively, implement community-specific outreach efforts, and mitigate the disproportionate impact of COVID-19 on racialized populations.

MENTAL HEALTH STRAIN AND SOCIAL ISOLATION

The COVID-19 pandemic brought existing inequalities to the forefront, particularly for racialized communities, which faced significant mental health challenges and social isolation. Many individuals reported increased anxiety due to concerns about contracting and transmitting the virus, uncertainty around work and income, and feelings of disconnection from friends and community. These stressors were further amplified by fear and stigma, as racialized groups—particularly immigrants—were unjustly blamed for spreading the virus (Public Health Agency of Canada, 2021). A Statistics Canada survey found that 29% of immigrants feared being targeted due to perceived exposure risks, with 42% of these individuals attributing their fears to racial stigma (Public Health Agency of Canada, 2021).

Racialized communities also saw a rise in discriminatory incidents, further contributing to mental health distress. A Statistics Canada study revealed that 30% of participants of Chinese descent reported more race-based incidents since the pandemic began, compared to 18% of visible minorities and just 6% of non-visible minorities (Public Health Agency of Canada, 2021).

This rise in discriminatory behavior was part of a broader trend of anti-Asian hate, including sinophobic actions (a fear, dislike, prejudice, or discrimination against China, Chinese people, or Chinese culture) and online stigmatization (Public Health Agency of Canada, 2021). As a result, East Asian communities—particularly Chinese, Korean, and Japanese Canadians—faced both greater mental health distress and higher levels of discrimination than their White counterparts (Public Health Agency of Canada, 2021).

The role of the media in amplifying discrimination is another key factor. South Asian communities, for example, were often unfairly portrayed as non-compliant with public health measures, with media narratives blaming their 'cultural practices'—such as large gatherings and celebrations—for the virus's transmission (Thombani & Butt, 2022). These harmful portrayals reinforced negative stereotypes and contributed to increased levels of discrimination. As a result, racialized individuals felt more alienated and fearful, further worsening mental health challenges, including heightened anxiety, depression, and a pervasive sense of being targeted.

Compounding these struggles was the disruption to family and community life, which is especially significant in racialized communities that are rooted in collectivist cultural values. Multigenerational families, who traditionally rely on in-person gatherings for social and cultural support, faced increased stress as physical distancing measures severed these vital connections. This isolation, in combination with rising discrimination, fear, and economic hardship, deepened mental health struggles. For example, Latin American communities in Canada experienced a significant decline in self-rated mental health, dropping from 68% in Fall 2020 to just 43% by late 2021/early 2022 (Molina et al., 2024). This highlights the emotional toll that social disconnection and increased discrimination took on these communities (Molina et al., 2024).

VACCINE ACCESS, UPTAKE, AND HESITANCY

Barriers to vaccine access and uptake persist across various communities in Canada, particularly among racialized and marginalized populations. For many, the combination of limited access to healthcare services, lack of paid sick leave or vaccination leave, and systemic inequities creates a significant barrier to vaccination efforts (Olanlesi-Aliu et al., 2024). These structural barriers not only reduce access but also contribute to lower vaccine uptake. Additionally, the failure to prioritize these populations during vaccine rollouts has led to lower vaccine acceptance, with BAC Canadians showing a 56.7% vaccination rate, compared to 77.7% among White Canadians and 82.5% among South Asian Canadians

Closely tied to these barriers is the deep-rooted distrust of healthcare systems and vaccine manufacturers, particularly in BAC communities. Historical injustices in healthcare, including medical exploitation and unethical research, have left a legacy of skepticism toward healthcare providers (Olanlesi-Aliu et al., 2024). Studies have consistently found that BAC populations exhibit lower vaccine acceptance and higher hesitancy. Among Black Canadians, only 18.3% reported being vaccinated, while 32.9% remained unvaccinated (Olanlesi-Aliu et al., 2024). This hesitancy is largely driven by experiences of systemic racism and past medical mistreatment, which have eroded trust in healthcare institutions (Olanlesi-Aliu et al., 2024). Additionally, skepticism toward vaccine manufacturers plays a role, as many believe pharmaceutical companies prioritize profit over public health (Olanlesi-Aliu et al., 2024). The rapid development of COVID-19 vaccines has further heightened concerns about their safety, particularly among communities with limited access to trusted health information (Olanlesi-Aliu et al., 2024).

Misinformation exacerbates vaccine hesitancy, particularly through social media, where false claims about vaccine safety and efficacy spread rapidly. Research has shown that misinformation often spreads faster than accurate information, especially when it is sensationalized or framed negatively (Public Health Agency of Canada, 2021). For example, over 60 million views of non-factual COVID-19 videos were recorded, highlighting how misinformation can shape public perception on a large scale (Public Health Agency of Canada, 2021). The spread of conspiracy theories further complicates efforts to combat vaccine hesitancy, as individuals may believe they can distinguish factual from non-factual information yet still embrace false claims (Olanlesi-Aliu et al., 2024).

RESEARCH METHODOLOGY

4.1 RESEARCH DESIGN

The research employed a mixed-methods design, combining both quantitative and qualitative approaches to provide a comprehensive understanding of the health disparities experienced by racialized communities in Ontario. This approach allowed for the collection of both numerical data to measure disparities and qualitative data to explore the lived experiences of individuals from racialized communities.

The research was conducted in two main phases:

Quantiative Phase

The quantitative phase involved analyzing existing race-based data, including health statistics from public health units and other relevant sources, along with a structured survey that was created to assess healthcare experiences. It examined trends in healthcare access, utilization, health outcomes, and disparities exacerbated by the COVID-19 pandemic. The analysis aimed to quantify the extent of disparities within racialized communities and identify key areas of concern.

Qualitative Phase

The qualitative phase involved collecting first-hand accounts and insights from individuals within racialized communities, healthcare providers, and stakeholders involved in policy advocacy and research. This included focus groups and semi-structured interviews to explore the lived experiences of individuals navigating the healthcare system, the barriers they faced, and their perspectives on potential solutions.

This mixed-methods approach ensured a well-rounded analysis, drawing from both statistical trends and the qualitative narratives that provided deeper insights into the challenges faced by racialized communities in accessing equitable healthcare.

4.2 DATA COLLECTION METHODS

Data was collected through a combination of secondary data analysis and primary data collection methods, providing a comprehensive view of the healthcare challenges faced by racialized communities in Ontario. The aim was to gather both broad statistical data and personal insights that would highlight the systemic inequities within the healthcare system.

1. **Secondary Data Analysis:**
    - **Race-Based Data Review:** A comprehensive review of existing race-based data from Ontario's public health units, including health outcomes, vaccination statistics, and healthcare access during and post-pandemic.
    - **Literature Review:** Publicly available reports from health and social service agencies, government publications, and relevant academic literature will be reviewed to understand the broader landscape of healthcare inequities affecting racialized populations.
2. **Primary Data Collection:**
    - **Community Surveys:** A structured survey was distributed to individuals from racialized communities to assess their experiences with healthcare services, including barriers they encounter, perceived discrimination, and their overall satisfaction with the system. To ensure comprehensive representation, the survey collected key demographic data, such as age, gender, ethnicity, language, income level, and immigration status. The survey was designed to ensure accessibility to diverse populations, considering language, literacy levels, and cultural nuances.
    - **Subject Matter Expert Interviews:** Semi-structured interviews were conducted with healthcare professionals and providers, researchers, policy experts, and community leaders. These interviews explored barriers to equitable healthcare from a systemic perspective, the impact of the COVID-19 pandemic, and opportunities for reform. The interviews were conducted flexibly, allowing interviewees to share in-depth insights.
    - **Community Focus Group Discussions (FGDs):** FGDs were organized with members of racialized communities to facilitate open discussions about their healthcare experiences. This method provided an opportunity for participants to engage with each other, share common experiences, and collectively identify potential policy solutions. The FGDs were conducted in multiple languages, such as Arabic, Hindi, Urdu, Spanish, and Chinese, to ensure inclusivity.

Quantitative data will be analyzed in this report using statistical methods to identify patterns and trends in healthcare access and outcomes among racialized communities. Qualitative data will be analyzed through thematic analysis of surveys, interviews, and FGDs to uncover key barriers and community experiences. These findings inform actionable policy recommendations aimed at reducing healthcare disparities near the end of this report. The results will also be shared through academic publications, conferences, and community outreach to ensure widespread impact.

4.3 PARTICIPANT DEMOGRAPHICS

The research study included a total of 3,314 participants from diverse racialized communities in Ontario, ensuring comprehensive representation of populations experiencing healthcare disparities. The inclusion criteria focused on individuals from the South Asian, BAC, LatinX Hispanic, MENA, and East Asian communities. Participants were selected to capture a wide range of experiences, considering intersectional factors such as age, gender, socioeconomic status, and immigration history. The total breakdown of participants is as follows:

3,290
Community Survey Responses

25
Subject Matter Expert Interviews

114
Focus Group Participants

Quantitative data will be analyzed in this report using statistical methods to identify patterns and trends in healthcare access and outcomes among racialized communities. Qualitative data will be analyzed through thematic analysis of surveys, interviews, and FGDs to uncover key barriers and community experiences. These findings inform actionable policy recommendations aimed at reducing healthcare disparities near the end of this report. The results will also be shared through academic publications, conferences, and community outreach to ensure widespread impact.

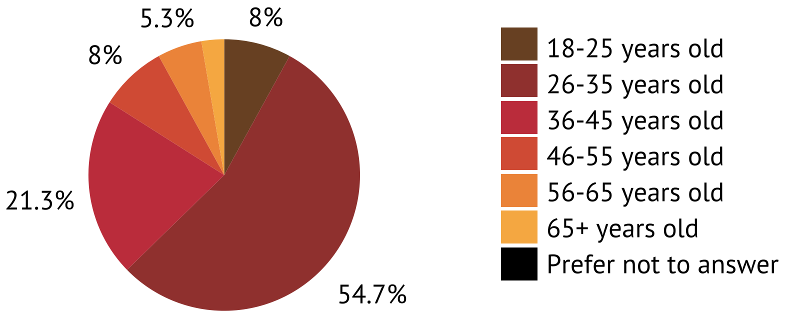
SOUTH ASIAN COMMUNITIES

COMMUNITY SURVEY FINDINGS

The survey recorded 75 responses between October 2024 and January 2025. Participants were required to be 18 years or older, reside within Ontario, and identify with South Asian communities. Data collection was conducted entirely online, and respondents had the option to skip certain questions.

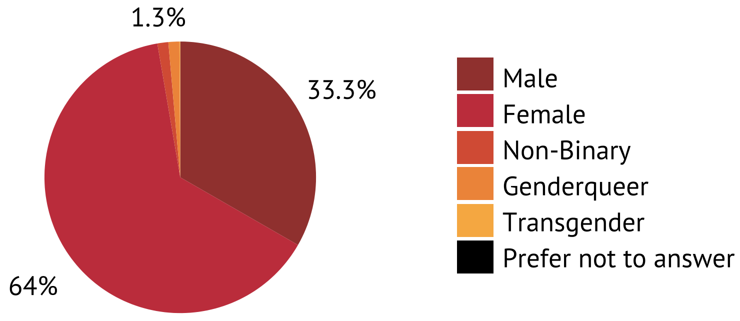
Age distribution indicates that a majority (54.6%) of respondents belong to the 26-35 age group, with smaller proportions represented in younger and older cohorts (Figure 1). This suggests that the survey findings predominantly reflect the perspectives of young adults within the South Asian community.

Figure 1: Age distribution



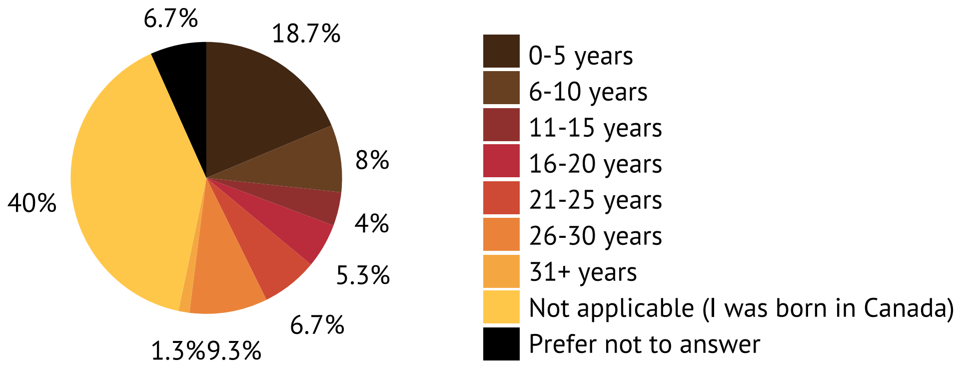
Gender representation shows a predominantly female participant base (64%), followed by male respondents (33.3%), and a smaller proportion (2.6%) identifying as transgender or non-binary (Figure 2). This gender skew may suggest greater engagement from women in discussions surrounding healthcare access and equity.

Figure 2: Gender distribution



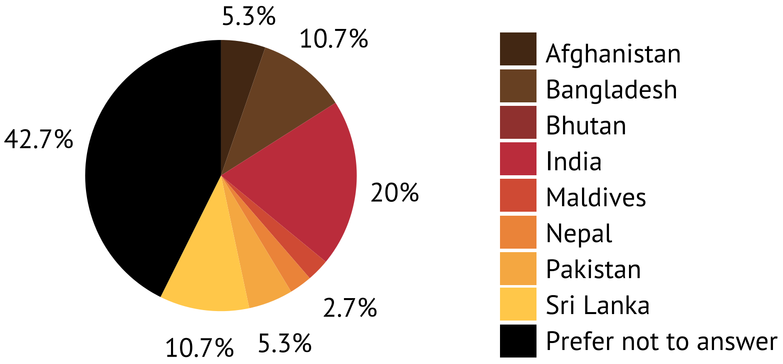
Birthplace data highlight that 52% of participants were born in Canada, while 48% were not, demonstrating a nearly even split between Canadian-born and immigrant experiences. Among those not born in Canada, a significant portion (18.7%) have lived in the country for 0-5 years, while another notable group (17.3%) have resided in Canada for more than 20 years (Figure 3). This diversity in migration timelines may shape different perspectives on healthcare accessibility and systemic barriers.

Figure 3: Number of years in Canada



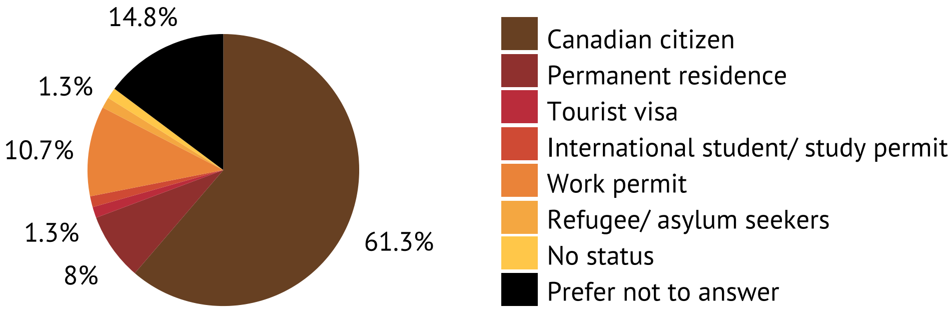
In terms of heritage, respondents identified various South Asian countries such as India, Sri Lanka, Bangladesh, and Pakistan. However, a substantial 42.7% chose not to disclose their heritage (Figure 4), which may indicate privacy concerns or a preference not to define identity strictly by national origin.

Figure 4: Country of origin



Immigration status varied among respondents, with 61.3% identifying as Canadian citizens, followed by smaller groups holding work permits (10.7%), permanent residency (8%), and other statuses (Figure 5). This distribution underscores the range of legal and systemic barriers different groups may face in accessing healthcare services.

Figure 5: Immigration status



Notably, 34.7% of respondents identified as having a disability, highlighting the importance of inclusive and accessible healthcare systems (Figure 6). The most commonly reported disability types were chronic health conditions (25.3%), such as diabetes, hypertension, and asthma; mental health conditions (22.7%), including depression, anxiety disorders, and bipolar disorder; and physical disabilities (16%), which encompassed mobility impairments and limited dexterity (Figure 7). Since Figure 7 allowed respondents to select multiple options, the percentages do not sum to 100%. Given the significant proportion of respondents with disabilities, healthcare interventions should prioritize accessibility in both service delivery and policy-making.

Figure 6: Disability status

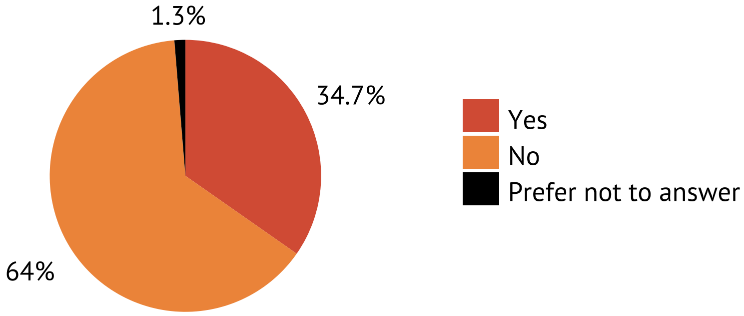
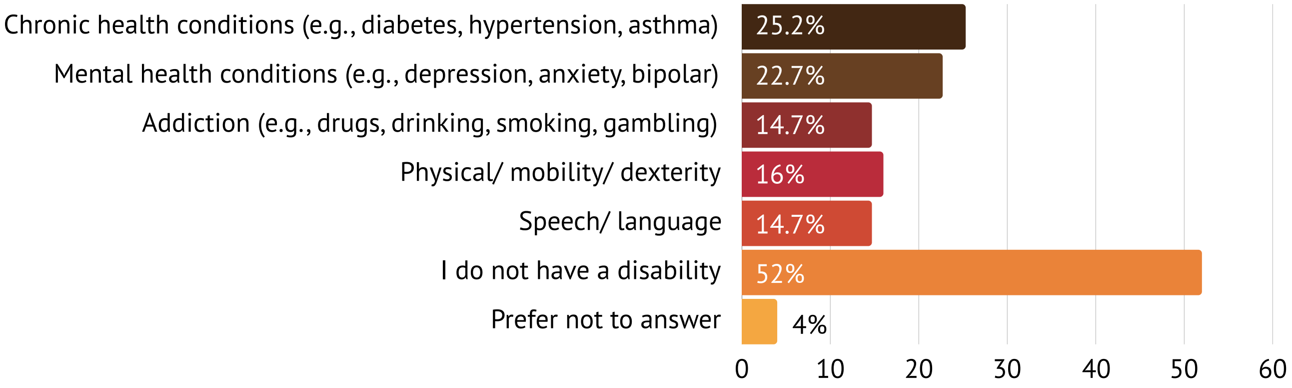
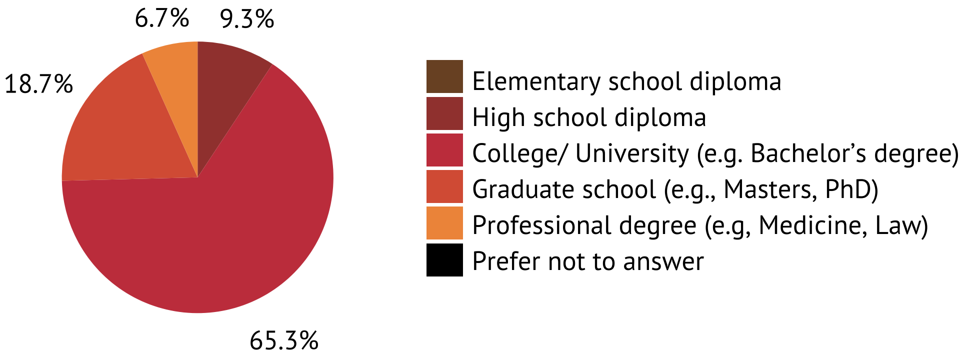


Figure 7: Disability categories



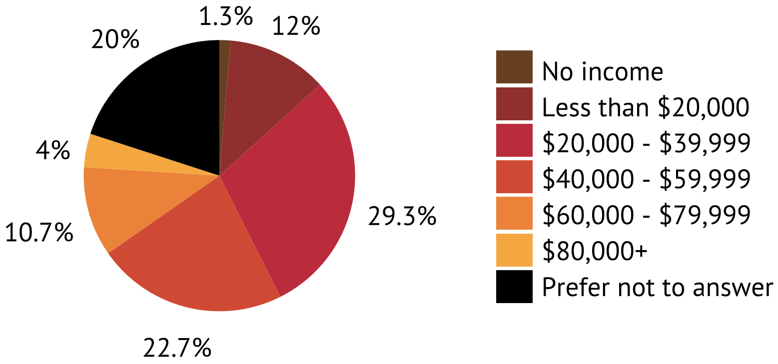
Educational attainment was high, with 65.3% of respondents holding a bachelor's degree, 18.7% possessing a graduate degree, and 9.3% having completed high school (Figure 8). This indicates that most participants have attained post-secondary education, potentially influencing their healthcare literacy and engagement with health services.

Figure 8: Education status



In terms of income, 29.3% of participants reported earning $20,000-$39,999 annually, while 22.7% fell within the $40,000-$59,999 range. Additionally, 12% reported earning less than $20,000, while 20% preferred not to disclose their income (Figure 9). These figures suggest that while a substantial portion of respondents have moderate incomes, a notable percentage fall below $20,000, emphasizing the need to address financial barriers to healthcare access.

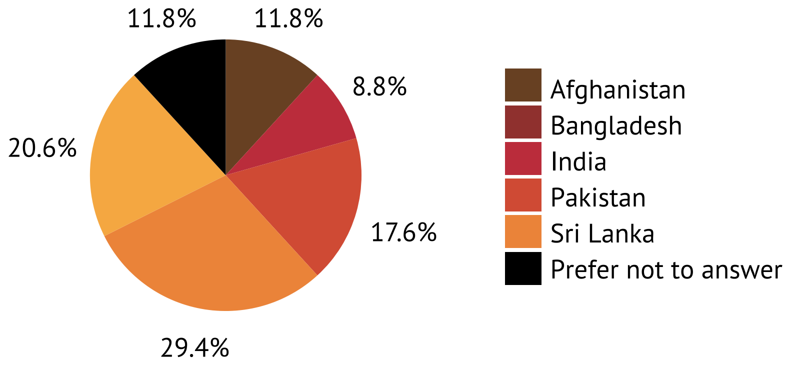
Figure 9: Annual personal income



COMMUNITY FOCUS GROUP DISCUSSIONS FINDINGS

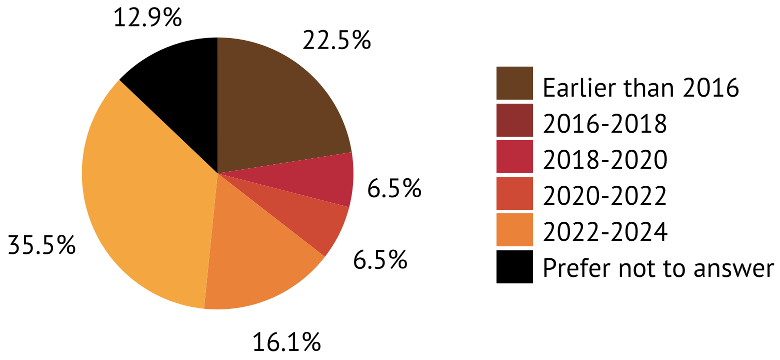
Between November 2024 and January 2025, three FGDs were conducted with a total of 31 participants from the GTA, primarily consisting of newly arrived immigrants. The group had 80.6% female participants and 19.4% male participants, with a diverse representation from Pakistan (29.4%), Sri Lanka (20.6%), India (17.6%), Afghanistan (11.8%), and Bangladesh (8.8%) (Figure 10).

Figure 10: Country of origin



A significant portion of participants (35.5%) arrived in Canada in the last two years (2024-2022), while 16.1% arrived between 2022 and 2020. Additionally, 22.5% of participants have been in Canada for over eight years (Figure 11). These findings indicate a large proportion of recent immigrants who may require targeted healthcare support and resources to navigate the Canadian healthcare system effectively.

Figure 11: Year of arrival



SUBJECT MATTER EXPERT INTERVIEW FINDINGS

Between October 2024 and January 2025, four 1-hour virtual interviews were conducted with SMEs, three of whom identified as female. The experts provided valuable insights on topics surrounding public health, mental health, and healthcare access for South Asian communities.

- **Dr. Ananya Tina Banerjee** – Assistant Professor at McGill University; focuses on community-based participatory research, anti-racism, and South Asian health.
- **Dr. Farah Islam** – Mental Health Advocate, Educator, and Researcher; expert in social determinants of mental health and South Asian mental health.
- **Dr. Danish Rahim** – Family & Walk-in Physician; specializes in family medicine, primary care, and immigrant health.
- **Anonymous SME** – Assistant Professor at McMaster University; expertise in chronic disease prevention, Indigenous Peoples' health, and immigrant health.

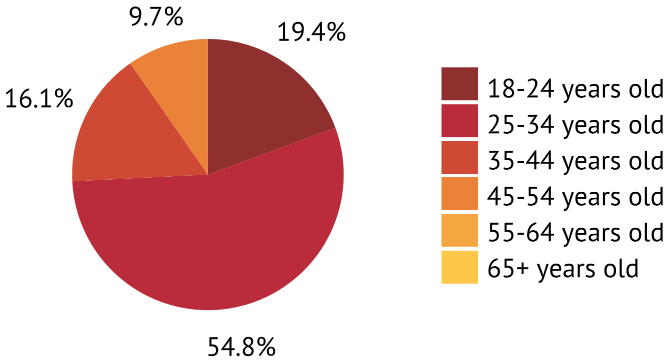
BLACK-AFRICAN-CARIBBEAN COMMUNITIES

COMMUNITY SURVEY FINDINGS

The survey recorded 31 responses between August and October 2024. Participants were required to be 18 years or older, reside within the GTA, and identify with BAC communities. While data collection was primarily conducted online, printed copies were made available to ensure inclusivity and representation.

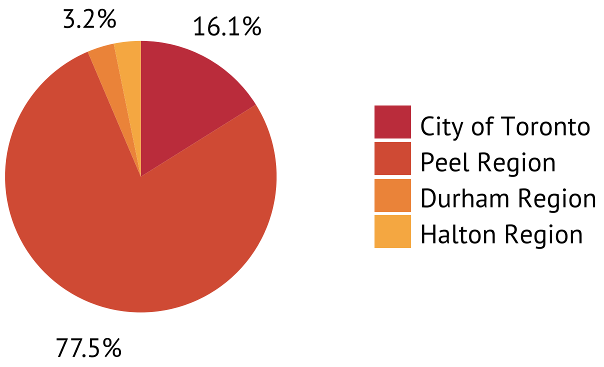
Age distribution shows that a majority (54.8%) of participants fall within the 25-34 age group, with fewer participants from older and younger cohorts (Figure 12). No seniors (65+) completed the survey, indicating that the senior BAC population was not effectively reached. This suggests potential barriers in engaging older community members, such as digital literacy or outreach limitations.

Figure 12: Age distribution



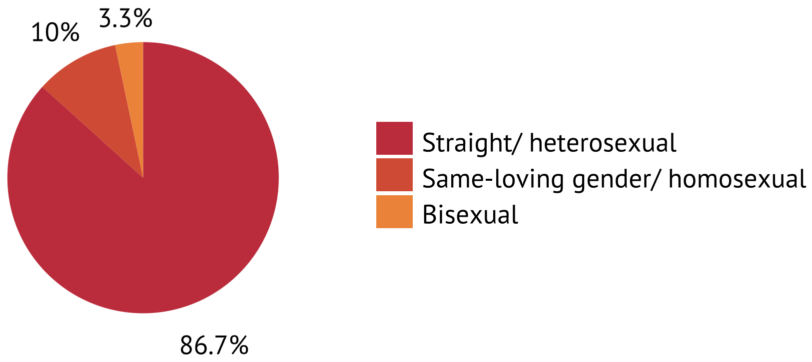
The majority of respondents (77.5%) reside in the Region of Peel, followed by 16.1% in the City of Toronto (Figure 13). Other reported municipalities include Halton Region and Durham Region. This data suggests that health-related challenges and experiences captured in this survey may be more reflective of BAC communities in Peel Region rather than those in Toronto or other GTA areas.

Figure 13: City of residence



Most respondents (86.7%) identify as straight/heterosexual, while 10% are bisexual and 3.3% are same-gender-loving (Figure 14). The relatively small representation of LGBTQ+ individuals suggests that further engagement is needed to better understand the healthcare experiences of sexual minorities within BAC communities.

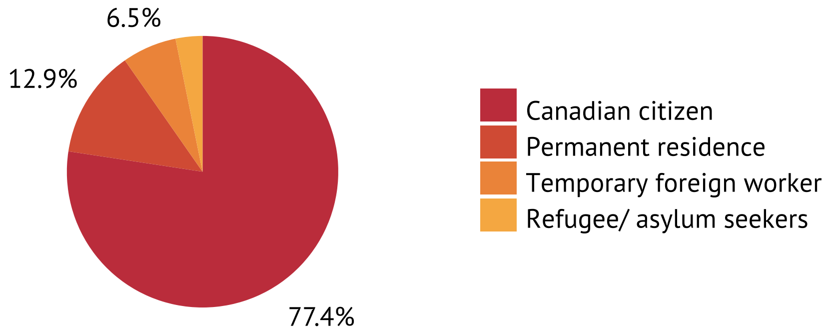
Figure 14: Sexual orientation



Moreover, a significant portion (74.2%) of respondents reported being single, never married, whereas 16.1% were married or in a domestic relationship. This suggests that responses may be skewed towards individuals without immediate family responsibilities, which could impact perspectives on healthcare access and family-related healthcare needs.

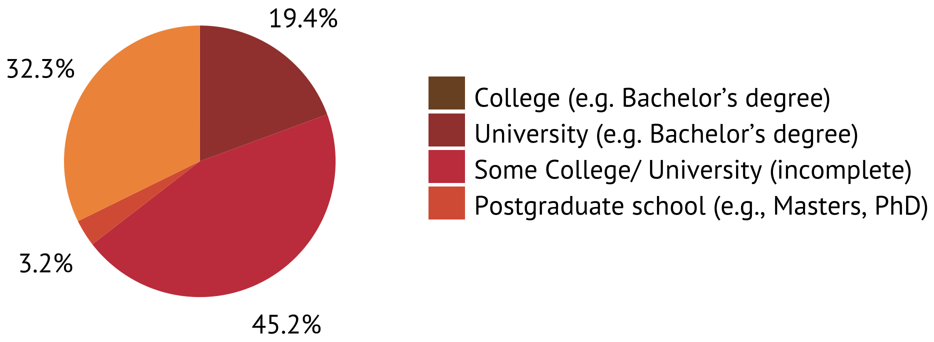
A large share of respondents (77.4%) are Canadian citizens (Figure 15), while 12.9% hold permanent resident status. Smaller groups include temporary foreign workers (6.5%) and refugees or asylum seekers (3.2%). Given the lower response rates from non-citizens, further research is needed to explore healthcare access challenges for temporary and refugee populations.

Figure 15: Immigration status



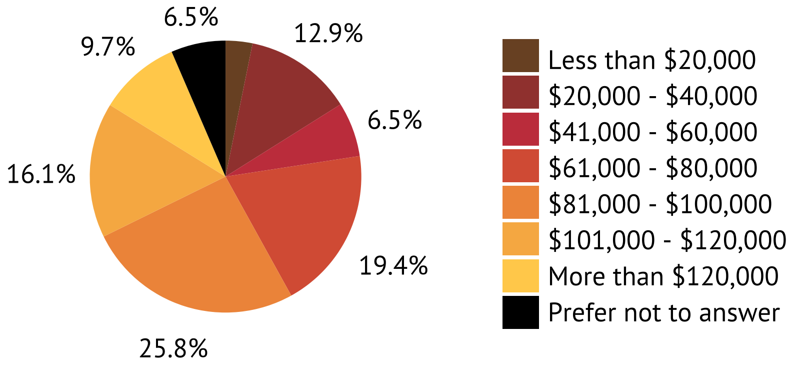
Nearly all respondents (96.9%) have at least a college or university degree, reflecting a high level of educational attainment (Figure 16). However, this also suggests that the survey does not adequately capture the experiences of individuals with lower education levels, who may face different barriers in accessing healthcare.

Figure 16: Education status



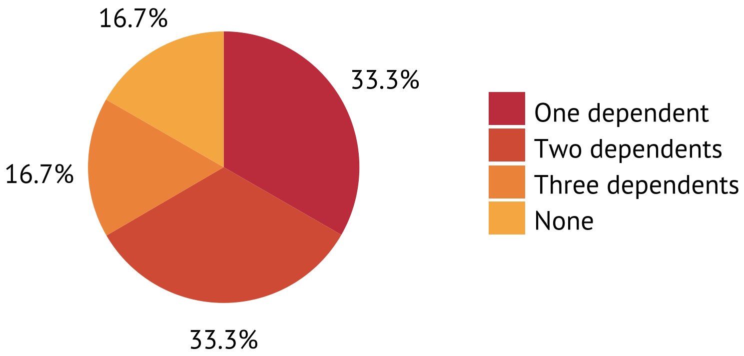
Responses indicate a wide range of income levels, with the vast majority earning below Ontario’s median family income before tax in 2020 ($111,000) (Figure 17). This highlights financial constraints as a potential factor influencing healthcare access. Additionally, 6.5% of respondents declined to disclose their income, possibly reflecting discomfort in sharing financial details.

Figure 17: Annual household income



Finally, family dynamics revealed variation in responses, particularly in the number of dependents within households. A dependent is defined as a family member who is under 18 years of age or a family member 18 years or older with a physical or psychological impairment. A third of respondents (33.3%) reported having one dependent in their household, while another 33.3% reported having two dependents (Figure 18). Additionally, 16.7% of respondents reported having three dependents, while another 16.7% reported having none (Figure 18). These responses reflect a diversity of family structures, which may influence healthcare needs and access.

Figure 18: Family dynamics



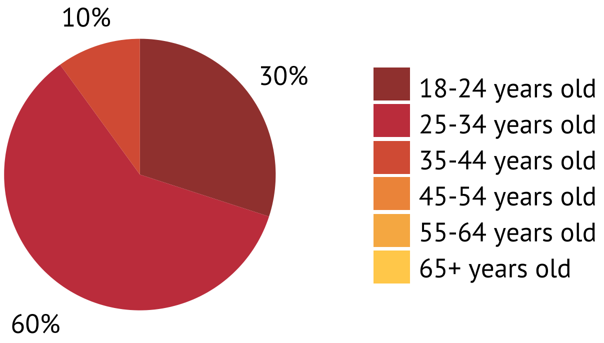
COMMUNITY FOCUS GROUP DISCUSSIONS FINDINGS

Between September and October 2024, five FGDs were conducted with a total of 20 participants. All participants, except for one man, identified as women, highlighting the absence of male and non-binary voices. This calls for future research to include a broader range of gender identities.

In terms of residence, 70% of participants reside within the Region of Peel, followed by 25% in the City of Toronto. The data suggests that perspectives from other regions, especially those outside the GTA, were underrepresented. Future research could benefit from a broader geographic scope to ensure a more comprehensive understanding of healthcare access across diverse areas.

In terms of age distribution, 60% of participants were between 25-34 years old, followed by 30% in the 18-24 age range and 10% in the 35-44 age range. No participants were represented in the 45-54 or 65+ age groups, indicating that the perspectives of older community members were underrepresented. (Figure 19)

Figure 19: Age distribution



The vast majority (90%) of participants are single and never married, and 90% identify as straight/heterosexual, while 10% identify as bisexual. This reflects limited representation of individuals from sexual minorities, indicating a gap in understanding the healthcare needs of this group.

As for legal status, most participants (85%) are Canadian citizens, which may limit the diversity of insights into the healthcare experiences of temporary foreign workers, international or exchange students, and refugees/asylum seekers.

Regarding education, 95% of participants have at least a college or university degree, suggesting a high level of educational attainment. However, this also means the experiences of individuals without post-secondary education are not captured, warranting future research to address this gap and explore healthcare access challenges for less educated populations.

SUBJECT MATTER EXPERT INTERVIEWS FINDINGS

Between August and October, 2024, five 1-hour virtual interviews were conducted with the following SMEs, providing further insights into the BAC communities during the COVID-19 pandemic:

- **Dr. Trudy McFarlane** – Family Physician, General Practitioner, Psychotherapist, and Medical Consultant; Black Health Lead at Toronto Metropolitan University School of Medicine.
- **Dr. Ato Sekyi-Otu** – Orthopedic Surgeon at William Osler Health System; Lecturer in the Department of Surgery at the University of Toronto.
- **Suleman Sule** – Project Manager at Health Commons Solutions Lab, Sinai Health; specializes in knowledge mobilization in racialized communities, program development, and implementation.
- **Lydia-Joi Marshall** – Director of Evaluation and Practice at Health Commons Solutions Lab, Sinai Health; expert in human genetics, health equity, advocacy, and community-based participatory research.
- **Angela Carter** – Advisor for Strategic Initiatives at Black Health & Social Services (BHSS); focuses on community engagement, health equity, advocacy, and anti-Black racism.

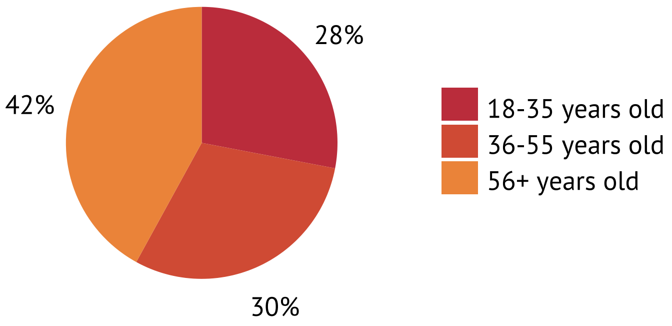
LATINX HISPANIC COMMUNITIES

COMMUNITY SURVEY FINDINGS

The survey recorded 40 responses between September and October 2024. Participants were required to be 18 years or older, reside within the GTA, and self-identify as LatinX or Hispanic. The primary mode of data collection was online, though accommodations were made for participants facing connectivity challenges or lacking digital access. In such cases, surveys were completed in person using paper forms to ensure inclusivity and representation.

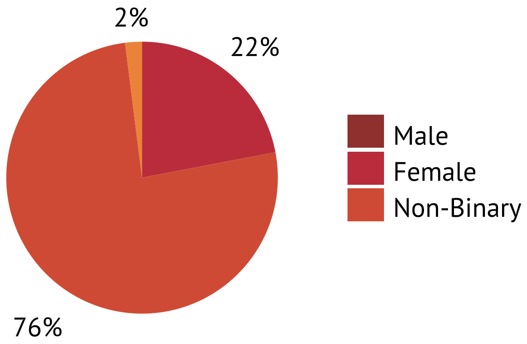
Age distribution within the sample reveals a fairly balanced spread, though it leans slightly toward older individuals. The largest group of participants (42%) are aged 56 and older, followed by 30% in the 36-55 age group, and 28% in the 18-35 age group (Figure 20). This suggests that the survey captures a diverse range of age demographics, with a notable emphasis on older participants. However, the largest group of respondents is aged 56 and older, which may shape the perspectives shared by this cohort.

Figure 20: Age distribution



Gender representation shows a predominantly female participant base (76%), followed by male respondents (22%), and a smaller proportion identifying as non-binary (2%) (Figure 21). There is a significant female predominance, which could influence gender-based analyses and considerations.

Figure 21: Gender distribution



In terms of sexual orientation, the survey indicates that 93% of participants identify as straight/ heterosexual, while 7% identify as lesbian, gay, bisexual, queer, or Two-Spirit (LGBTQ2S+). This suggests limited representation of sexual minorities within the sample, reflecting a largely heterosexual group.

Immigration status reveals a relatively diverse mix, with 58% of participants identifying as Canadian citizens or permanent residents, while 42% are non-permanent residents. This near-equal distribution suggests that the sample includes individuals with varied legal statuses, offering a broad perspective on this demographic characteristic.

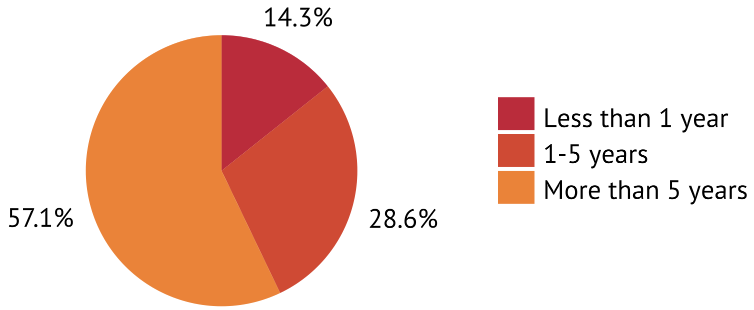
Educational attainment among participants shows that 75% have completed high school or less, while only 25% have pursued post-secondary education, such as university or college. This highlights that the majority of respondents have lower formal education levels, which may influence their socioeconomic perspectives and access to healthcare.

COMMUNITY FOCUS GROUP DISCUSSIONS FINDINGS

Between September and October 2024, four focus groups were conducted with 28 participants from diverse subpopulations within the LatinX Hispanic community, including women (31-65 years), seniors (65+), youth (16-30 years), and LGBTQ2S+ individuals.

Permanent residents and Canadian citizens made up 75% of the sample, while non-permanent residents accounted for 25%. A majority (57.1%) had been in Canada for over five years, indicating a well-established immigrant population (Figure 22). Only 14.3% had been in Canada for less than one year, suggesting fewer recent arrivals compared to long-term residents (Figure 22). The FGDs aimed to address the unique experiences and barriers faced by both groups, ensuring the study captured a broad spectrum of voices within the community.

Figure 22: Number of years in Canada



SUBJECT MATTER EXPERT INTERVIEWS FINDINGS

Between September and October 2024, six 1-hour virtual interviews were conducted with SMEs, five of whom identified as female. The interviews were conducted with experienced community workers and public health professionals in Toronto, selected for their expertise and hands-on experience in addressing the needs and challenges of the Latinx population.

- **Anonymous SME** – Community Legal Advocate at the Center for Spanish-Speaking People; specializes in legal support, advocacy, and facilitating access to essential services for Spanish-speaking communities.
- **Anonymous SME** – Health Outreach Coordinator at Scarborough Centre for Healthy Communities; expert in senior health, targeted health interventions, and community-based wellness programs.
- **Anonymous SME** – Youth and Women's Empowerment Facilitator at Jane and Finch Community and Family Centre; focuses on program development, women's and youth empowerment, and supporting marginalized communities.
- **Anonymous SME** – Senior Services Specialist at Family Service Toronto; expert in senior care, community engagement, and comprehensive support services for aging populations.
- **Anonymous SME** – Refugee Support Coordinator at FCJ Refugee Centre; specializes in refugee assistance, healthcare access, and legal and social support networks.
- **Anonymous SME** – Community Housing Advocate at the Center for Spanish-Speaking People; expert in legal advocacy, housing rights, and support for Spanish-speaking communities.

MIDDLE EASTERN AND NORTH AFRICAN COMMUNITIES

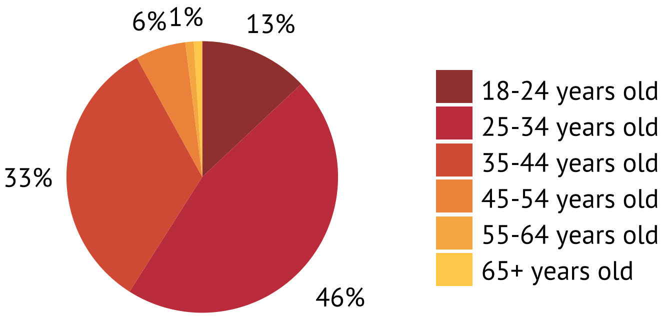
COMMUNITY SURVEY FINDINGS

The survey recorded 3,115 responses between September 23, 2024 and October 23, 2024. Participants were required to be 18 years or older, reside within Ontario, speak either English or Arabic, and self-identify as Arab. The data collection was conducted entirely online, with the survey available in both languages to ensure accessibility.

The majority of participants, 94.7% (2,949 responses), completed the survey in English, while 5.3% (166) completed in Arabic. This indicates that most respondents were comfortable engaging with health-related topics online in English, though Arabic-language accessibility remains an important factor.

The survey findings showed that the largest demographic group consisted of young and middle-aged adults. 46% of respondents were between the ages of 25 and 34, while 33% were between 35 and 44 years old (Figure 23). The concentration of responses within this age range suggests a high level of engagement with health-related issues among young Arab Canadians. It is also possible that the recruitment strategy, which relied heavily on social media outreach, contributed to this trend by attracting a younger audience.

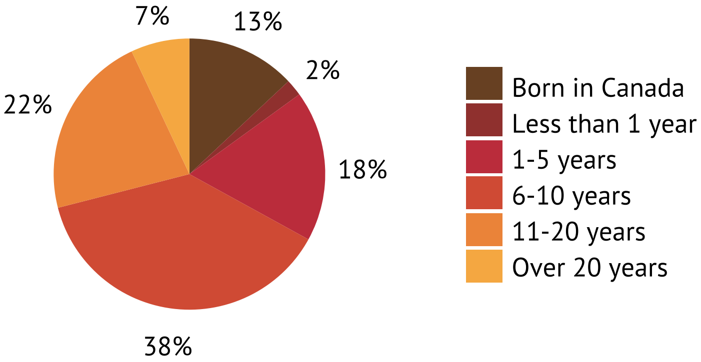
Figure 23: Age distribution



In terms of gender representation, 63% of participants identified as male, 36% identified as female, and 1% preferred not to disclose their gender identity. The gender distribution in the survey indicates a slight male skew, which may reflect differences in how men and women engage with health-related surveys within the Arab Canadian community.

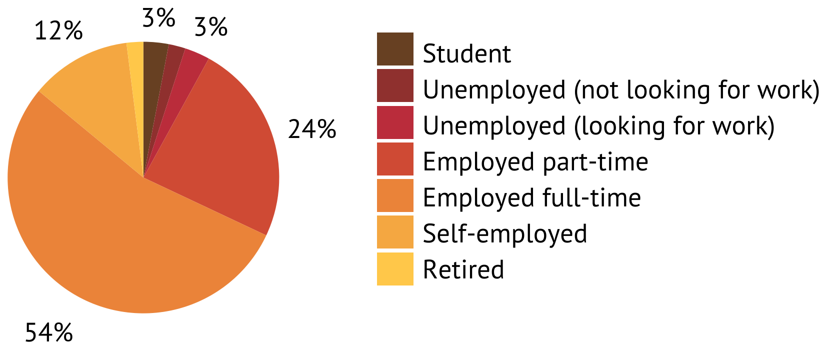
While a majority of respondents were born in Canada, the survey also captured the experiences of immigrants from various Arab countries, including Saudi Arabia, Qatar, Lebanon, Syria, and Egypt. Among those not born in Canada, 38% had been living in the country for six to ten years, while 20% had arrived within the past five years (Figure 24). The significant proportion of recent immigrants highlights potential challenges related to healthcare access, system navigation, and overall integration into Canadian health services.

Figure 24: Number of years in Canada



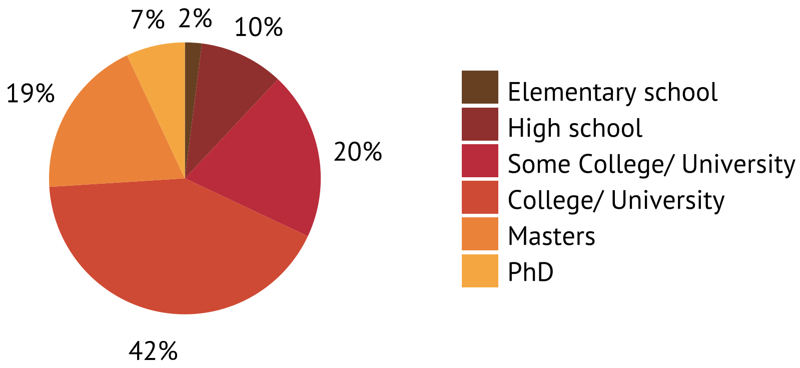
Employment status data indicated that 54% of respondents were employed full-time, while 24% were working part-time (Figure 25). The remaining respondents included unemployed individuals, students, and those who were self-employed or engaged in other activities.

Figure 25: Employment status



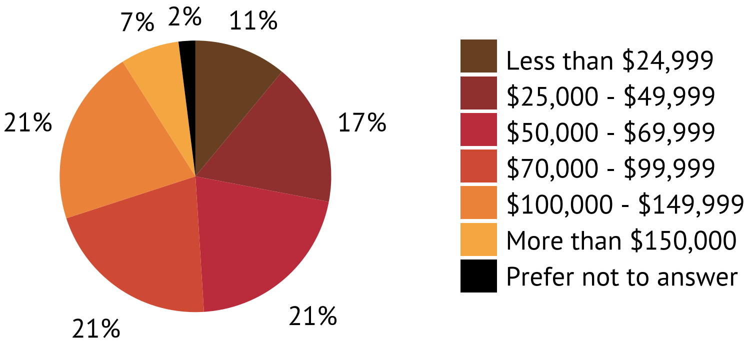
The survey also found that educational attainment levels were relatively high, with 64% of participants holding a bachelor's degree or higher (Figure 26). This suggests that a significant portion of the Arab Canadian population surveyed has access to post-secondary education, which may influence their awareness of healthcare services and their ability to navigate the healthcare system effectively.

Figure 26: Education status



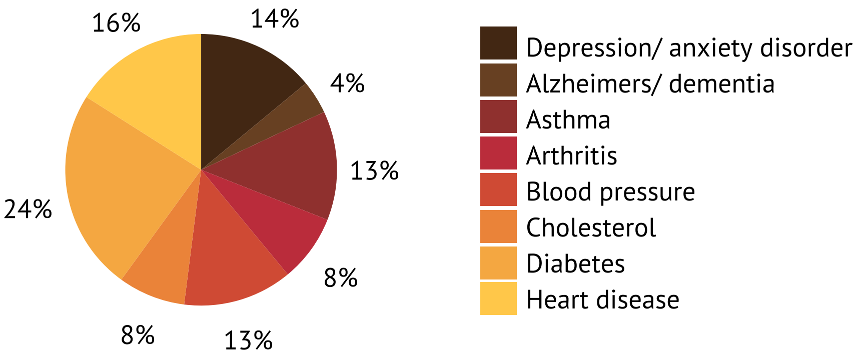
Income levels among respondents varied, reflecting a diverse range of financial situations. Twenty-eight percent of participants reported earning less than $50,000 annually, while 21% had an annual income between $50,000 and $69,999 (Figure 27). The presence of a considerable number of individuals in lower income brackets suggests that financial constraints could be a barrier to accessing healthcare services.

Figure 27: Annual household income



While most respondents reported positive perceptions of their physical and mental well-being, a significant proportion were living with chronic health conditions. Forty percent of participants indicated they had been diagnosed with at least one chronic condition—diabetes, heart disease, and mental health issues being the most common. Diabetes was the most prevalent, affecting 24% of respondents, followed by heart disease at 16%, and mental health conditions, including depression and anxiety, at 14% (Figure 28). The high prevalence of diabetes within the Arab Canadian community appears to surpass the national average, underscoring the need for targeted chronic disease prevention and management programs tailored to this population’s specific health needs

Figure 28: Chronic health conditions



SUBJECT MATTER EXPERT INTERVIEWS FINDINGS

Between July 24th to August 25th 2024, five 1-hour virtual interviews were conducted with SMEs, three of whom identified as female, with ages ranging from the mid-30s to late 50s. These interviews aimed to gather expert insights into the healthcare experiences, challenges, and priorities of Arab residents in Ontario.

- **Anonymous SME** – Executive Director; expert in newcomer community support.
- **Anonymous SME** – Executive Director; expert in newcomer community support.
- **Anonymous SME** – Doctor and Business Owner; specializes in the healthcare system and disability support.
- **Anonymous SME** – Hospital Media Manager; expert in healthcare promotion.
- **Anonymous SME** – Professor and Nurse; specializes in refugee and immigrant health, food and housing insecurities, intersectionality, and social justice.

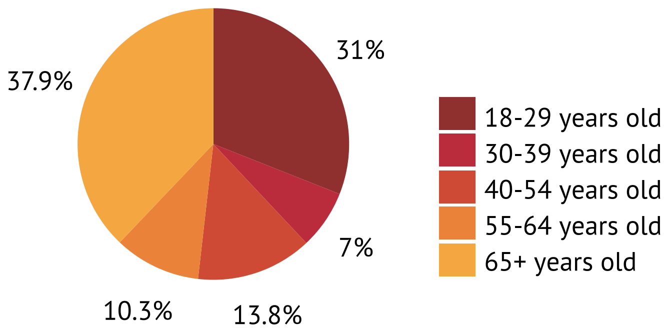
EAST ASIAN COMMUNITIES

COMMUNITY SURVEY FINDINGS

The survey recorded 29 responses between September 2024 and October 2024. Participants were required to be 18 years or older, reside within the GTA, and identify as Chinese. The survey was conducted entirely online via Google Forms, the survey was bilingual, allowing responses in Traditional Chinese, Simplified Chinese, and English. However, to accommodate seniors requiring assistance with digital input, one in-person survey session was held, during which nine seniors provided their responses with support.

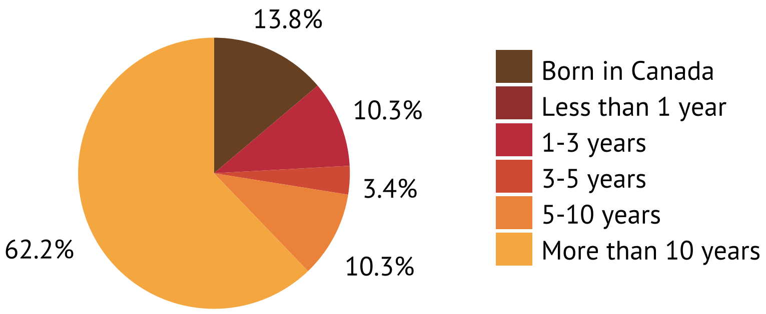
Age distribution indicates that a majority (37.9%) of respondents belong to the 65+ age group, with a close proportion (31%) represented in the 18-29 age group (Figure 29). This suggests that the survey findings predominantly reflect the perspectives of seniors and young adults within the Chinese community.

Figure 29: Age distribution



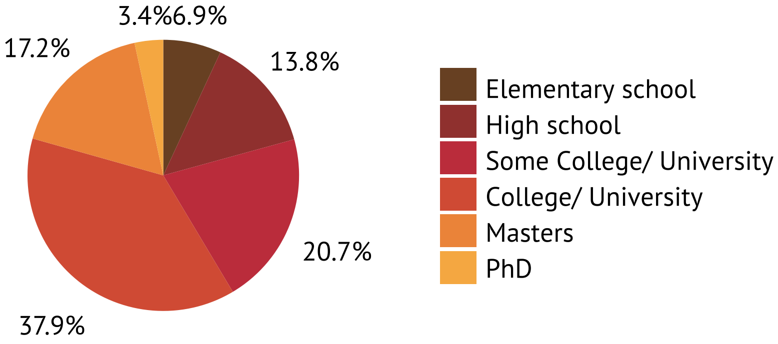
Duration of stay data highlight that the majority (62.1%) of participants have been in Canada for over 10 years, while a quarter (24%) are recent or older immigrants (in Canada for less than 1 year to under 10 years) (Figure 30). In contrast to the focus group demographics, survey data reflected a split in age groups, with participants primarily falling into two categories: young adults (39 and below) and seniors (65 and older). This suggests a willingness of both younger and older community members to engage in the study.

Figure 30: Number of years in Canada



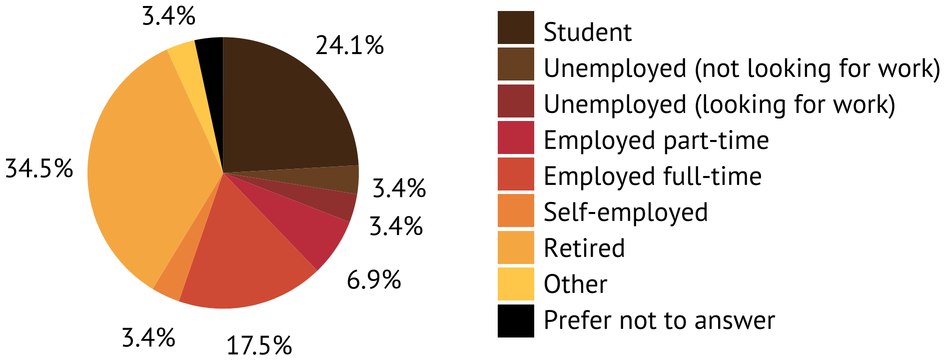
Educational attainment was significantly high, with the majority (58.5%) of respondents holding a Bachelor's degree, college diploma, graduate degree, Master and/or PhD (Figure 31). This indicates that most participants have attained post-secondary education, potentially influencing their healthcare literacy and engagement with health services.

Figure 31: Education status



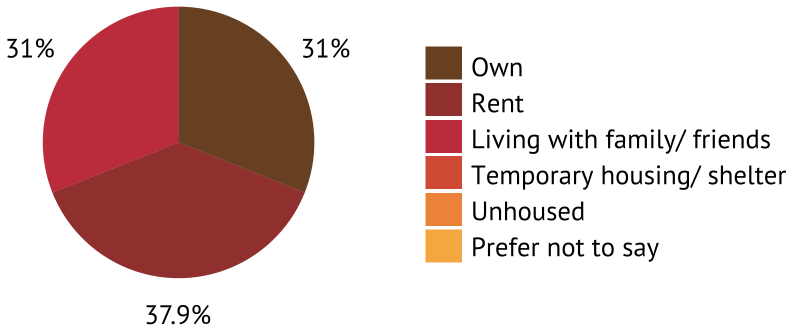
The majority of respondents (58.6%) were either students or retired (i.e., not employed) (Figure 32). In addition to the predefined categories in the Google Form, one respondent indicated they were unemployed and actively seeking work, another stated they were unemployed but not looking for work, and a third described themselves as elderly and resting (i.e., not working).

Figure 32: Employment status



In terms of housing, the majority (68.9%) of respondents rented or lived with family or friends (Figure 33). It highlights that homeownership may not be as common among this group, and could suggest a need for housing support or policies addressing rental and shared living situations.

Figure 33: Housing situation



Although income disclosure was optional, the responses varied significantly between the survey and the FGDs. Only 44.83% of survey respondents chose to share their income. Of those, 10.3% reported an income level of $60,000-$66,000 annually, while 6.9% shared an income level of over $100,000 annually.

COMMUNITY FOCUS GROUP DISCUSSIONS FINDINGS

Between September 2024 and October 2024, five focus groups were conducted with a total of 35 participants. All participants were required to be 18 years or older, reside within the GTA, and identify as Chinese.

The majority of focus group participants (51.4%) were adults aged 25-54, while a substantial portion (45.7%) were older adults (55+) and seniors (Figure 34). To broaden the project's reach, CCNC-TO collaborated with Friends of Chinatown (FOCT) and 105 Gibson Center, two organizations that serve and engage marginalized Chinese workers and seniors. All 15 focus group participants recruited through FOCT and 105 Gibson Center were 25 years or older (Figure 35).

Figure 34: Age distribution (CCNC-TO)

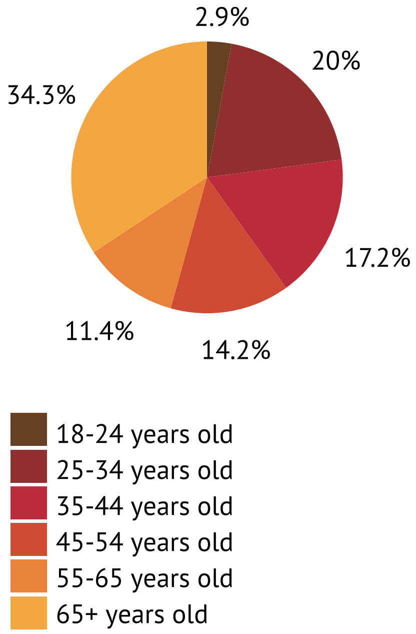
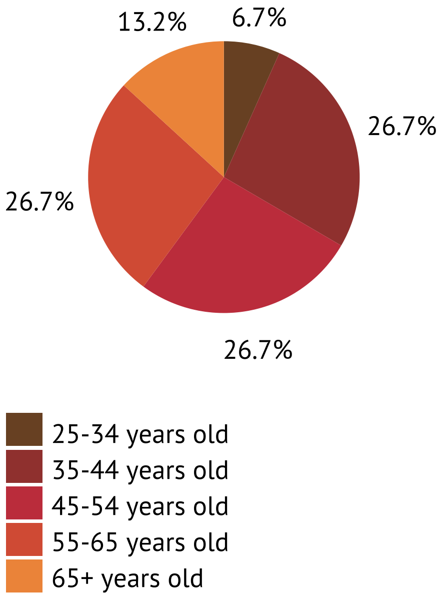
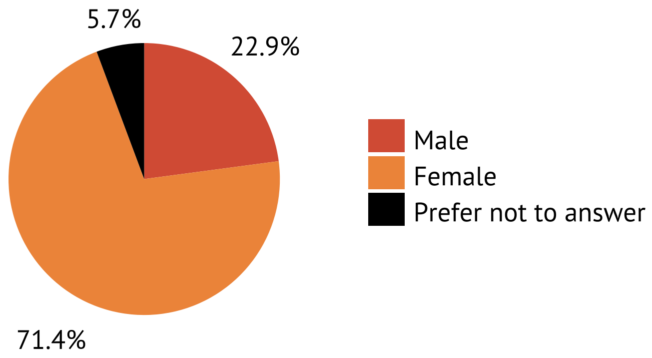


Figure 35: Age distribution (FOCT & 105 Gibson Centre)



The majority of participants (71.4%) identified as female, while 22.9% identified as male. Additionally, 5.7% of focus group participants chose not to disclose their sex or gender. (Figure 36)

Figure 36: Gender distribution



Nearly half of the participants (48.6%) had lived in Canada for over 10 years, while a significant portion (34.2%) had been in Canada for less than 1 year to 5 years (2020-2025) (Figure 37). These findings reflect both a well-established immigrant demographic and a substantial group of new and recent immigrants. In the FOCT and 105 Gibson Center focus groups, 50% of participants were new and recent immigrants (Figure 38). Their responses suggest that a considerable segment of the Chinese community may need targeted healthcare support and resources to navigate the Canadian healthcare system effectively.

Figure 37: Number of years in Canada (CCNC-TO)

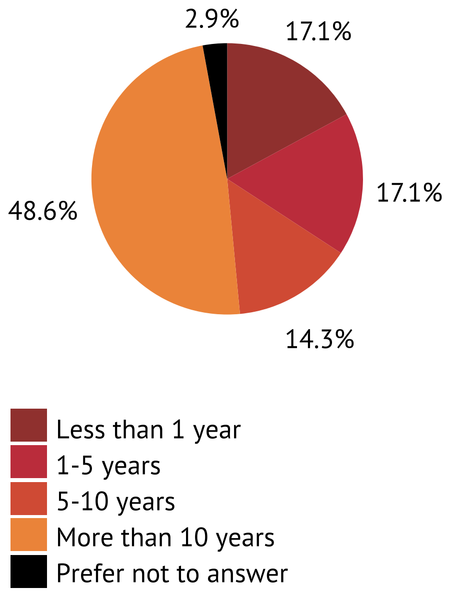
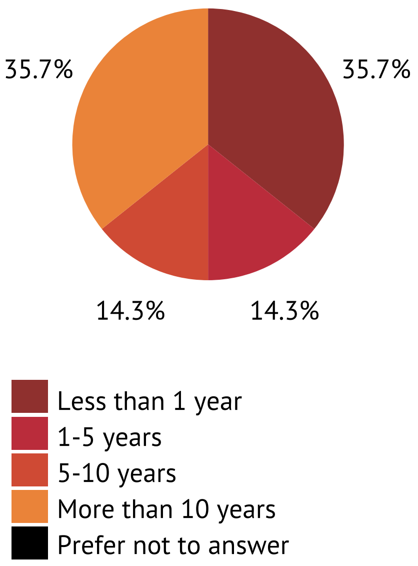
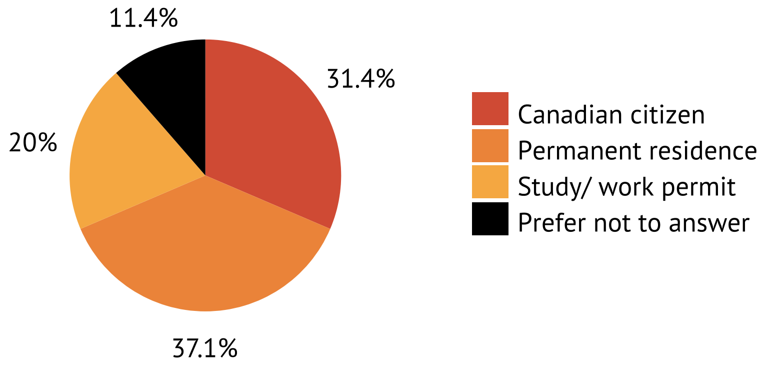


Figure 38: Number of years in Canada (FOCT & 105 Gibson Centre)



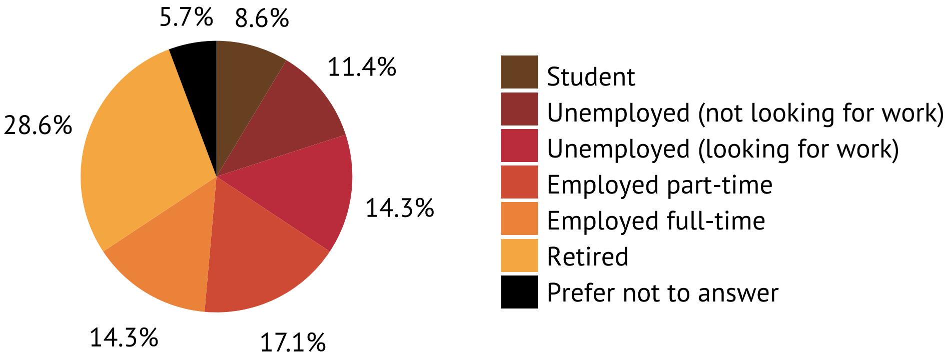
A significant majority of respondents (68.5%) identified as Canadian citizens or Permanent Residents (Figure 39). However, their participation in this research study suggests that many long-term and established immigrants still face challenges navigating the Canadian healthcare system. Their insights and recommendations highlight ongoing gaps and opportunities to improve healthcare experiences and outcomes for Chinese Canadian immigrants.

Figure 39: Immigration status



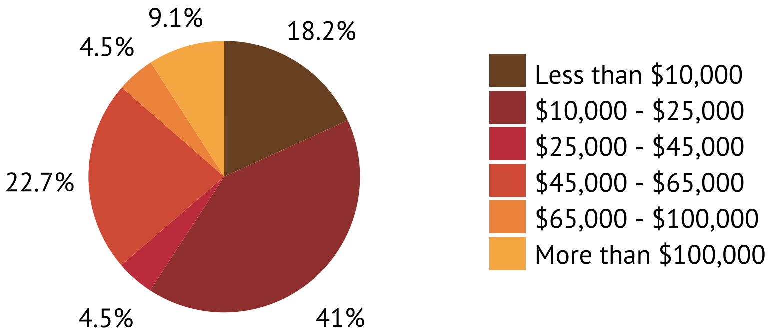
Most participants (34.4%) were retired or not seeking employment, while a nearly equal proportion (31.4%) were employed either full-time or part-time (Figure 40). This suggests varied employment statuses, which could influence healthcare access and disparities. Those not in the workforce may face different challenges in accessing healthcare compared to those who are employed.

Figure 40: Employment status



Although not all focus group participants disclosed their income, 62.8% chose to share this information. Among them, the majority (41%) reported earning less than $25,000 annually. This is consistent with the fact that most participants (62.9%) were retired, unemployed, not seeking work, or students (Figure 41).

Figure 41: Annual household income



SUBJECT MATTER EXPERT INTERVIEW FINDINGS

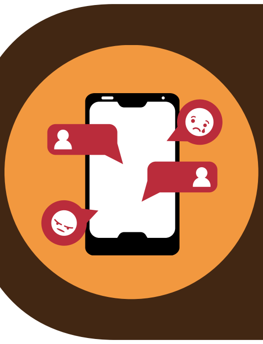
Between September 18-24, 2024, five SMEs participated in one-on-one virtual interviews. The interviews, which lasted between 1 to 1.5 hours, were conducted in Cantonese (1), English (1), and Mandarin (3). The experts had between 2 and 20 years of experience working in various health-related settings with Chinese community members. Four of the experts specialized in mental health service support, while one worked as a community worker, addressing various healthcare needs within the community.

- **Anonymous SME** – Expert in healthcare promotion, self-management of chronic conditions, and mental health wellness.
- **Anonymous SME** – Expert in newcomer community support, integration, and services for immigrant populations.
- Anonymous SME – Expert in mental health case management
- **Hannah Xu** – Lead of Youth and Family Services at Hong Fook Mental Health Association; specializes in youth mental health and health promotion.
- **Tin Man Cheung (RSW**) – Newcomer Youth Mental Health Worker at the Centre for Immigrant and Community Services; specializes in newcomer mental health and culturally sensitive care.

4.4 LIMITATIONS OF THE STUDY

The study faced limitations in reaching diverse racialized communities, with challenges in outreach, participation, and data collection, which may have impacted the representation and understanding of their healthcare experiences.

Methodological Variation and Community-Specific Adaptations
The study employed diverse research methods (surveys, FGDs, SME interviews) and adapted questionnaires and guides to the cultural and linguistic contexts of each community. While this ensured relevance, it introduced inconsistencies in data collection, potentially affecting the comparability of findings across groups.



Sampling and Access Bias
Despite efforts to include diverse participants, outreach limitations (e.g., social media advertising restrictions), mistrust, language barriers, and digital inaccessibility may have led to underrepresentation or overrepresentation of certain groups, affecting the data quality and depth of healthcare insights.

Limited Healthcare Worker Representation
Ethical protocols and logistical challenges hindered effective outreach to certain healthcare workers, limiting the inclusion of their perspectives and experiences in the study. As a result, the study may not fully reflect the diverse viewpoints of healthcare providers

Self-Reported Data
The study's reliance on surveys, FGDs, and SME interviews meant the findings were based on self-reported experiences, which may have been influenced by personal biases, memory recall issues, and social desirability bias, potentially affecting the accuracy of the data.

Automated Responses
Bots and individuals outside the target population may have submitted survey responses, skewing the data's validity and reliability. Although manual cleaning was conducted to remove suspicious, duplicate, or irrelevant entries, this limitation may have still impacted the accuracy of the healthcare experiences represented in the findings.

Cultural Sensitivity and Interpretation
While efforts were made to ensure cultural relevance and language accessibility, subtle nuances in experiences, expressions, and meanings may not have been fully captured or accurately interpreted across diverse cultural contexts, potentially impacting the depth of the findings.

Limited Longitudinal Data
The study primarily relies on cross-sectional data, capturing experiences and trends at a single point in time. This approach limits the ability to track long-term changes, developments, or causality in healthcare disparities, offering only a snapshot of the current situation.

Generalizability
The findings from this study may not be fully generalizable to all racialized communities in Ontario, as experiences can vary across regions, socio-economic statuses, immigration statuses, and other factors like cultural backgrounds and healthcare access. s a result, the conclusions drawn from this study may not fully capture the diversity of experiences within all racialized groups across the province.

Resource Limitations
The scope of the study was constrained by the available resources, including time, funding, and personnel. These limitations may have affected the depth and comprehensiveness of data collection and analysis, restricting the ability to explore certain aspects of the healthcare experiences in more detail.

While these limitations present challenges to the generalizability and completeness of the study's findings, they also highlight areas for further exploration. Future research should address the gaps in representation, particularly by developing strategies to reach underrepresented groups, improving outreach to healthcare workers, and incorporating longitudinal data to capture changes over time. Additionally, refining data collection methods to minimize biases and cultural misinterpretations will help ensure that future studies offer a more comprehensive and accurate understanding of the healthcare experiences of racialized communities. By expanding research scope and resources will lead to more nuanced insights, informing better policies and interventions for racialized communities.

FINDINGS

5.1 SOUTH ASIAN COMMUNITIES

COMMUNITY SURVEY FINDINGS

This survey recorded 75 responses between October 2024 and January 2025. Participants were required to be 18 years or older, reside within Ontario, and identify with South Asian communities. The data collection was conducted exclusively online.

The survey explored several key areas, including:

- Demographics (refer to section 4.3)
- Access to Healthcare Services During the Pandemic
- Experiences with Care Quality and Health Outcomes
- Personal Well-being and Coping Strategies During the Pandemic
- Discrimination and Cultural & Religious Barriers in Healthcare
- Support Systems: Family, Community, and Government
- Concerns and Recommendations for Future Healthcare Needs

A total of 41 questions were included, ensuring a comprehensive exploration of these themes.

ACCESSING HEALTHCARE SERVICES DURING THE PANDEMIC

Of the respondents, 89.3% reported navigating healthcare services during the pandemic in Canada, while 10.7% did not. This suggests that most individuals sought out healthcare services during this period, although it does not confirm whether they were successful in accessing care.

Frequency of healthcare use among respondents was mixed. While 48% sought healthcare services occasionally, 25.3% did so often, and 17.3% rarely (Figure 42). The most commonly sought services were primary care through family doctors (60%), COVID-19 vaccine & screening clinics (49.3%), and specialized care services (46.7%), particularly for mental health and chronic conditions (Figure 43). However, despite being the most commonly sought, primary care services were also the most difficult to access (48%), followed by specialized care (38.6%) and emergency services (33.3%) (Figure 44). This indicates that while there is a strong demand for these services, barriers such as availability, wait times, and access limitations make them challenging to obtain, suggesting a gap between need and access.

Figure 42: How often did you seek healthcare services during the pandemic?

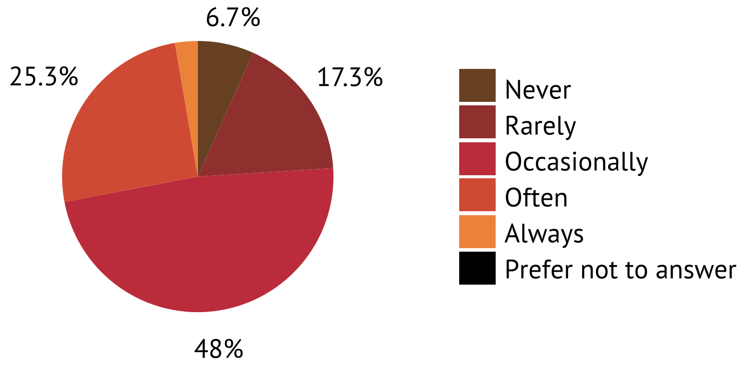


Figure 43: Which types of healthcare services did you need most frequently during the pandemic? (Select all that apply)

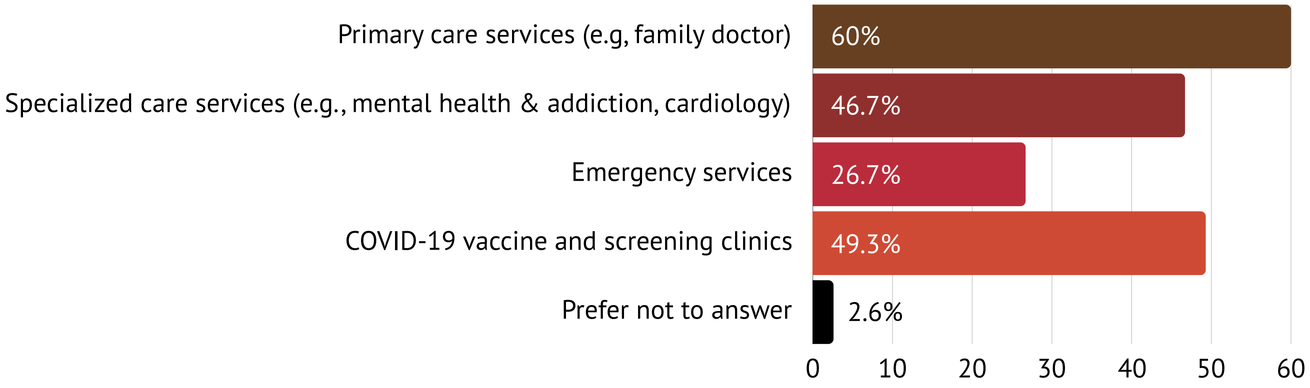
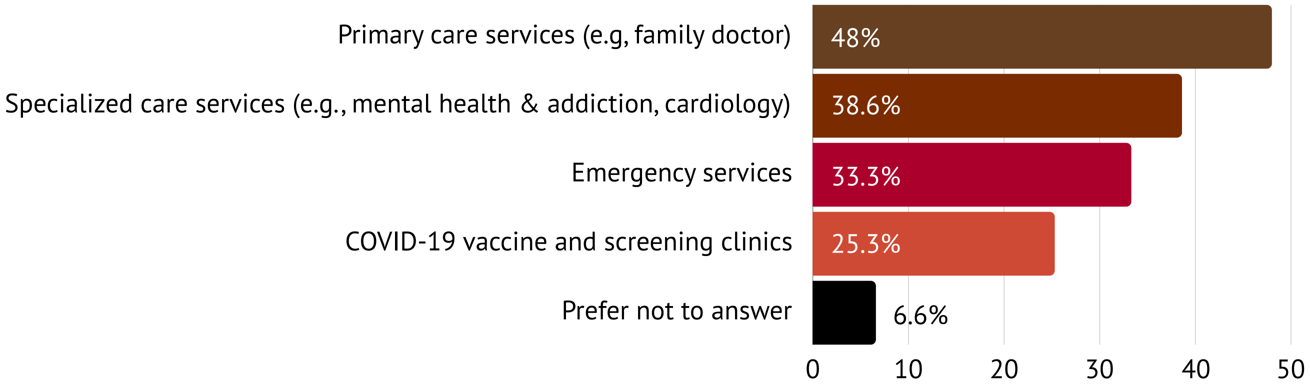
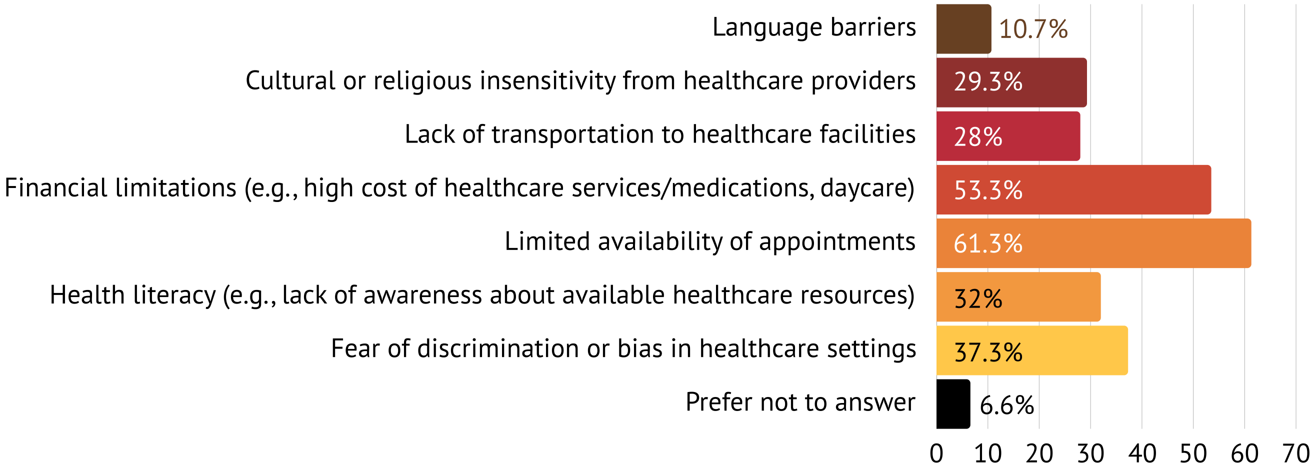


Figure 44: Which healthcare service was the most difficult to access? (Select all that apply)



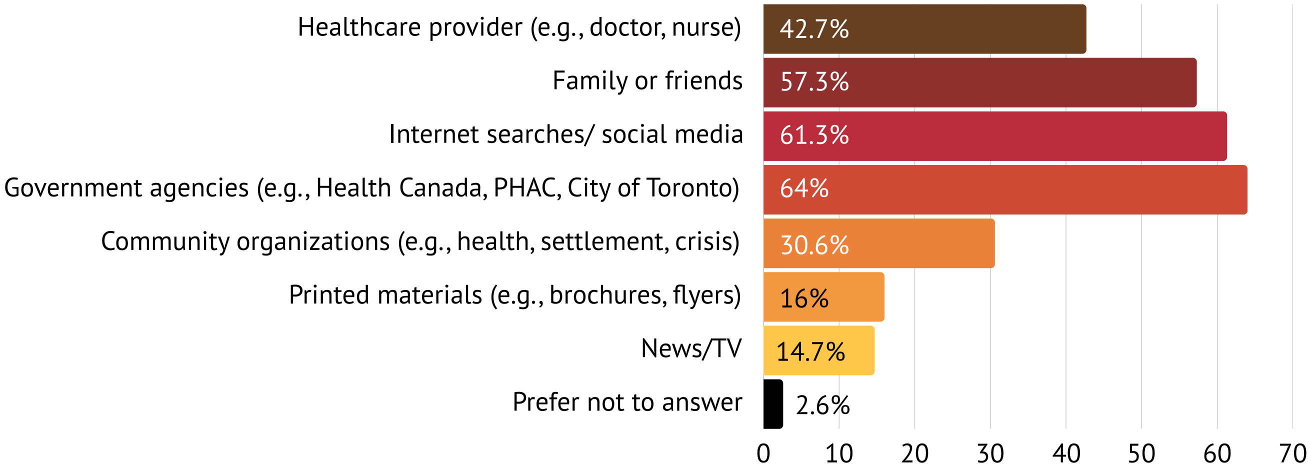
Barriers to accessing healthcare were commonly reported, with 61.3% of respondents citing limited availability of appointments as a major issue. Language barriers and health literacy challenges were identified by 42.7% of participants, indicating that a significant portion of the community struggles with understanding medical information or communicating effectively with healthcare providers. Additionally, 29.3% of respondents reported experiencing cultural or religious insensitivity from healthcare providers, which may contribute to distrust and reluctance in seeking medical care. Another 37.3% cited fear of discrimination or bias in healthcare settings, which can further deter individuals from engaging with the system. Furthermore, 53.3% mentioned financial limitations, such as the difficulty of taking time off work to attend appointments or arranging childcare during medical visits, highlighting additional barriers to accessing care. (Figure 45)

Figure 45: What barriers did you face in accessing these services? (Select all that apply)



During the pandemic, respondents relied on various sources for health information. The most common sources included government agencies such as Health Canada, the Public Health Agency of Canada, and the City of Toronto (64%), followed by internet searches and social media (61.3%). Family or friends were also a significant source of information for 57.3% of respondents, while 42.7% turned to healthcare providers such as doctors or nurses. This indicates that, while official government sources were widely trusted, there was also a significant reliance on informal sources like social media and personal networks for health guidance. Healthcare providers, though less frequently cited than other sources, continued to play a vital role in offering professional advice, reflecting the community's reliance on both formal and informal channels for accurate information. (Figure 46)

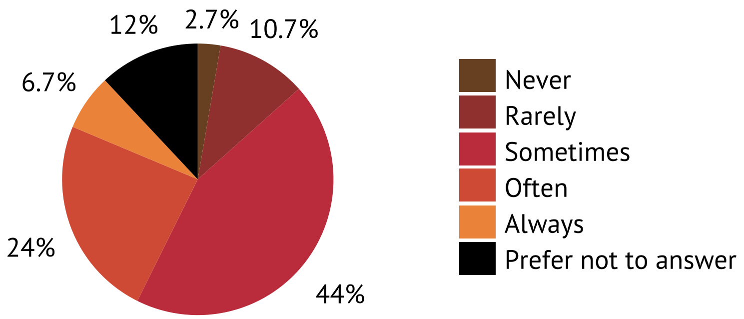
Figure 46: Which sources did you rely on for health information during the pandemic? (Select all that apply)



EXPERIENCES OF CARE QUALITY AND HEALTH OUTCOMES

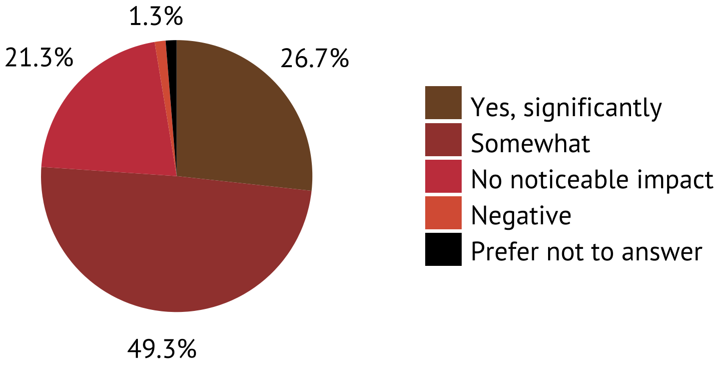
Regarding the extent to which healthcare providers addressed health concerns, 44% of respondents felt that their concerns were addressed sometimes, 24% often, and 10.7% rarely. Additionally, 12% preferred not to answer (Figure 47). This indicates that while a large portion of respondents felt that their concerns were at least somewhat addressed, there remains a substantial gap in the frequency with which healthcare providers are able to fully address patient concerns.

Figure 47: How often did you feel that healthcare providers thoroughly addressed your health concerns?



When asked whether the healthcare received had a positive impact on their physical or mental health during the pandemic, 49.3% of respondents reported a somewhat positive impact, 26.7% reported a significant positive impact, and 21.3% noted no noticeable impact (Figure 48). This suggests that healthcare during the pandemic had a generally positive effect on many individuals, though a significant number experienced little to no improvement in their physical or mental health.

Figure 48: Did the healthcare you received have a positive impact on your physical or mental health during the pandemic?



Some respondents shared negative health impacts from the care they received during the pandemic, highlighting significant gaps and challenges in healthcare delivery. These experiences reveal how certain aspects of the healthcare system, under strain due to the pandemic, contributed to worsened physical and emotional well-being for some individuals.

The elderly in our family live in a nursing home. For a period of time, we noticed that they always had bruises. At first, we thought it was because they accidentally bumped into something. Later, after careful observation, we realized that during the daily care process, such as helping them get up and move, the nursing staff in the nursing home were relatively rough in their actions and did not show enough patience or care. This led to multiple soft tissue contusions. The mental state of the elderly individuals was also affected. They became taciturn and resisted the nursing staff. Their physical condition also deteriorated due to the pain, which made us, as family members, particularly worried and angry.

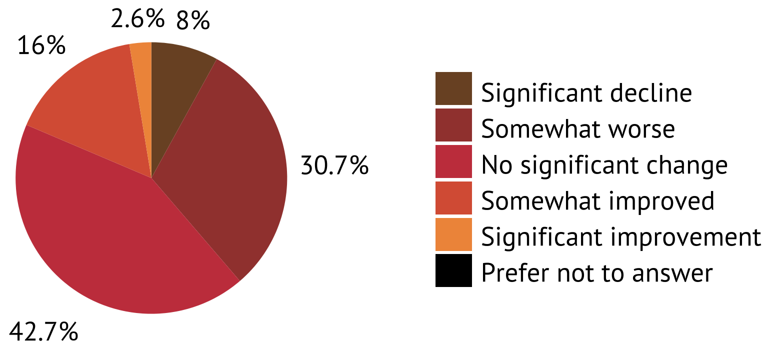
I had a suture operation due to a leg injury. During the postoperative nursing process, the nurse did not strictly follow aseptic procedures when changing the dressings, resulting in an infection at the wound. Initially, the wound healing was relatively normal. However, after the infection, the wound became red, swollen, and began to suppurate. It was also accompanied by significant pain. My body temperature also increased. I felt listless for several consecutive days and my body became very weak. The healing time was greatly delayed, which caused significant inconvenience to my daily activities, and I was also very anxious.

The walk-in clinic suddenly refused to allow in-person doctor visits, and the telephone line was not accessible when needed. My health condition worsened due to COVID-related anxiety, isolation, and the complications of my diabetes. In that situation, only a telephone call was not enough, and explaining my new critical health problems was extremely challenging. I felt helpless because of the lack of response from the walk-in clinic.

PERSONAL WELL-BEING AND COPING STRATEGIES DURING THE PANDEMIC

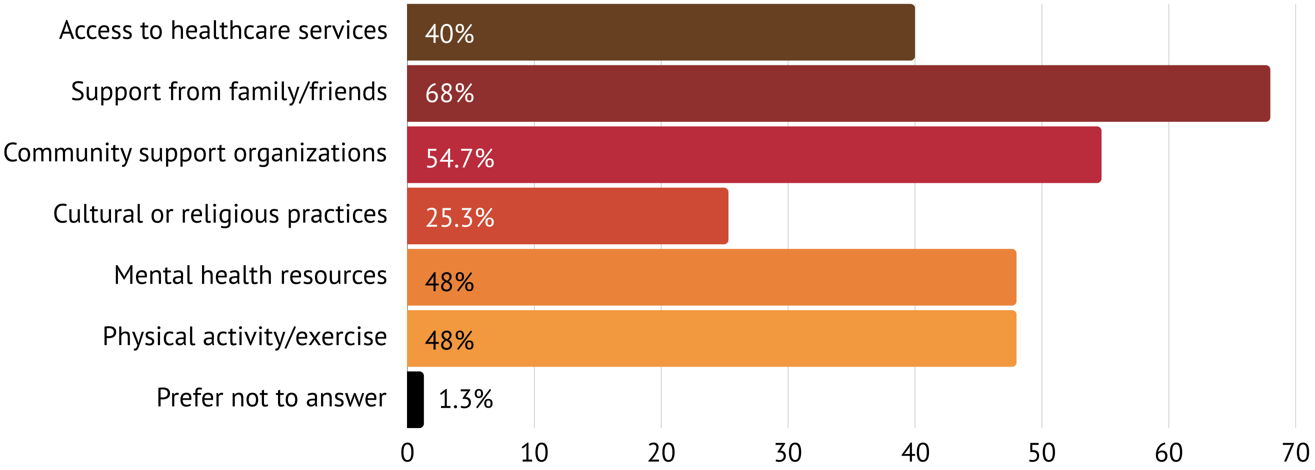
The pandemic had a significant impact on respondents' mental health and well-being. While 42.7% of respondents reported no significant change, 30.7% indicated their mental health had somewhat worsened, and 8% experienced a significant decline. On the other hand, 16% of participants felt their well-being somewhat improved during this challenging period. This suggests that while some individuals were able to maintain or even improve their mental health, a large portion of the community faced negative mental health impacts, likely due to the stress, isolation, and uncertainty brought on by the pandemic. (Figure 49)

Figure 49: How did the pandemic affect your mental health or well-being?



To cope with these challenges, respondents turned to various strategies and resources to maintain their well-being. The most common source of support was family and friends, with 68% relying on their social circles for emotional support. Additionally, 54.7% sought help from community or non-profit organizations, which provided critical services like food assistance, mental health support, and virtual social connection, helping to alleviate isolation. Furthermore, 48% of participants used mental health resources or engaged in physical activity to manage stress, highlighting the importance of both social and self-care strategies in maintaining well-being during difficult times. (Figure 50)

Figure 50: What strategies or resources helped you maintain well-being during the pandemic? (Select all that apply)



DISCRIMINATION AND CULTURAL & RELIGIOUS BARRIERS IN HEALTHCARE

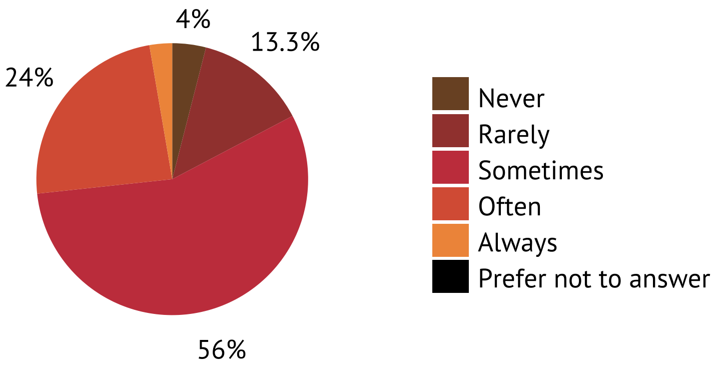
During the pandemic, many respondents experienced discrimination or unfair treatment while accessing healthcare, with 62.7% reporting such encounters and 37.3% not experiencing any discrimination. The selected experiences highlight how discrimination exacerbated healthcare barriers, from racial and gender bias in treatment recommendations to unequal access to care, making it even more difficult for marginalized individuals to receive equitable, patient-centered support.

> *Fatphobia, combined with being a South Asian woman, made seeking care for PCOS a million times more difficult. Physicians bring up the risk of diabetes but are terrible at understanding and communicating preventative efforts. My family doctor is also terrible. The only reason I've been able to see specialists is that I possess a level of health literacy that allowed me to request this from my family doctor. If I don't ask, my family doctor doesn't even think to recommend specialists.*

> *I once had symptoms of fever and cough and hurried to the hospital's fever clinic for medical treatment. At that time, before the nucleic acid test result came out, the medical staff placed me in a relatively remote and temporary observation room with poor conditions and left me to wait there alone. They didn't check on my situation very often, while other patients with similar symptoms but known negative nucleic acid test results were placed in a more comfortable area with more medical attention. I think it was very unfair. Just because my result hadn't come out yet, I was treated differently. I felt extremely uneasy and anxious, not knowing how serious my illness was.*

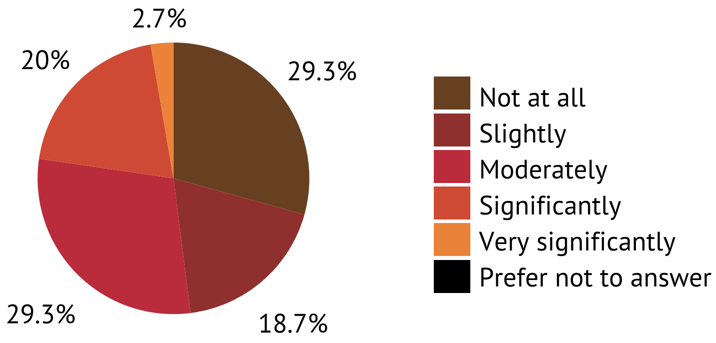
When asked about their experiences with healthcare providers' understanding of cultural backgrounds, 56% of respondents felt that providers understood their cultural background sometimes, while 24% felt understood often, and 13.3% rarely felt understood. This indicates that while some healthcare providers made an effort to consider patients' cultural backgrounds, there is a significant gap in consistently providing culturally competent care. (Figure 51)

Figure 51: How often did you feel that healthcare providers understood your cultural background?



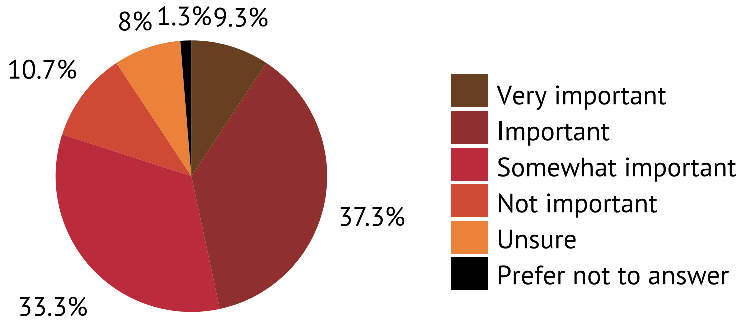
Language and communication barriers had a noticeable impact on respondents' healthcare experiences. 29.3% reported moderate impacts, while 20% indicated significant difficulties in communication. Another 18.7% stated that the barriers slightly impacted their experience, and 29.3% reported that there were no communication issues at all. This indicates that while some individuals experienced smooth communication, a significant portion of respondents faced challenges that likely affected the quality of their care. (Figure 52)

Figure 52: To what extent did language or communication barriers impact your care experience?



When asked about integrating traditional remedies into mainstream healthcare, 37.3% of respondents believed it was important, 33.3% felt it was somewhat important, and only 9.3% were unsure (Figure 53). This suggests a significant openness toward incorporating traditional remedies and practices into conventional healthcare, reflecting a desire for more culturally relevant care. Many respondents may see the value in blending traditional practices with modern healthcare approaches, especially for those from communities that prioritize holistic or culturally rooted healthcare methods.

Figure 53: To what extent do you believe that traditional remedies should be integrated into mainstream healthcare practices?



In response to whether their cultural or religious practices were respected in healthcare settings, 65.3% of respondents reported that their practices were respected, while 34.7% indicated that they were not. These selected quotes illustrate the challenges some individuals faced when their cultural and religious practices were not respected in healthcare settings. They emphasize the need for healthcare systems to better accommodate and honor diverse practices, ensuring that all patients feel valued and understood during their care.

I think there was a big gap in understanding family dynamics. For example, why extended family might be accompanying someone to their healthcare appointments or other interactions with the healthcare system.

I couldn't cover my hair properly at times. I couldn't pray when I needed to.

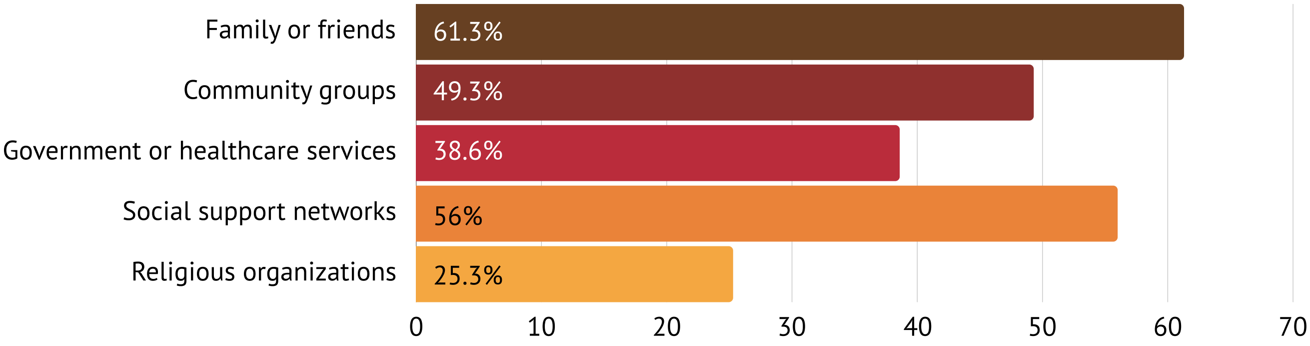
It's more food-related than anything (i.e., being perceived as "unhealthy")

They cannot even pronounce my name.

SUPPORT SYSTEMS: FAMILY, COMMUNITY, AND GOVERNMENT

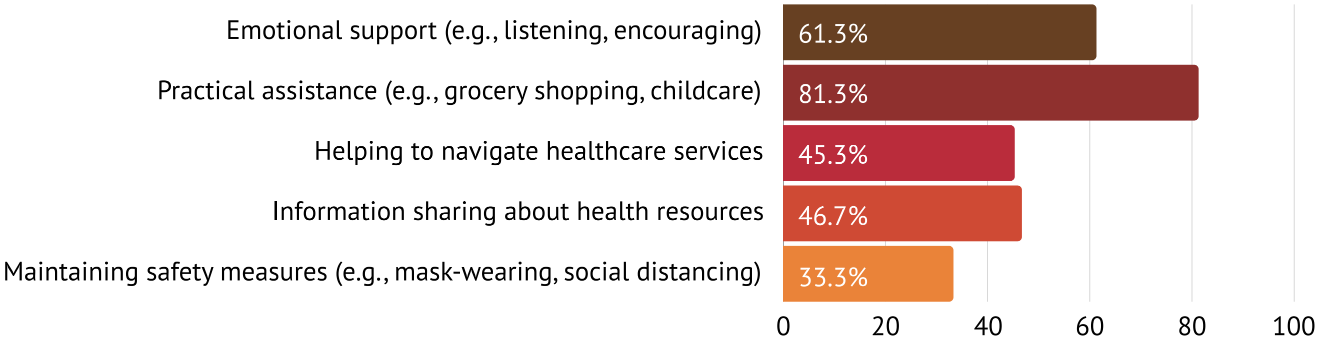
During the pandemic, individuals relied on a variety of support systems to navigate challenges. The most commonly cited sources of support were family and friends (61.3%), followed by social support networks (56%), community groups (49.3%), government and healthcare services (38.6%), and religious organizations (25.3%). These statistics highlight the critical role of personal relationships and grassroots efforts in filling the gaps where institutional support was insufficient. (Figure 54)

Figure 54: What type of support system did you find most helpful during the pandemic? (Select all that apply)



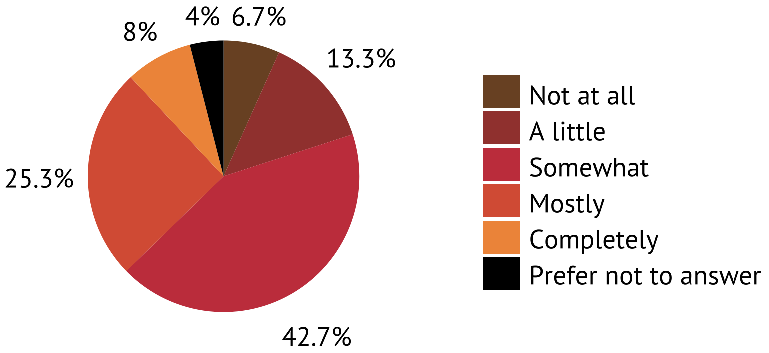
Family played a particularly significant role in providing both practical assistance (81.3%), such as grocery shopping and childcare, and emotional support (61.3%), including listening and encouragement. Additionally, 46.7% of respondents noted that their family helped by sharing important health-related information. This underscores the importance of familial bonds during crises, as they provide not only tangible aid but also mental and emotional reassurance. (Figure 55)

Figure 55: In what ways did your family support you during the pandemic? (Select all that apply)



Despite these informal support systems, government assistance was perceived as limited in meeting healthcare needs. Only 25.3% of respondents felt that government support mostly met their needs, while 42.7% said it somewhat did, and 13.3% reported that it only met their needs a little. This indicates that while government initiatives played a role, they were often inadequate in addressing the full scope of public health challenges. (Figure 56)

Figure 56: To what extent did you feel that government support met your healthcare needs during the pandemic?



Community organizations stepped in to bridge many of the gaps left by the government, offering vital resources and services. The following selected quotes illustrate these experiences:

> *Community organizations provided essential services such as food banks, mental health support, and virtual social events, helping to address gaps in government support. They also played a crucial role in disseminating culturally sensitive information and resources, which was particularly helpful for immigrant communities like mine.*

> *Community organizations mobilized volunteers to provide residents with purchasing and delivery services for daily necessities, solving the problem of residents being unable to go out shopping due to lockdowns. Especially for vulnerable groups such as the elderly and disabled, volunteers regularly purchased and delivered goods to their doorsteps based on their demand lists, ensuring a steady supply of essential living materials.*

> *Providing practical and accessible information about navigating the pandemic, including efforts to debunk myths and misconceptions; acknowledging the unavoidable direct impacts of the pandemic on people's mental, emotional, and spiritual well-being; and creating mutual aid resources.*

> *For residents needing medical treatment, especially those with fever or chronic diseases, community organizations actively coordinated with medical institutions, provided medical treatment guidance, and arranged necessary transportation assistance to ensure patients received timely care. This helped prevent delays in treatment due to difficulties in accessing healthcare.*

CONCERNS AND RECOMMENDATIONS FOR FUTURE HEALTHCARE NEEDS

Primary Concerns and Future Healthcare Needs for the South Asian Community

Chronic Disease Burden and Healthcare Disparities

The South Asian community faces a high burden of chronic diseases such as diabetes, hypertension, and heart disease, often developing these conditions earlier than other groups. Additionally, they encounter healthcare disparities, including limited access to medical resources such as hospitals, clinics, and healthcare professionals. This results in reduced availability of preventive care, early diagnosis, and culturally competent treatment.

> *The South Asian population has a relatively high genetic susceptibility to chronic diseases such as diabetes, cardiovascular disease, and hypertension. In the future, with changes in lifestyle and the aging population, the incidence of these chronic diseases may increase further, placing greater pressure on the community's healthcare system.*

> *Compared to more affluent communities, South Asian communities face significant disparities in the distribution of medical resources, including fewer hospitals and clinics, a shortage of essential medical equipment, and a lack of qualified healthcare professionals. Additionally, there is often limited access to culturally competent care, further hindering effective treatment and health outcomes.*

Economic Barriers to Healthcare

Economic challenges, such as low-paying jobs, underinsurance, and high out-of-pocket costs, make healthcare less accessible. Many in the community also struggle with food insecurity, which worsens chronic disease risk, and may lack affordable medications and therapies.

Some residents in South Asian communities face poor economic conditions and may find it difficult to bear the rising medical expenses, including diagnostic and treatment fees, drug costs, and hospitalization charges. As a result, some individuals may forgo necessary treatment or preventive healthcare measures due to financial difficulties.

Cultural, Religious, and Traditional Beliefs

Cultural, religious, and traditional beliefs can delay diagnosis and treatment for South Asians by shaping health perceptions, promoting alternative remedies, and discouraging open discussions on stigmatized conditions. Mistrust of Western medicine, reliance on traditional healing, language barriers, and reluctance of Western medical practitioners to explore and learn from traditional medicine further hinder timely medical care. Additionally, healthcare decisions are sometimes made by families, creating conflicts between modern treatments and traditional practices.

There are traditional beliefs in South Asian cultures that can act as barriers to modern healthcare. For example, some people may prefer using traditional herbs or home remedies and may be reluctant to seek professional medical help in the early stages of a disease.

The South Asian community contains a variety of religious beliefs, such as Hinduism, Sikhism, Islam, etc. These religious beliefs may have an impact on health care, such as dietary prohibitions, treatment practices (such as ideas about blood transfusions, organ transplants), etc., which may conflict with modern medical treatment options.

Stigma Around Mental Health and Chronic Disease Management

Mental health issues and chronic diseases are stigmatized in the South Asian community, leading to reluctance in seeking care. Mental health conditions are often seen as personal weaknesses, while chronic diseases like diabetes may be ignored or poorly managed due to fear of judgment. The importance of culturally tailored preventive care and support for chronic conditions was emphasized:

Combating stigma around mental health and managing the prevalence of chronic diseases like diabetes and heart conditions are crucial. Strengthening preventive care and ensuring equitable access to resources tailored to the community's unique cultural and health needs is essential.

Recommendations for Government, Healthcare Providers, and Community Organizations

Establish Dedicated Liaison and Language Support Services

The Ontario Ministry of Health and local municipal governments should establish dedicated liaison offices or personnel within South Asian communities to serve as intermediaries between healthcare systems and residents. This service should facilitate communication, help understand cultural nuances, and ensure that community members' healthcare needs are adequately addressed. Additionally, language support should be integrated across all aspects of healthcare in Ontario to eliminate barriers to access and care for South Asian communities. This includes providing multilingual signage, offering written materials in various languages, and ensuring that interpreters or bilingual staff are available during medical visits. These language support services would help ensure that community members fully understand their medical conditions, treatment options, and healthcare rights, and can engage more confidently with healthcare providers.

Set up a dedicated liaison office or liaison personnel within the South Asian community. Regularly communicate and exchange with community leaders, resident representatives, etc., to understand the community's needs, concerns, and feedback regarding health, and timely convey information on policies and measures related to health crises to enhance two-way interaction.

Recruit or train staff and volunteers who speak the main South Asian languages such as Hindi, Urdu, and Bengali to provide language support in healthcare services, including appointment registration, medical guidance, and illness explanation, to ensure smooth communication

Cultural Sensitivity and Training for Healthcare Providers
Healthcare providers must undergo comprehensive training on cultural sensitivity to better understand South Asian customs, religious beliefs, dietary practices, and family dynamics. This training should include guidance on how to respect and incorporate these cultural values into medical care. By improving cultural competence, healthcare providers can build stronger relationships with patients, offer more personalized care, and ensure that treatments are both medically sound and culturally appropriate.

Organize healthcare providers to learn about South Asian cultural customs, including religious beliefs, dietary restrictions, and family values, to ensure respectful and culturally sensitive medical care. For example, during Ramadan, healthcare providers can adjust treatment and dietary plans for Muslim patients observing fasting.

Community organizations can create and distribute culturally appropriate healthcare information for South Asians. This may include brochures on healthy eating to prevent diabetes and cardiovascular diseases, incorporating South Asian dietary habits, languages, and familiar cultural elements—such as mythological stories or traditional proverbs—to simplify complex medical concepts and enhance accessibility.

Improving Access to Healthcare Resources and Support
Strategic investment in healthcare infrastructure is essential for South Asian communities, particularly in areas with large South Asian populations. Governments and healthcare organizations should prioritize building hospitals, clinics, and community health centers, with services that are linguistically and culturally appropriate. These facilities should be equipped with the resources necessary to serve the community's diverse needs, including healthcare professionals who understand cultural sensitivities and who can offer culturally competent care.

Increase investment in medical resources in areas where South Asian communities are located. Based on the population size and needs of the communities, plan and build medical institutions, including hospitals, clinics, and community health service centers, to ensure that residents can access medical services conveniently and quickly during health crises.

Targeted Health Education and Promotion

Health education efforts must be designed with cultural and linguistic competence in mind. Creating educational materials such as posters, brochures, and videos in languages spoken within South Asian communities ensures that important health information is accessible to all residents. These materials should focus on common health issues, preventative measures, and available treatment options, while also being culturally relevant. In addition, implementing one-on-one medical resource navigation services can help individuals understand their healthcare options, ensuring they receive the right care in a timely manner.

Produce health promotion materials suitable for the cultural background of South Asian communities, such as promotional posters, brochures, videos, etc. The content should cover the symptoms, preventive measures, and treatment methods of common diseases.

Provides South Asian community residents with detailed information about nearby medical resources, including the location, services offered, charges, and operating hours of hospitals, clinics, and pharmacies.

Integrating Traditional Practices in Modern Healthcare

Healthcare systems should move beyond a purely Western medical model and adopt an approach that integrates traditional practices with strong positive outcomes, alongside conventional healthcare methods. By integrating traditional practices with modern medical care, healthcare providers can offer a more holistic and culturally competent approach.

Adjust the medical service model according to the cultural characteristics of South Asian communities. For example, since family values are strong in South Asian communities, family members' opinions are often considered in the medical decision-making process.

Policy Approaches to Healthcare Support for South Asians

The Ontario Ministry of Health should implement policies that address the unique healthcare challenges faced by the South Asian community during health crises. This includes improving access to multilingual healthcare services, expanding insurance coverage for chronic disease management, and providing financial support for those facing additional medical costs due to language barriers or cultural needs. At the federal level, the Government of Canada, through Health Canada, should collaborate with provincial ministries to ensure nationwide implementation. Additionally, a monitoring framework should be established to assess the effectiveness of these policies and ensure they meet the specific needs of South Asian communities.

> *The government should formulate support policies specifically for the South Asian community during health crises. For example, medical insurance reimbursement policies should provide subsidies for additional medical expenses incurred by South Asian residents due to language barriers, and preferential treatment should be given to the long-term treatment costs of patients with chronic diseases.*

In summary, addressing these concerns and future recommendations requires a multifaceted approach that incorporates cultural sensitivity, resource allocation, language support, and community engagement to ensure equitable healthcare access for the South Asian community.

COMMUNITY FOCUS GROUP DISCUSSIONS FINDINGS

Between November 2024 and January 2025, four FGDs were conducted with a total of 31 participants. These participants came from a variety of South Asian countries, including Pakistan, Afghanistan, India, Sri Lanka, Bangladesh, and Nepal. The group's age range was diverse, including both young adults and older individuals, each offering unique perspectives on healthcare. Many of the participants were recent immigrants to Canada, arriving as late as 2023 or early 2024, while others had been in the country for several years. English proficiency among participants varied; while some were fluent, many faced challenges in fully expressing themselves, particularly in healthcare-related contexts. Settlement Assistance & Family Services supported recruitment and provided translation services during the FGDs to facilitate communication.

HEALTHCARE ACCESS AND UTILIZATION

Participants discussed their varied experiences with accessing healthcare services. Some had positive experiences, while others struggled to find the right healthcare professionals or understand the steps for accessing care. Many participants experienced barriers related to system navigation, wait times, and healthcare provider availability. Despite these obstacles, most participants were aware of the healthcare services available to them, although understanding how to access them was still a challenge for some. This could have been influenced by the fact that many FGD participants were newly arrived immigrants and may not have encountered the need for extensive healthcare access. This is a widely documented phenomenon called the “healthy immigrant effect”.

Health Card Access and Delays

Health card acquisition, a key step in accessing healthcare, was mostly smooth for many, but some participants experienced significant delays, especially during the COVID-19 pandemic when processing times were slower due to government backlogs and office closures. This led to frustration, confusion, and uncertainty when seeking care, especially for newcomers who lacked clarity on the process.

> *I applied for my health card right after arriving, but it took so long to arrive. I wasn't sure if I could see a doctor or how much it would cost. It was really stressful and confusing.*

Navigational Challenges

Newcomers faced confusion about how to find doctors, how to book appointments, and what to do in cases of emergency. Many are unfamiliar with the concept of a family doctor and may experience long delays in securing one. These challenges emphasize the need for stronger support systems, such as community outreach or navigators, to help newcomers understand these processes.

> *When I first came here, I didn't understand what a family doctor was. I went to the hospital, and a nurse told me I needed to find one. I didn't know what that meant because back home, we don't have family doctors. We just walk into the hospital and get checked. It was a different experience here. Later, I realized that having a family doctor is important. Now, I have one, and even when I go to the emergency room, they always ask, "Who is your family doctor?" They check all the details.*

> *When I first arrived here, it took me more than three months to find a doctor. I went to the website and luckily found one, but I still have doubts about whether I'm in the right place. Every time I go, the doctor suggests a blood test, but even then, it takes a long time to actually get the test done.*

Appointment Availability

While many reported that accessing general practitioners was relatively easy, there were issues with wait times, particularly for emergency and specialist care. Some waited several hours in emergency rooms without being seen by a doctor, sometimes having to return the next day for treatment. Others expressed frustration with delays of weeks or even months for specialist appointments and follow-ups.

My son fell on the road and went to the emergency room at 8 PM. We waited until 4 AM, but the doctor never saw him. We had to come back the next day for an X-ray. It was very frustrating.

It took a long time to get referrals for tests and specialists, and the wait times for appointments were very long. I was concerned that something serious could happen during the long waits between appointments.

When I had COVID, it was really difficult to get tested, and it was a terrible experience. They should have handled it better. People were waiting and calling, but I had to stand in line for three hours with a high fever.

Language Barriers

Effective communication with healthcare professionals is significantly impacted by language. Having a doctor who speaks the same language as the patient can enhance comfort, understanding, and the ability to express concerns clearly. For many individuals, being able to communicate in their native language is crucial for accurate and thorough healthcare interactions.

I have a Tamil-speaking doctor. It's more comfortable for me because I can express my feelings in my own language.

During COVID, my main concern was language. It was very difficult to communicate with the doctor, and because of that, I wasn't allowed to attend my daughter's appointments. Only my husband was allowed in. I couldn't see my child during the visit or ask relevant questions or have my concerns addressed.

Shift to Online Healthcare

Participants noted that the transition to phone and online appointments with healthcare providers posed challenges, particularly regarding the quality of care and communication. Many expressed frustration with long wait times for referrals, tests, and specialist consultations, which were exacerbated by the reliance on virtual appointments. While virtual appointments were a necessary adaptation during the pandemic, participants felt that they were insufficient for addressing more complex healthcare needs and worried that delays could result in serious health issues being overlooked.

> *I only had phone appointments with my doctor, and it took a long time to get referrals for tests and other specialists. The wait times for appointments were also very long, and I was concerned that something serious could happen during the lengthy wait between appointments.*

> *It was hard to explain my symptoms to the doctor over the phone, and it was frustrating because I kept worrying it might be something serious.*

QUALITY OF CARE

The quality of healthcare was generally perceived as high, but there were concerns related to the consistency of care. Some participants felt that healthcare providers were not always attentive to their needs, particularly when it came to cultural or language differences. Some reported feeling rushed during appointments, which left them dissatisfied with the overall quality of care. However, there were some positive experiences, particularly in areas of treatment for chronic conditions.

Doctor-Patient Interaction

A frequent concern was the rushed nature of appointments, which sometimes led to delayed or misdiagnosed health issues. Many participants felt that healthcare providers didn’t take the time to listen to them, especially when dealing with complex health histories or when cultural context played a role in the diagnosis or treatment.

> *My toddler had a fever and I went to emergency, but they didn't bother listening and just told me to give him Tylenol. When the fever didn't go down after three days, I went to a walk-in clinic, and that's when I found out he was severely affected by a virus. It was a nightmare for me.*

Cultural & Religious Sensitivity

Some participants shared their dissatisfaction with healthcare providers' lack of cultural consideration, such as not accommodating preferences for a female doctor in a Muslim context, which made them uncomfortable during sensitive healthcare experiences. However, there was also acknowledgment of positive cultural accommodations, like halal food in hospitals and interpreters, although the consistency of cultural competence among healthcare providers varied.

> *In my experience, the healthcare in Halton was very different from my experience in the Peel District. For my first childbirth, I was part of the Credit Valley Trillium system. That system doesn't give you a choice in who you see, so wherever you deliver, you're assigned doctors and nurses. For example, at Credit Valley, there was no consideration for my preference to be seen by a female doctor, which was important to me as a Muslim. After giving birth, there were male nurses in the room who helped me with breastfeeding, which made me very uncomfortable, especially considering the trauma I experienced during the birth. There were times when my mother-in-law was present, and a male nurse would come in to check on me, which felt very invasive and uncomfortable.*

> *I had heart surgery two years ago, and the hospital gave me translators and halal food, which made me feel more comfortable and supported.*

Inconsistent Care

While some participants had positive, responsive experiences with healthcare providers, others reported receiving less personal or detached care, especially when seeking emergency services. In these instances, the overwhelming number of patients, long wait times, and potential lack of familiarity with cultural or specific health needs seemed to impact the quality of care received.

I actually gave birth to my daughter in the first month of the pandemic, so I was meeting with my healthcare provider regularly. She was very responsive. But there were times when we had to go to emergent care, and while I wouldn't say they didn't address our needs, the experience wasn't as smooth. There were a lot of patients, and the wait times were absolutely crazy.

HEALTHCARE NEEDS AND PREFERENCES

A common thread across the focus groups was the need for better access to information about healthcare services, especially for newcomers. Participants highlighted the importance of culturally appropriate healthcare resources and preferred that materials be available in languages other than English. They also emphasized the need for stronger community engagement, with healthcare providers collaborating more closely with local organizations to bridge access gaps and raise awareness about available resources.

Language Resources

Many participants reported that healthcare resources, such as pamphlets, websites, or instructions, should be made available in a wider variety of languages, including Punjabi, Urdu, Hindi, Tamil, and Bengali. This would ensure more accessible healthcare information, particularly for non-English speakers.

I think healthcare resources should be made in the languages we speak.

Tailored Healthcare Services

There were frequent calls for healthcare providers to offer more personalized care that took cultural and religious practices into account, such as diet restrictions, gender preferences in medical settings, and the importance of community-based care.

I am diabetic, and my doctor tells me to stop eating rice or that our curry is too oily, but they don’t understand that our South Asian dishes need these ingredients.

As a Muslim [woman], I have a preference for female doctors and nurses.

Community Engagement and Outreach

Participants emphasized the need for better awareness of available healthcare resources, particularly within the South Asian community. They suggested that healthcare providers collaborate more closely with community organizations to bridge gaps in access, guide patients through the system, and provide culturally relevant health information through outreach efforts like pamphlets and education campaigns.

> *I've been working in healthcare in Canada for the past 7-8 years, but I wasn't even aware of certain resources. If someone like me, working within the system, doesn't know, it's even more common for those outside of it to be unaware. There are resources available for mental health, dental care, and community support, but many people don't know they exist. I would appreciate more outreach—like pamphlets or other ways to spread awareness—because better access to this information could really help the South Asian community.*

> *It would be useful to have someone like a healthcare navigator, similar to a social worker, but specifically working in healthcare. They could conduct intake assessments and assist with resource allocation for patients. Our healthcare system is so broad that it's difficult to know where to go or who to contact, especially with long waiting lists. As a result, people often get lost in the system.*

> *I want to inform our community because many people don't know about the available resources. There are numerous services from public health, the city, and medical organizations. Even community spaces like mosques receive government funding for support, but we are often unaware of these resources. Once you know about them, they become much more accessible.*

PERCEPTIONS OF HEALTH AND WELL-BEING

Health and well-being were often discussed in terms of both physical and mental health. Participants generally felt that the Canadian healthcare system provided good access to services, but mental health was seen as an under-addressed issue. Many participants expressed that the focus on physical health often overshadowed mental health care, despite the recognition of mental health issues within their community.

Impact of COVID-19

Many participants discussed how the COVID-19 pandemic significantly affected their health, particularly their mental well-being. They noted feelings of isolation, lack of direct medical support, and the uncertainty during the pandemic, which worsened pre-existing mental health challenges. Participants often felt neglected by healthcare providers, with limited guidance or advice available to them. Additionally, confusion around the vaccines and misinformation about their effectiveness added to the stress and uncertainty experienced by many.

> *As soon as I found out I had COVID, someone called me and told me to stay home, but that was the extent of the guidance I received. I just kept buying Tylenol and that was it. It was really exhausting. Throughout the whole experience, I stayed in my room, feeling isolated and lonely. I didn't have a family doctor at the time and couldn't find one, and even now, I still don't have one. I didn't have anyone to reach out to for advice, like "I'm feeling like this, what should I do?"*

> *I was confused about the different vaccines and there was misinformation about which one was better or worse.*

Mental Health Stigma

Mental health was a highly stigmatized topic in the South Asian community, with many participants indicating that they were hesitant to seek help due to fear of judgment from their family and community. There was a strong desire for healthcare providers to address these concerns in a culturally sensitive way.

> *We do have our own biases as well, and sometimes we are heavily locked into our culture. For example, if someone wants to access mental health support, certain family members or the community might look down on certain treatments. I think that's one drawback and something we need to work on in our communities.*

Physical Health Concerns

In terms of physical health, chronic diseases like diabetes, hypertension, and heart disease were frequently mentioned. There was a strong preference for preventive care to help manage these issues before they became more serious, and many participants wished that more attention was given to education around managing these diseases.

My parents, aunts, and uncles are all diabetic, and I really wish there was more education so I don't end up a diabetic.

SOCIAL AND CULTURAL INFLUENCES

Cultural and social factors heavily influenced participants' healthcare decisions and their willingness to seek medical care. Family plays a key role in decision-making, and healthcare choices are often guided by familial expectations and traditional beliefs. Alternative and traditional medicine, including herbal treatments, spiritual healing, and home remedies, were commonly utilized, especially for chronic conditions.

Role of Family

Family members in South Asian communities often play a central role in healthcare decisions, with their advice sometimes taking precedence over professional medical guidance. This strong family involvement can lead to hesitancy in seeking professional care, especially when traditional remedies are preferred or when family members express doubts about the advice given by healthcare providers. The influence of family can sometimes overshadow individual consultation with doctors, creating a barrier to open and direct communication in medical settings.

I see that the South Asian community is very tight-knit, and the family dynamic can act like a double-edged sword. On one hand, they are very interested in your health and encourage you, but on the other hand, they can also discourage you. This can have a significant impact on a patient's mental health, especially when they are already dealing with challenges like infertility or hormonal issues.

My parents are immigrants, so when we go to a doctor, or if they happen to come to the ER and hear something they don't like, they're very vocal about it and might say, 'Don't believe them.' I always thought it would be better if doctors handled things one-on-one, so there wouldn't be too much external input.

Traditional Healing

Many participants, especially older individuals, expressed a preference for traditional medicine and natural remedies over pharmaceutical treatments. They felt that these practices aligned more closely with their cultural values and beliefs. Some participants also highlighted that healthcare providers were often reluctant to consider these approaches, emphasizing the use of medication as the primary option despite growing interest in integrating traditional healing practices with modern medicine.

I was recently diagnosed with something, and I asked if there was a way to address it naturally before resorting to medication. The immediate response was, "No, no way. You have to take the medication, that's it." I found that interesting because there's been some work lately to integrate traditional medicine with modern healthcare practices.

It's about acknowledgement. It's about recognizing that our ancestors, our families, and our traditions have rooted spiritual and physical health remedies that have worked for years. Sure, there hasn't been enough research or backing, but now some of these traditional remedies are coming to light with evidence-based support. It's about changing the status quo and giving these practices the recognition they deserve.

Community Support & Engagement

Participants highlighted the significant role of community support in managing health, especially mental health concerns. Many individuals felt more comfortable discussing health issues within their cultural communities, such as religious spaces or cultural centers, than with healthcare professionals. They suggested leveraging cultural centers for greater collaboration with public health services, as these centers are trusted spaces within rapidly growing communities.

I found a lot of like-minded people at the mosque who gave me support, especially during the pandemic period, it was difficult.

We can leverage our cultural centers to collaborate directly with public health. We have one of the fastest-growing communities in North America, and they attend these centers.

SUBJECT MATTER EXPERT INTERVIEW FINDINGS

South Asian communities in Canada face systemic barriers to healthcare, including colonial legacies, economic constraints, migration stress, stigma, institutional racism, language barriers, and a lack of cultural competency. The Western-centric healthcare system often overlooks their diverse needs, while financial instability, long working hours, and unfamiliarity with the system further limit access.

These insights are based on four SME interviews with healthcare professionals and researchers who provided valuable perspectives on the challenges South Asians faced during COVID-19:

- **Dr. Ananya Tina Banerjee** – Assistant Professor, McGill University
- **Dr. Farah Islam** – Mental Health Advocate, Educator, and Researcher
- **Dr. Danish Rahim** – Family & Walk-in Physician
- **Anonymous SME** – Assistant Professor, McMaster University

BARRIERS TO HEALTHCARE ACCESS

The South Asian community in Canada faces several barriers to accessing adequate healthcare services, which are deeply intertwined with social, economic, and cultural factors. Many of these barriers are structural and institutional in nature, deeply rooted in colonial frameworks, which continue to influence healthcare delivery systems. These barriers prevent South Asians from receiving culturally competent care and meaningful access to health services.

Colonial Legacies

The healthcare system in Canada was designed with a Western-centric approach that is ill-suited for South Asian populations. Many healthcare institutions continue to operate under outdated colonial structures that do not take into account the diverse needs of South Asian communities. This lack of consideration for cultural differences significantly impacts the quality of care South Asians receive.

> *"We work in healthcare institutions that are clearly colonial and haven't been designed for communities like ours. ~ Dr. Ananya Tina Banerjee*

Economic Constraints

Many South Asians, particularly immigrants, face financial instability, which limits their access to healthcare services. The high cost of uninsured medical care, transportation, and other related expenses often creates significant barriers. For those working long hours or multiple jobs, it becomes even more difficult to prioritize health due to time and financial constraints. Removing financial barriers to healthcare could significantly increase access to necessary services, enabling more individuals to seek the care they need.

If you're working long hours or multiple jobs, it can be difficult to prioritize your health due to your work situation and financial constraints. This creates barriers to accessing necessary resources ~ Anonymous SME

So many people would utilize mental health care services if the financial barrier, particularly the cost, was removed. Trust me, if that obstacle were eliminated, more people would seek help. ~ Dr. Farah Islam

Migration Stress

The migration and resettlement process significantly impacts the health of South Asian communities, contributing to both physical and mental health challenges. The stress of adjusting to a new environment, coupled with unemployment, challenges in credential recognition, and financial insecurity, often leads to feelings of isolation and emotional strain. Family dynamics are also affected, as generational and cultural shifts can create tensions, with parents struggling to connect with children who adopt new behaviors and preferences. Additionally, many first-generation immigrants face challenges navigating the Canadian healthcare system, often compounded by language barriers and unfamiliarity with Western medical models, which complicates their access to care.

For example, the wife would be at home, isolated, and her children were changing. She no longer recognized them—they started speaking with a different accent, wanting different food, and treating her very differently. She didn't recognize her own kids. And then, her husband would come home every day feeling demoralized because he couldn't find work. ~ Dr. Farah Islam

For newcomers, there are additional socio-economic challenges that prevent them from putting health and wellness first. With concerns like securing a job, finding work in your field, and ensuring you can afford to live, it becomes even harder to focus on your well-being. ~ Anonymous SME

Stigmatization of Health Issues

Health issues, especially mental health struggles and chronic conditions, are often surrounded by stigma in South Asian communities. Particularly among older generations, there is a prevailing belief that experiencing health challenges—whether mental or physical—reflects personal failure or weakness. Mental health struggles, in particular, are frequently dismissed or minimized, viewed with shame, while chronic physical health conditions are often ignored or downplayed. This stigma is reinforced by cultural values, where seeking external support or care can be seen as a failure to manage one's personal struggles. As a result, many individuals avoid seeking help, either suffering in silence or feeling too ashamed to pursue the necessary care, treatment, or support.

When I hear my parents talk about mental health, they're like, "Oh, it's just like a facade, it's not really an issue." And I'm like, we've actually progressed so much further than where I guess the older generation's mindset is still stuck in. ~ Dr. Farah Islam

We're very community-oriented people. We really do value our family and our community, and seeking outside support can be a very foreign and strange thing. ~ Dr. Farah Islam

Many South Asians are reluctant to access mental health services because it feels like a personal failure—like we haven't worked hard enough to overcome our struggles. ~ Dr. Ananya Tina Banerjee

Institutional Racism

South Asians face racism within healthcare settings that discourages them from seeking care or results in delayed diagnoses. This is particularly evident in areas where healthcare professionals may lack cultural competence and fail to recognize the unique needs of South Asian patients. Racism at institutional levels exacerbates health disparities by discouraging trust in healthcare systems.

In Western countries, racism does come up, particularly for minorities. You may find that certain providers have biases—whether racial or political—and that can affect the way they deliver care. One way to combat this is through education. ~ Dr. Danish Rahim

Language Barriers

For many South Asians, language is a significant barrier to accessing healthcare. While English or French may be understood, they are often not the first language, which can make communication with healthcare providers challenging. This can be particularly important when patients are able to speak in a language they are comfortable with and can connect with providers who share similar cultural backgrounds or experiences. When patients and providers share these commonalities, it can lead to more effective communication, reducing misunderstandings and improving the overall healthcare experience.

> *Being able to communicate with healthcare providers in a language they are comfortable with, and with providers who share similar histories or look like them, I think is really special. ~ Dr. Ananya Tina Banerjee*

> *An important aspect of linguistic determinants is that you simply feel more comfortable when speaking in your native language. It's not that you don't understand English, but it's about building trust and comfort. When you're able to communicate in a language you're familiar with, you can share more openly and discuss your concerns more effectively. Trust is crucial in healthcare; for someone to care for you and for you to feel comfortable asking questions or addressing issues, there has to be a baseline level of trust. ~ Anonymous SME*

Cultural Competency

A lack of cultural competence among healthcare providers can exacerbate challenges for South Asian patients. When providers are not familiar with the cultural nuances, religions, traditions, or specific health practices of South Asian communities, it can result in a lack of trust, poor patient-provider communication, and failure to provide culturally sensitive care. This lack of cultural safety can make patients feel misunderstood and excluded, as seen in examples like diet and nutrition guidelines. Such oversights can leave patients feeling unrepresented and less likely to engage with the healthcare system.

> *I think it's also the lack of cultural safety—the feeling that I won't be understood when I enter these services or spaces. ~ Dr. Farah Islam*

> *For example, in diabetes screening and similar health initiatives, many of the recommendations are in English and often use Westernized foods. These guidelines don't account for the diverse diets that South Asian people may be more familiar with, which can indirectly exclude them and make them feel unrepresented in the outreach materials.*
> *~ Anonymous SME*

Healthcare Literacy and Educational Gaps

Healthcare literacy can be a significant barrier for South Asian communities, particularly for first-generation immigrants. Limited knowledge of the Canadian healthcare system, medical terminology, and available services can make it difficult for individuals to make informed decisions about their health. Educational gaps, often compounded by language barriers, may prevent individuals from fully understanding medical advice, treatment options, or preventive care. This lack of healthcare literacy can lead to miscommunication with providers, delayed diagnoses, and inadequate treatment, further deepening health disparities.

> *It goes back to that education piece. It's like educating... If your symptoms are not severe, try these things, and if it's still not better, then come to the walk-in or ER. That also cuts down your wait times and increases access for people who really need care. ~ Dr. Danish Rahim*

RECOMMENDATIONS FOR ADDRESSING HEALTHCARE GAPS

Addressing the healthcare gaps experienced by South Asians requires a multifaceted approach that includes policy reform, community engagement, and institutional change. The following recommendations aim to improve healthcare access, outcomes, and equity for South Asian communities.

Culturally Competent Training

Healthcare providers should undergo regular cultural sensitivity training to ensure they understand, respect, and integrate the cultural and religious nuances of the communities they serve. This includes addressing cultural stigma, particularly around mental health, and understanding how religion can influence health practices, beliefs, and decision-making. Recognizing and incorporating the importance of religious traditions, dietary restrictions, and spiritual care is essential to providing care that is both relevant and respectful to South Asian patients. Healthcare workers must be equipped to offer culturally appropriate treatment while being mindful of religious customs and values.

> *I emphasize the importance of intersectionality, cultural humility, and cultural safety. You'll never fully know your patient or their entire story, but it's crucial to acknowledge how they present and identify themselves. It's also important to consider the systems they are part of and how those systems shape their experiences. ~ Dr. Ananya Tina Banerjee*

Community-Based Research & Strengthening Community Partnerships
Engaging South Asian community leaders and local organizations in the research process is essential. Trusted leaders, including those from religious centers, cultural centers, and other spaces where the community feels safe, can play a critical role in facilitating this engagement. These community spaces often serve as trusted points of contact and provide support, advocacy, and education. Collaboration with these trusted spaces ensures that research is reflective of the community's unique needs and that findings are actionable. Strengthening partnerships with such organizations can also help bridge gaps in healthcare access by offering language support, cultural understanding, and advocacy.

> *We need to use trusted spaces in the community—like religious centers and community hubs—to educate and foster trust. - Dr. Danish Rahim*

Policy Change and Healthcare Reform
Reforming the healthcare system to better serve racialized communities is crucial. Policies should be revised to address the diversity within South Asian populations, ensuring that healthcare services are tailored to meet their specific needs. This includes promoting equitable access to care, particularly in underserved areas, and implementing targeted health strategies for these communities.

> *We are not a monolith, yet healthcare services treat us as if we are. Policies need to reflect the diversity within our communities. ~ Dr. Ananya Tina Banerjee*

Disaggregated Data Collection & Inclusive Research
Collecting disaggregated health data from South Asian communities is essential to identify specific health disparities. Research should recognize the diversity within the South Asian diaspora, as "South Asian" is a heterogeneous term. There is also a need to create more opportunities for healthcare professionals and researchers who represent their communities, ensuring that those who understand the lived experiences of their people are included in the

research process. This will help avoid tokenization and exploitation and ensure that research is both relevant and beneficial to the community. Ongoing community engagement and inclusion of diverse voices in research are critical to creating actionable and effective healthcare strategies.

> *“South Asian” is such a heterogeneous term. Some people who are geographically South Asian may not even identify with being called South Asian. For example, some individuals prioritize their language or ethnicity as their primary identity, rather than identifying as South Asian. So, this discourse becomes challenging—how do we group all these people under “South Asian?” Is it truly a unified South Asian experience, or should we break it down further to focus on specific communities within the South Asian diaspora for a more accurate understanding? ~ Anonymous SME*

> *I’ll be honest, I don’t think our communities benefited at all from the research during the pandemic. It primarily served academic groups at elite institutions. As you mentioned, other researchers who had never previously worked with South Asians used this as an opportunity to exploit our communities. ~ Dr. Ananya Tina Banerjee*

Educational Outreach & Advocacy

Increasing healthcare literacy within South Asian communities is essential. This includes providing clear, accessible information on lifestyle changes by distributing easy-to-understand materials, hosting community events, and offering information on healthcare options. Educational initiatives should focus on empowering individuals to make healthier choices, even in the face of resistance to change. Community outreach, events, and advocacy for health policy improvements can ensure that South Asians feel informed and supported in accessing the care they need.

> *We need to improve health literacy, especially regarding lifestyle choices, as this can positively impact every aspect of our lives. For example, South Asians have higher rates of diabetes and cardiovascular diseases. However, we often face resistance to changing our lifestyle. In fact, more than 50% of patients are resistant to altering their lifestyle, even when they have established health conditions. Despite this resistance, some patients eventually return for further guidance on improving their health behaviors. ~ Dr. Danish Rahim*

Ongoing Evaluation

Regular evaluation of healthcare programs and community outreach efforts is crucial to ensuring that South Asian communities receive the care they need. By involving community partners and gathering feedback on their experiences, we can make informed adjustments to improve services and better serve the community.

> *Some cities will involve community partners, but they don't always try to understand the community's experience or how to improve it moving forward. So, I think the evaluation process has always lagged behind. ~ Anonymous SME*

Integrating Holistic and Western Medical Models

Incorporating both holistic and Western medical approaches is crucial to meeting the diverse healthcare needs of South Asian communities. Traditional medicine is often misunderstood or seen as less informed, but by recognizing its value and integrating it with modern healthcare, we can provide culturally sensitive care that respects patients' values and ultimately improves health outcomes. A more inclusive healthcare model fosters better patient experiences and enhances overall well-being.

> *Our beliefs about traditional medicine often assume a level of ignorance or misunderstanding. ~ Dr. Ananya Tina Banerjee*

Integrating Holistic and Western Medical Models

Incorporating both holistic and Western medical approaches is crucial to meeting the diverse healthcare needs of South Asian communities. Traditional medicine is often misunderstood or seen as less informed, but by recognizing its value and integrating it with modern healthcare, we can provide culturally sensitive care that respects patients' values and ultimately improves health outcomes. A more inclusive healthcare model fosters better patient experiences and enhances overall well-being.

> *I think we need to be better prepared to meet the needs of communities more broadly so that if a crisis arises, it doesn't lead to the same damaging impacts we saw during COVID-19. We just weren't ready—none of the infrastructure was there. Even from a public health perspective, they didn't have the systems in place to collect infection data. When that foundation isn't there, you're always trying to catch up during a crisis, scrambling to address emerging needs in real time. ~ Anonymous SME*

5.2 BLACK-AFRICAN-CARIBBEAN COMMUNITIES

COMMUNITY SURVEY FINDINGS

The survey recorded 31 responses between August and October 2024. Participants were required to be 18 years or older, reside within the GTA, and identify with BAC communities. While data collection was primarily conducted online, printed copies were made available to ensure inclusivity and representation.

The survey explored several key areas, including:
- Demographics (refer to section 4.3)
- Access to Healthcare Services (e.g., Family Doctors, General Practitioners, Nurse Practitioners)
- Access to Specialized Medical Care (e.g., Cardiologist, Paediatrician)
- Satisfaction with Healthcare Services

ACCESSING HEALTHCARE SERVICES

Out of 31 survey respondents, 83.9% reported having access to a family doctor, general practitioner, or nurse practitioner, while 16.1% did not. The reasons provided by those without a family doctor included:

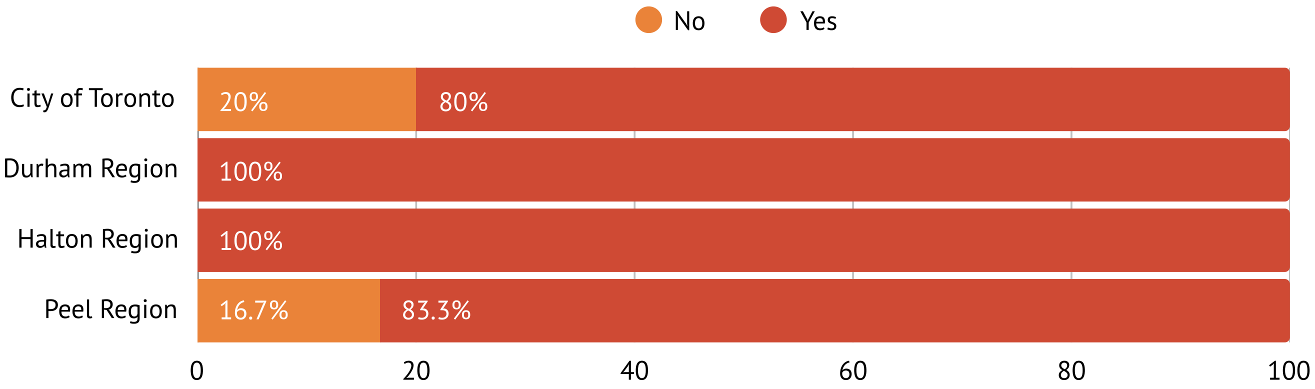
No one is accepting new patients in my area

I don't know how to find one

There was one who retired or changed their practice.

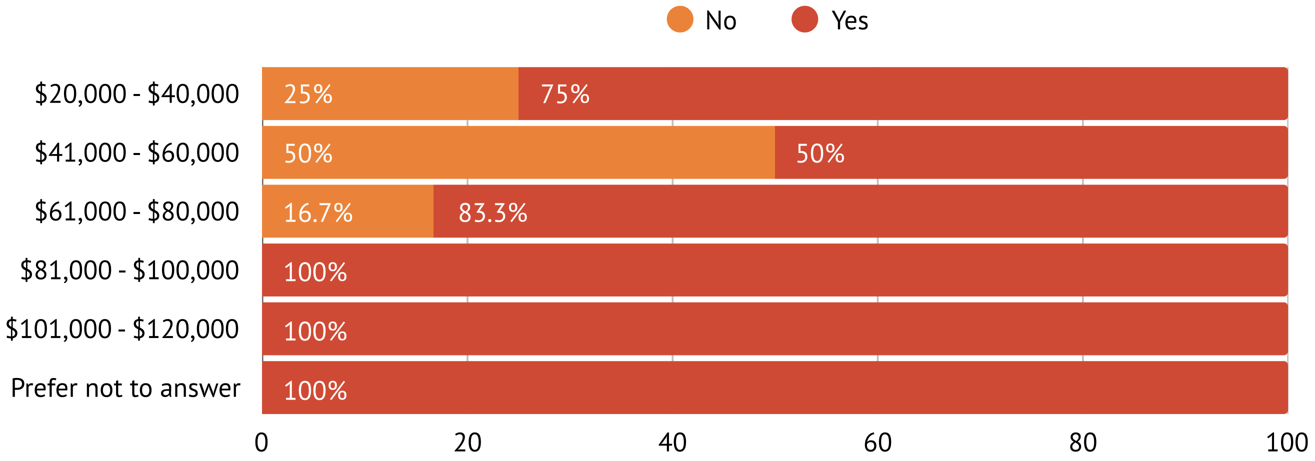
The majority of participants report having access to a primary healthcare provider, specifically a family doctor or general practitioner. However, accessibility varies by region, with Peel Region and the City of Toronto showing a higher percentage of individuals without a family doctor. This suggests potential regional disparities in healthcare access, indicating the need for further exploration into barriers to primary care in these municipalities (Figure 57).

Figure 57: Access to family doctor/general practitioner or nurse by regional municipality



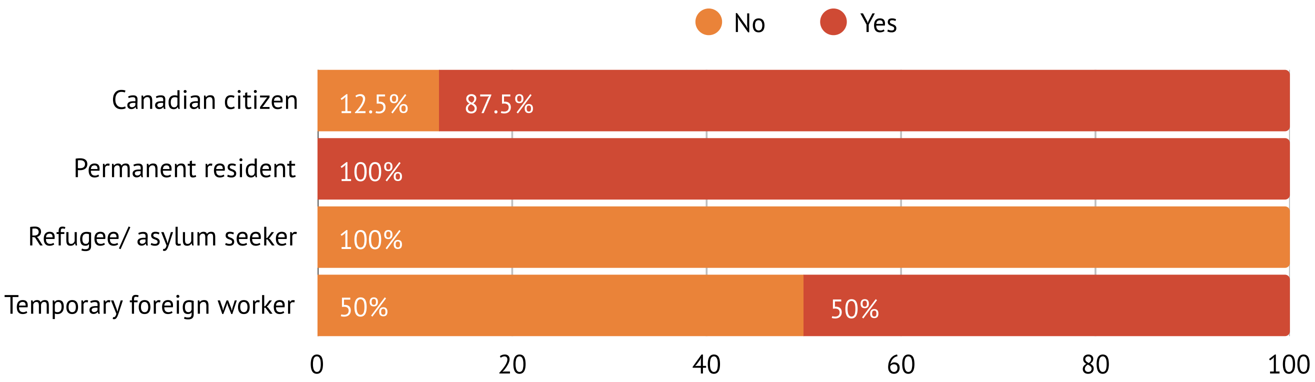
The relationship between annual household income and access to a family doctor or general practitioner shows that while most participants across all income levels report having access to a primary healthcare provider, there are notable variations (Figure 58). Lower-income groups have a slightly higher proportion of individuals without a family doctor, highlighting the need to address barriers to primary care, especially for those in lower-income households.

Figure 58: Access to family doctor/general practitioner by income



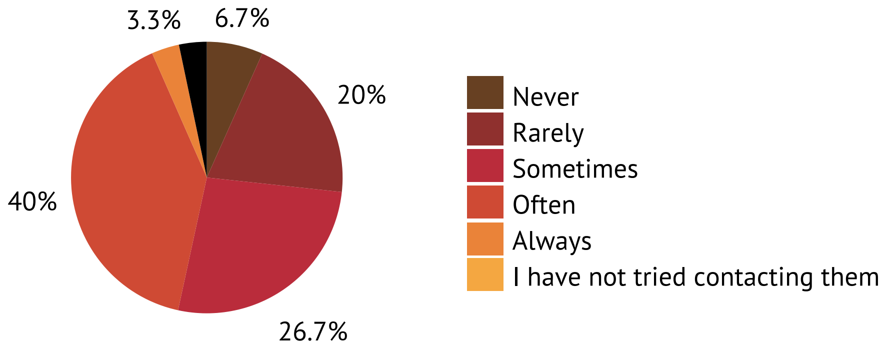
The relationship between access to a family doctor or general practitioner and immigration/citizen status reveals that Canadian citizens have the highest percentage of respondents with access to a primary healthcare provider (Figure 59). In comparison, individuals with other statuses—such as refugees, asylum seekers, and temporary foreign workers—show a higher proportion without a family doctor. This suggests that immigration status may influence access to primary healthcare, potentially due to barriers such as eligibility criteria, limited health coverage, or challenges navigating the healthcare system. However, it is important to note that the small and unbalanced sample of different immigration statuses in this study limits the generalizability of these findings. The underrepresentation of certain groups, like refugees and temporary foreign workers, makes it difficult to draw firm conclusions about healthcare access disparities for BAC community members. Future studies with a larger, more diverse sample would provide a more accurate and comprehensive understanding of these trends.

Figure 59: Access to family doctor/general practitioner by immigration/citizen status



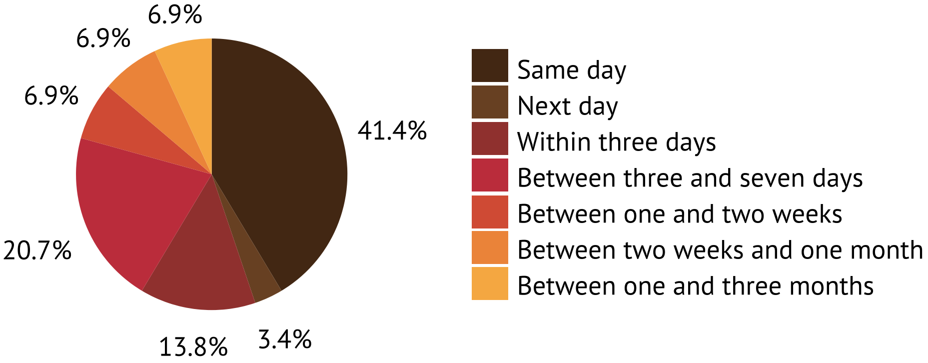
Moreover, the data reveals that timely responses from healthcare providers during regular practice hours are inconsistent. While 40% of respondents reported often receiving a response within 24 hours, 26.7% only sometimes did, and 20% rarely received one. Additionally, 3.3% had never attempted to contact their provider, suggesting a lack of need or possible uncertainty about the process. (Figure 60)

Figure 60: When you contact your healthcare provider during regular practice hours with a medical concern or question unrelated to appointments, do you typically receive a response within 24 hours?



Regarding wait times, 41.4% of respondents were able to see their healthcare provider on the same day they requested care, indicating relatively quick access for many. However, 20.7% had to wait between three and seven days, while 6.9% experienced delays of one to three months, highlighting notable disparities in timely access to care. (Figure 61).

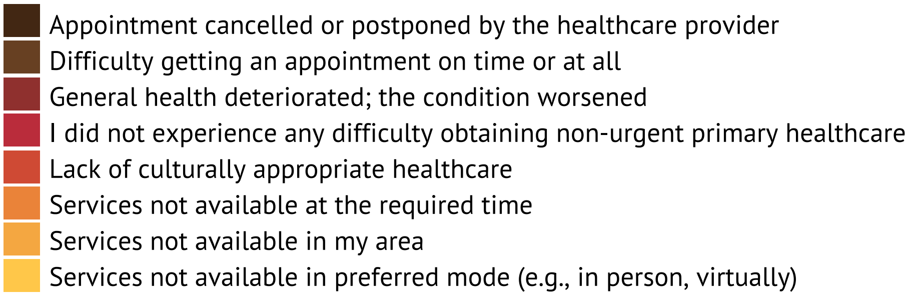
Figure 61: How long did you wait between requesting care and seeing your healthcare provider?

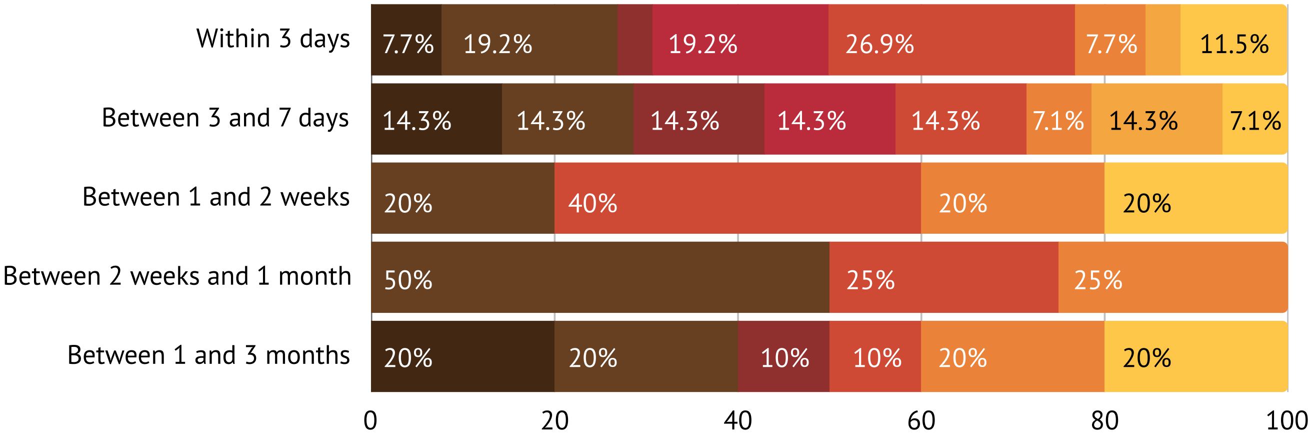


A comparative analysis was conducted to explore the relationship between wait times and difficulties experienced when accessing healthcare within 12 months of completing the survey (Figure 62). The findings show a clear link between longer wait times and an increase in reported challenges in accessing non-urgent primary healthcare. Shorter wait times, such as appointments within 3 days, were generally associated with fewer reported difficulties, with many respondents (19.2%) indicating they faced no issues. In contrast, as wait times extended to one week to three months, a higher percentage of respondents reported difficulties, including "difficulty getting an appointment on time or at all" and "service not available at the required time."

Interestingly, as wait times increases, the variety of difficulties reported decreases, suggesting that specific barriers become more dominant. For example, respondents who waited between 2 weeks and 1 month or 1 to 3 months reported fewer types of difficulties overall, but with higher percentages per barrier. However, the overarching trend points to a clear correlation between increased wait times and heightened barriers to care, which can potentially lead to deteriorating health conditions and delays in receiving necessary treatment.

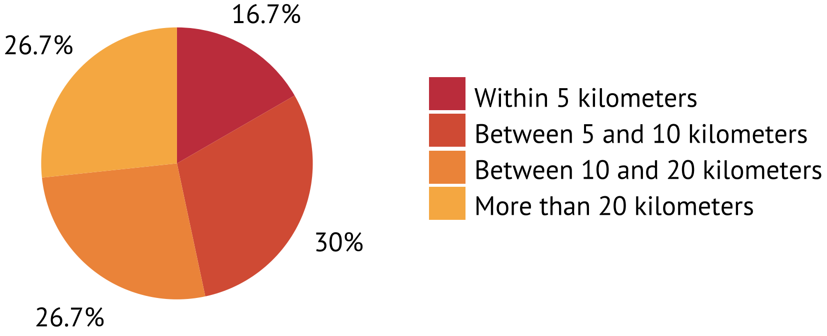
Figure 62: Difficulties experienced when accessing non-urgent primary healthcare by wait time





Respondents were also asked about the distance they travel to access their family doctor, general practitioner, or specialized nurse. The results revealed a fairly even distribution, with 26.7% of respondents reporting travel distances of both 10-20 kilometers and more than 20 kilometers (Figure 63). These longer travel distances can present substantial barriers to timely healthcare access, especially for individuals with mobility challenges, limited transportation options, or urgent medical needs.

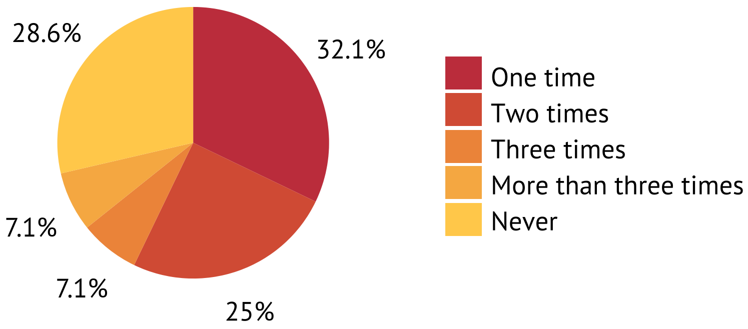
Figure 63: How close is your family doctor, general practitioner, or nurse practitioner?



ACCESS TO SPECIALIZED MEDICAL CARE

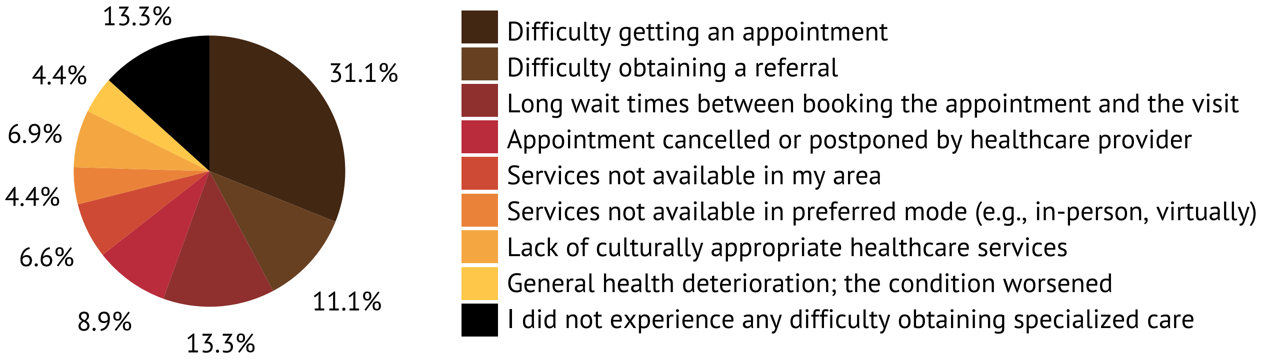
The survey revealed that 28.6% of respondents did not consult a medical specialist within 12 months of completing the survey. Additionally, 32.1% of respondents consulted a specialist only once during this period. These findings suggest that while some individuals are able to access specialist care, a significant portion of the population faces barriers to regular consultations, potentially due to challenges such as wait times, specialist availability, or healthcare access limitations. (Figure 64)

Figure 64: How many times did you consult with a medical specialist within 12 months of completing the survey?



The findings indicate several significant difficulties experienced by respondents when accessing specialized care in the past 12 months. The most common issue was difficulty getting an appointment, reported by 30.4% of respondents. Additionally, 13% of participants faced long wait times between booking their appointment and the actual visit, while 10.9% experienced challenges obtaining a referral. (Figure 65)

Figure 65: In the past 12 months, did you experience any of the following difficulties in accessing the specialized care you needed?



SATISFACTION WITH HEALTHCARE SERVICES

Of the 31 survey respondents, 20.7% rated the quality of care they received from a healthcare provider as excellent (a 5 on the Likert scale) within the 12 months prior to completing the survey (Figure 66).

Lower ratings (1-3) reflect dissatisfaction with healthcare experiences, with respondents describing interactions as dismissive, rushed, and impersonal. Many patients felt their concerns were minimized, appointments were difficult to schedule, and doctors were unable to dedicate sufficient time to address multiple issues. Several respondents also reported challenges related to language barriers (especially languages other than English and French), discrimination (such as anti-Black racism and misogynoir), and lack of cultural sensitivity, which undermined their trust in seeking care.

Mid-range ratings (4) indicate generally respectful and professional interactions, but with room for improvement. While some participants felt comfortable with their healthcare provider, others noted issues such as short appointment times, rushed consultations, and long wait times for specialized referrals. Some respondents felt the need to advocate for themselves to ensure comprehensive care, suggesting gaps in proactive medical attention.

The highest rating (5) reflects strong patient-provider relationships, effective communication, and compassionate care. Respondents who had long-standing relationships with their healthcare providers expressed trust and familiarity, contributing to positive experiences. Those who received care from urgent care clinics also noted thorough and respectful service, although hospitals were frequently mentioned as more problematic settings.

Figure 66: Overall, how would you rate the quality of care you received from a healthcare provider within 12 months of completing the survey?

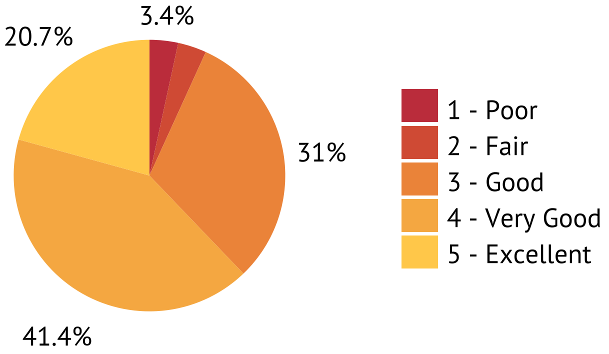
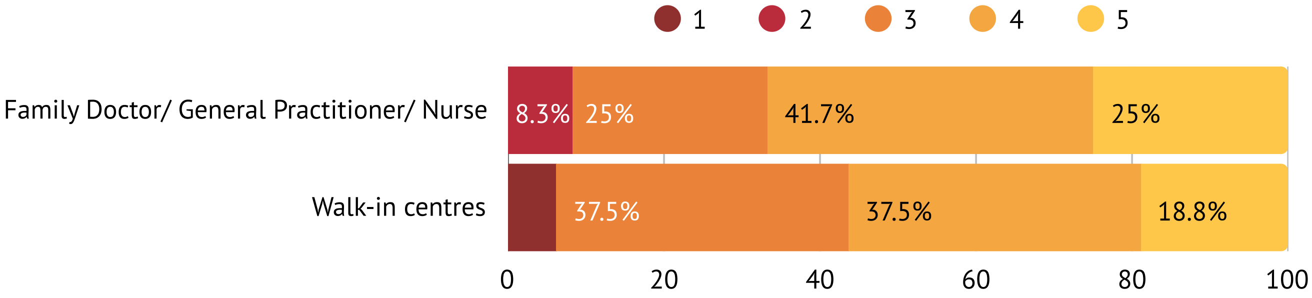


Figure 67 illustrates the variation in quality ratings based on the type of primary care received in the past 12 months. Respondents reported higher satisfaction with Family Doctors/General Practitioners and Nurses compared to walk-in centers. This indicates that having a consistent healthcare provider, such as a family doctor, may lead to a more positive patient experience. In contrast, walk-in centers appear to offer more varied experiences, likely influenced by factors like availability and the quality of care provided.

Figure 67: How would you rate the quality of the consultation based on the type of non-urgent primary healthcare you received?



In terms of treatment, 20.7% of respondents reported experiencing discrimination by a healthcare provider within the past 12 months. The reported reasons for discrimination included factors such as lifestyle, age, race/ethnicity, gender, language, personal beliefs, and income.

COMMUNITY FOCUS GROUP FINDINGS

Between September and October 2024, five FGDs were conducted with 20 participants, each lasting 2 hours and held virtually in English via Zoom. The discussions centered on key issues such as long wait times, rushed appointments, resource shortages, and racial and gender disparities in healthcare treatment. Participants also highlighted mistrust in the healthcare system, language barriers, and inconsistent government communication as factors exacerbating these inequities. The pandemic's impact on mental health was also evident, with many individuals struggling to access the necessary support. In response, participants recommended enhancing culturally competent care, improving public health messaging, decentralizing healthcare decision-making, and expanding community outreach initiatives. These findings underscore the urgent need for systemic reforms to ensure equitable healthcare access for racialized communities.

BARRIERS TO ACCESSING HEALTHCARE SERVICES

Participants highlighted significant challenges in accessing healthcare during the COVID-19 pandemic, driven by systemic barriers, resource shortages, and discrimination. Overcrowded facilities and long wait times made timely care difficult, while frontline workers faced increased risks due to safety lapses. Racialized individuals experienced discrimination and had to self-advocate for proper care. Language barriers and limited access to technology also hindered healthcare access, contributing to a growing mistrust in the healthcare system among racialized and immigrant communities.

Delayed Healthcare Access: Overcrowded healthcare facilities led to long wait times and backlogs. Some participants waited for hours to see a doctor in Toronto, while others opted to travel to nearby cities, such as Oakville, where wait times were shorter. The strain on healthcare resources during the pandemic made it increasingly difficult to access timely care.

> *It was also more difficult to access other forms of healthcare, because everything was just overflowing with hospitalizations from COVID.*

> *Would have hours to get checks at Humber River Hospital in Toronto, but only waited a maximum of 20 minutes in Oakville to get thorough tests done. In Toronto, it was more oversaturated.*

> *My brother and my mom, both like, had a hard time getting appointments with their primary doctors and because of that, it was just super challenging to update their medications as needed.*

Rushed Healthcare Visits: Some participants felt that healthcare visits were rushed, with minimal follow-up and poor communication. They expressed frustration that healthcare providers often seemed too busy to fully address their concerns or provide detailed explanations. This lack of thorough communication and continuity in care was attributed to overworked healthcare staff, who were juggling high patient volumes and increased workloads.

Poor Allocation of Resources: Several participants highlighted critical shortages of essential resources, including personal protective equipment (PPE), vaccines, and COVID-19 testing kits. Additionally, one participant pointed out that some community members faced barriers due to limited access to technology or the internet, which made it difficult for them to stay informed about the latest pandemic updates or to book vaccine appointments. These shortages and lack of access further deepened existing inequities, preventing vulnerable individuals from receiving timely care and information.

> *There were popup vaccine clinics in my city, but...they had limited supply. There would be thousands of people lined up to get vaccinated which is already increasing the risk of getting COVID....People were turned away because they ran out [of vaccines]. Some of the pop ups also were scheduled with little to no notice.*

Employment Vulnerability: Several participants, particularly those with frontline work experience during the pandemic, expressed concern about their heightened risk of contracting COVID-19. Despite this increased vulnerability, many noted a lack of adequate safety measures in their workplaces. This included insufficient access to COVID-19 vaccinations and other protective protocols, which left them exposed to the virus while performing essential duties.

Racial and Gender Discrimination: Many participants linked the challenges they faced during the COVID-19 pandemic to their racial or ethnic background, feeling overlooked and misunderstood. They pointed to unconscious bias, medical racism, and inadequate cultural competence among healthcare providers. Some felt dismissed or received subpar care, with stereotypes like the belief that Black women tolerate more pain influencing treatment. Historical mistrust in the medical system fueled vaccine skepticism, while socio-economic barriers, such as reliance on public transportation, limited healthcare access. One participant shared that after struggling with non-Black providers, she requested a Black doctor, leading to proper diagnosis and care. Racialized individuals often face the exhausting task of self-advocating for care, which is not always feasible.

There is a stereotype with Black women that you know we're stronger and would feel less pain and if you present the same symptoms as a white woman, you're less likely to be prescribed the proper medication.

The medical system has never favored us throughout history, and it just feels like mind control almost. So when the vaccination came out everything happened so fast, and I guess a lot of Black people felt like they were an experiment to the government.

I'd rather stay at home actually and self-medicate than to access health care, because one, my issue would be dismissed because it's not covid. It's like "Can you breathe, or can you not breathe?". Yeah, I can breathe, but then, like my insides, are eating me up you know. That's not a prerequisite for being seen or being taken care of in the same capacity, so that was a bit difficult. And then also with the medical racism...it's just that idea that Black women can tolerate a lot of a lot more pain. And so during those times when I was always in serious pain. It felt like it was just kind of sidelined.

I'll have to be begging my doctor to let me get a requisition for an X, Y, Z, and he's like, "Oh, you don't really need to do it", but then he tested, and it was so low that I had to get on like prescription vitamin D. But it's like, why am I begging you to do this when it's coming out of my pocket....So it's just doctors not taking you seriously all the time and then something more serious happens down the line.

It undertones unconscious bias and racism, and also just the mere fact that healthcare workers are uneducated about a disease in the healthcare system. I think that because it does not affect the majority of the population.

Mistrust in Healthcare: Participants reported that the pandemic deepened existing mistrust in the healthcare system. Concerns were raised about the rushed development of the COVID-19 vaccine and its long-term safety. Many felt pressured to take the vaccine for job security, compounded by limited transparency and communication, which fueled feelings of manipulation. Historical injustices, including the exploitation of Black communities in medical experiments, amplified these fears and reinforced the perception that racialized individuals are deprioritized in healthcare. Even those with healthcare or science backgrounds expressed difficulty trusting the system, citing the lack of reliable information and the emotional toll it had on their communities.

> *Being a new immigrant, you just think very differently. With every little thing you're like, 'Oh, let me just get everything because I don't want anything to affect my status in Canada.' So you can even think about that like you have to do it because Canada says you have to do it without looking into it, and you feel like you were coerced into doing it.*

> *Even after taking the vaccine, people were still getting sick and it was kind of scary, because, like, what did we really put in our bodies? How is it gonna affect us long term? Are we gonna get sick again like, are we gonna have to take another one?*

> *There is a historical context of the healthcare system not being fair. We were sort of like guinea pigs where we were used for experimental purposes, and we were operated on for experimental treatments. And we were given vaccines that were supposed to, instead of healing us, were damaging us. So lots of Black people don't really trust the healthcare system.*

Language Barriers: Some participants noted that many immigrants and their families struggled to access healthcare due to the absence of translated materials in languages beyond English and French, hindering their ability to understand important health information and navigate the healthcare system.

THE IMPACT OF COVID-19 ON MENTAL HEALTH AND WELLBEING

The COVID-19 pandemic created significant emotional strain due to isolation and the sudden loss of support systems. Participants shared feelings of loneliness and disorientation, especially those without close family or community support. The absence of normal routines left many struggling with a sense of instability, heightening emotional distress. While some managed through coping strategies like outdoor activities, others faced barriers to accessing mental health resources, with certain groups, such as essential workers and the unhoused, disproportionately affected by the lack of adequate support.

Impact of Isolation and Loss of Support Systems: The pandemic led to profound feelings of disorientation and emotional strain due to isolation and the sudden loss of support systems. Participants described how the absence of normal routines and social interactions, especially for those without nearby family or communal support, amplified feelings of loneliness and uncertainty. The lack of familiar social structures left many struggling to find stability, leading to heightened emotional distress and a sense of being stuck in an ongoing emotional limbo.

> *We are still living in some sort of funk...There's this feeling of like, you feel like time is not moving, and then other times you're like, time is rapidly moving. That's how I felt ever since COVID.*

> *When we had to self isolate and actually quarantine in March of 2020. That was really hard for me, because that source of support just got stripped away, and there was like no backups, and like it did take a long time before the counseling office was like, ‘Oh, we can actually do virtual because everyone was just like complete shutdown. So what do you do about people who only need a source of support, having no family around or your family is also self isolated in a different building. And you really couldn't go over there so that was really hard.*

Coping Strategies and Positive Experiences: While many struggled with the challenges of the pandemic, some participants shared positive experiences, citing coping mechanisms such as outdoor activities and virtual work. One participant found comfort in taking walks and utilizing government resources like CERB. For others, the lack of major losses until later in the pandemic made their experience more manageable.

> *I think my experience was more so positive because I didn't experience loss until like the very end of COVID and in terms of work it was all virtual and there were also a lot of resources to help like CERB. So in terms of actual lifestyle, I was able to do things like going out. I was taking walks, because, you know, that was recommended to go outside, get fresh air and stuff. So things like that were good for me and my mental health.*

Barriers to Accessing Mental Health Services: Access to mental health services during the pandemic was inconsistent across participants. While some were able to secure virtual therapy sessions, many faced barriers such as limited awareness of available resources and difficulty accessing services. The emphasis on vaccination efforts often overshadowed the need for mental health support, leaving many uncertain about where to find help. Although some participants observed an increase in mental health resources, these improvements were not equally accessible. Essential workers, unhoused populations, students, and immigrants were disproportionately affected, often lacking the support needed to manage the heightened stress and isolation during the crisis.

> *If I did [need mental health services], I wouldn't even know where to start or go. Lots of people weren't talking about mental health, they just wanted to make sure everyone was vaccinated. They didn't consider the implications of being at home [and] what that would cause for people in terms of mental health.*

> *It was very back and forth. Sometimes the government was maybe too quick to make a decision and like, tell everybody and publicize it for them to just take it back a couple days later. And I think that is part of what made people just stop caring and stop listening and stop following is because they were like, "Well, you know, tomorrow it's gonna be something different."*

Challenges with Media and Virtual Engagement: While the government relied heavily on media and virtual town halls to communicate essential COVID-19 information, participants expressed that these platforms often lacked opportunities for genuine community engagement. Many felt that these virtual events were one-sided, with limited space for participants to ask questions, share concerns, or provide feedback. The absence of interactive elements, such as live discussions or follow-up opportunities, left many feeling unheard and disconnected from the decision-making process.

BARRIERS TO EFFECTIVE COMMUNICATION AND ACCESS TO HEALTHCARE INFORMATION DURING THE COVID-19 PANDEMIC

Participants expressed overall dissatisfaction regarding the communication efforts by government and healthcare bodies during the COVID-19 pandemic, highlighting issues of inconsistency, lack of transparency, and accessibility. The rapid changes in public health guidelines and messaging, combined with limited engagement opportunities, led to widespread confusion and disengagement. Many participants also pointed out that essential information, particularly for immigrant populations, was not effectively communicated, creating barriers to understanding and accessing healthcare services. Culturally responsive, clear, and inclusive communication was identified as a key factor in improving the effectiveness of public health strategies.

Inconsistent and Confusing Messaging from Government Authorities: Participants expressed frustration with the government's COVID-19 messaging, noting that it was often inconsistent and confusing. Frequent changes to guidelines and rapid shifts in vaccine protocols created a sense of instability, leaving individuals unsure of what actions to take. This constant back-and-forth led to widespread mistrust, as many felt that the information they were being provided lacked clarity and was subject to sudden reversals. As a result, the failure to offer clear, consistent, and well-explained communication led to disengagement, with many participants either disregarding the information or becoming less inclined to follow the guidelines.

> *Very ineffective and numerous bulletins and contradicting information from the COVID task force. The feeling that many of the rules that were being imposed felt draconian and unconstitutional.*

> *t was very back and forth. Sometimes the government was maybe too quick to make a decision and like, tell everybody and publicize it for them to just take it back a couple days later. And I think that is part of what made people just stop caring and stop listening and stop following is because they were like, "Well, you know, tomorrow it's gonna be something different."*

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I felt like the government utilized a lot of social media a lot, but they failed to kind of inform a good chunk of the population, at least in like the GTA that did not have access to technology or Internet. They could have done a lot more in terms of having the messaging out in places where people would go to like in grocery stores.

Cultural and Linguistic Barriers in Health Communication: Participants highlighted significant gaps in culturally appropriate health communication, particularly affecting immigrant and newcomer populations. The use of technical jargon and limited translations of critical COVID-19 healthcare information made it challenging for individuals, especially those with limited English proficiency, to fully understand the guidelines. This lack of tailored communication excluded many, including older adults and newcomers, from accessing essential health resources and support. As a result, participants felt marginalized, further contributing to barriers in accessing and acting on vital health information.

The way that they set up the policies did not align with the way that we heal. A lot of us heal through communal things. A lot of the work that we do is through community, and everything was very isolated.

My grandparents' first language is Bengali. They speak English, but of course all the scientific terms, like Moderna and Pfizer they don't really know what that means, right? And then that can also contribute to marginalization when you're just literally putting your life into these healthcare workers because you're like, "I don't know what any of the stuff is".

There were a lot of my family that did come from Kenya or Somalia and they just did not understand anything and I feel like in the areas or the neighborhoods that they're from that have higher populations of Somalis, they didn't utilize Somali language as much.

ELEMENTS OF CULTURALLY-RELEVANT CARE

Participants emphasized several crucial elements of culturally relevant healthcare that can enhance the well-being of BAC communities. These elements include ensuring cultural representation among healthcare providers, incorporating holistic healing practices that integrate mental, spiritual, and physical health, and prioritizing preventive care to address common conditions like diabetes and hypertension. Collectively, these factors help create a healthcare environment where individuals feel understood, respected, and empowered to engage in their health and wellness in a way that aligns with their cultural values. This comprehensive approach promotes trust, comfort, and long-term health outcomes within the BAC community.

The Importance of Cultural Representation in Healthcare: A central theme in culturally relevant care is the need for healthcare providers who reflect the cultural backgrounds of the communities they serve. Participants noted that having providers who share similar cultural traits enhances comfort and trust, making patients feel understood and more willing to engage in their care. Representation in healthcare is seen as an essential step in fostering a sense of belonging and improving patient-provider relationships.

> *Seeing people who look like me would probably help me feel more comfortable, and trust the people who are administering any of these services.*

The Role of Holistic Healing Practices: Participants strongly advocated for the incorporation of alternative, holistic healing practices within healthcare settings. They emphasized that mental and spiritual well-being should not be treated separately from physical health but as integral components of overall wellness. A holistic approach that values these dimensions could better serve BAC communities, ensuring care that is both culturally appropriate and comprehensive.

> *I am a strong proponent that BAC people need to look into more holistic practices within our healthcare facilities. I don't believe that you can separate mental and spiritual wellbeing from physical wellbeing. The implementation of alternative scholarship around healthcare with empirically driven analysis would be very beneficial.*

Prioritizing Preventive Care: Participants highlighted the importance of prioritizing preventive care within culturally relevant healthcare frameworks, particularly for conditions like diabetes and hypertension, which disproportionately affect the BAC community. They noted that a focus on prevention, in alignment with cultural practices, can help manage these conditions before they escalate, reducing long-term health risks.

SUGGESTIONS FOR ENHANCING CULTURALLY RELEVANT AND ACCESSIBLE SERVICES

Participants provided valuable suggestions to improve healthcare and community services for racialized communities. They emphasized the importance of ongoing culturally responsive training for healthcare providers and greater community involvement in decision-making to build trust. Additionally, there were calls for clearer public health messaging, especially regarding non-COVID medical procedures, and the expansion of multilingual resources to ensure equitable access to healthcare. Participants also recognized the impact of social isolation during lockdowns and proposed increased mental health support for individuals, particularly children. Lastly, they recommended that food banks offer more culturally relevant food options to better meet the dietary needs of racialized families.

Addressing Gaps in Culturally Competent Care: Participants emphasized the need for ongoing culturally responsive training for healthcare providers to better understand the diverse needs of patients, including how conditions manifest across different ethnic backgrounds. They advocated for an inclusive approach that respects cultural beliefs and practices. Additionally, appointing community members to share health information could help bridge trust gaps, while decentralizing healthcare to involve communities in decision-making would further improve cultural competence in care.

> *It's important to take people's cultural differences into consideration especially when it comes to medical treatment because other cultures get taken so seriously. No one questions why they choose what they choose. They just kind of go along with it, but for some black people you just get questions like, "Oh, no! This is the best option for you" and they kind of diminish what you truly believe in.*

> *The decentralization of healthcare and allowing members of the community to represent ourselves and designate the manner in which healthcare is distributed within our communities. In the same manner that Indigenous communities are able to take control of certain facets of the mundane aspect of their societies..ombudsman...independent police force, etc.*

Improving Access to Healthcare and Mental Health Services: Participants stressed the need for clearer, more transparent public health messaging, particularly around non-COVID medical procedures, and emphasized the importance of follow-up care to ensure patients feel supported and informed. Public health strategies must guarantee equitable access to healthcare for all, regardless of socioeconomic status, gender, ethnicity, or location. To better serve diverse populations, multilingual services should extend beyond English and French. Additionally, community outreach efforts with BAC communities should take priority over impersonal, contactless communication to reach individuals who may not seek support on their own.

A lot of mental health services should be more available when it comes to Black families and also, just in general, like lower income families. I feel like they should make it mandatory to expand public funding because you know we have lower uninsured rates and things like that.

Having someone that would provide information anywhere possible where you see the BAC community kind of coming together, because I'm not going to pick up a flyer on my own accord.

Impact of Limited Social Interaction Opportunities: During lockdown and physical distancing, community members experienced social isolation, which hindered their ability to form and maintain connections. This isolation, particularly affecting children who attended online school, disrupted important social development. As restrictions were lifted, the transition proved challenging for many. Participants suggested expanding mental health resources to support both isolated individuals and children who lacked outlets for emotional expression, helping them navigate the long-term effects of social disconnection.

A service of having more community members looking out for one another. The use of technology for interconnectivity rather than just for commerce and entertainment. I think it showed that the internet and social media can be a great tool if utilized properly.

Inadequate Access to Culturally Relevant Foods at Food Banks: Racialized families who relied on local food banks often encountered difficulties due to the absence of culturally relevant foods. This gap in food offerings left many families unable to access ingredients that align with their cultural or dietary needs. Participants suggested that food banks should actively work to ensure a diverse selection of culturally appropriate groceries that reflect the demographics of the local population. By doing so, food banks can better serve the unique needs of racialized communities, fostering a sense of inclusion and support.

[There should be] more food bank services that provide more culturally specific foods. Even if they're doing the food bank 3 different days and on a specific day it's more catered to an Asian culture or certain African cultures, and like, it rotates on a monthly basis or something like that.

SUBJECT MATTER EXPERT INTERVIEW FINDINGS

Access to equitable healthcare for BAC communities is hindered by a range of systemic barriers, including anti-Black racism, historical mistrust, lack of cultural competency, and underrepresentation in the healthcare system. The pandemic has underscored the urgency for systemic reforms to address these inequities and improve both healthcare access and health outcomes for BAC communities.

These insights are drawn from five SME interviews with healthcare professionals and advocates who offered valuable perspectives on the challenges BAC communities faced during the pandemic:

- **Dr. Trudy McFarlane –** Family Physician, General Practitioner, Psychotherapist, and Medical Consultant; Black Health Lead, Toronto Metropolitan University, School of Medicine
- **Dr. Ato Sekyi-Otu –** Orthopedic Surgeon, William Osler Health System; Lecturer, University of Toronto
- **Suleman Sule –** Project Manager, Health Commons Solutions Lab, Sinai Health
- **Lydia-Joi Marshall –** Director of Evaluation and Practice, Health Commons Solutions Lab, Sinai Health
- **Angela Carter –** Advisor, Strategic Initiatives, Black Health & Social Services (BHSS)

SYSTEMIC BARRIERS TO HEALTHCARE ACCESS

Despite being labeled as 'universal,' Canada’s healthcare system remains inequitable, particularly for BAC communities who face systemic challenges that are often overlooked in mainstream healthcare planning. Rooted in Western medical models, the system fails to address the unique needs and experiences of BAC communities, with key issues such as cultural incompetence, anti-Black racism, underfunding, and lack of representation in healthcare decision-making. While these barriers have existed for years, many experts emphasized that the COVID-19 pandemic exacerbated and exposed these inequities, making them more visible and pronounced.

Centralization and Normalization of Western Healthcare: Canada’s healthcare system is largely based on Western medical models that predominantly cater to the needs of non-racialized groups. As a result, the system fails to recognize the unique experiences and intersectional barriers faced by BAC communities, often rooted in systemic inequities. This approach perpetuates colonial frameworks, further marginalizing BAC community members, limiting their access to culturally sensitive healthcare, and negatively impacting their health and well-being.

I would say non-racialized groups faced similar challenges during the pandemic. I think the healthcare system is already designed to cater to more effectively serve their needs. Meanwhile, for Black communities due to systemic exclusion, or, you could say, lack of inclusion. This further exacerbates the challenges they face, and then, as a result, makes them more vulnerable to the adverse effects of the pandemic. ~ Dr. Trudy McFarlane

Lack of Cultural Competence: Many healthcare providers, particularly in the Peel region, lack an understanding of cultural differences within the BAC communities. The tendency to treat BAC communities as a monolith, without accounting for the cultural diversity within the diaspora, further hinders effective care. This lack of cultural competence is compounded by anti-Black racism, which has led to mistrust in the healthcare system. As a result, many BAC community members avoid seeking care unless absolutely necessary.

We're spending so much time getting to know the specific needs and different cultures. And we're still seen as this one political monolith. That's the barrier that's still not progressing. ~ Lydia-Joi Marshall

Black men are more susceptible to prostate cancer, but there is a barrier in education for the healthcare providers of that susceptibility. ~ Dr. Ato Sekyi-Otu

Delayed and Inadequate Healthcare Services: In the Peel region, residents often face long wait times to access healthcare, which worsens their health conditions. Once seen by a healthcare provider, appointments are typically rushed, with a focus on getting patients in and out quickly. This time constraint, sometimes referred to as the "15-minute rule," means that healthcare providers spend limited time with each patient, leading to inadequate assessments and less comprehensive care. As a result, important health concerns may be overlooked, and patients are left feeling unsupported.

There's also the, I call the '15 minute rule' almost so where the providers, the general practitioners, or whoever it is sometimes the focus is just getting you in and out the door, and that sort of influences, how much attention, or the comprehensiveness of that interaction that you would get. ~ Suleman Sule

Anti-Black Racism: The centralization of Western healthcare structures has allowed anti-Black racism to permeate healthcare institutions. While non-racialized communities may face discrimination due to classism, Black identities experience compounded challenges that result in significant health disparities. As such, anti-Black racism must be completely dismantled to achieve true health equity.

> *Living as a Black person within Canada and North America, you have to constantly be challenging or ignore what is being said to you. And in Peel Region, we are very diverse, but every other racial group still sees us [BAC communities] as the most inferior of all groups. That is a very heavy burden to bear. ~ Angela Carter*

Lack of Healthcare Resources: Despite Peel Region being one of Canada's fastest-growing areas, Brampton—part of Peel—has historically received less funding per capita for healthcare, education, and criminal justice, contributing to health inequities within BAC communities. While recent improvements in funding are underway, the community continues to feel the long-term effects of years of underinvestment. The pandemic exacerbated these challenges, deprioritizing chronic conditions such as hypertension, diabetes, and sickle cell disease. Additionally, gaps in access to extended health benefits, medication, and non-medical services like gym memberships remain unaddressed.

Lack of Representation: Healthcare providers and policymakers in Peel Region do not sufficiently reflect the diverse demographic of the community. This underrepresentation results in decisions and policies that often fail to incorporate the perspectives of individuals with lived experiences from BAC communities, leaving their unique needs and voices excluded from critical discussions on health equity and policy development.

THE IMPACT OF COVID-19 ON BAC COMMUNITIES

The COVID-19 pandemic exacerbated existing health inequities within racialized communities, especially BAC populations, driven by factors such as socioeconomic disparities and limited healthcare access. The pandemic also intensified mistrust in the healthcare system due to inconsistent messaging, lack of culturally relevant information, and the dismissal of traditional healing practices. BAC communities, particularly frontline and essential workers, faced heightened exposure to COVID-19 with insufficient protective measures. Meanwhile, funding shifts and economic pressures reduced access to essential services, including housing and healthcare, and led to delays in chronic disease management and preventive care. A depletion of healthcare providers further strained services, while the rapid shift to digital healthcare provided some relief but also highlighted disparities in access.

Social Determinants of Health Inequities: Social determinants of health, such as socioeconomic status, education, and living conditions, have played a significant role in the high rates of COVID-19 within racialized communities, including BAC communities. For example, many BAC families live in multigenerational households, making self-isolation challenging. These inequities existed long before the pandemic, but COVID-19 brought them into sharper focus. Some experts noted that it wasn't until the pandemic began affecting non-racialized communities that the broader public started to recognize these disparities. The higher rates of infection in BAC communities, and the subsequent spread of the virus to non-racialized individuals, prompted a shift in awareness. This shift highlighted that these disparities are not just driven by socioeconomic factors but also by deeply rooted anti-Black racism, which needs to be addressed separately from other health inequities to achieve true equity.

Physical health is only a small part of your health outcome. You need to look at the social determinants of health. ~ Dr. Ato Sekyi-Otu

You didn't care about us when we didn't have housing, when we were sick in Brampton. Now they care because White folks are dying so we need to take vaccines to protect the White people. ~ Dr. Ato Sekyi-Otu

Mistrust in the Healthcare System: Mistrust in the healthcare system among BAC communities was heightened during the pandemic due to several factors, including inconsistent and changing public health messaging, a lack of culturally relevant information, and overall poor healthcare services. The absence of tailored communication that addressed the unique needs of BAC communities made it difficult for them to engage with public health efforts. Additionally, the disregard for traditional healing practices and the exclusive focus on Western medical approaches, without open dialogue or understanding, deepened the sense of exclusion and alienation.

We already have complementary and alternative ancestral ways of thinking about health and for people to be like, "Well, you have to get vaccinated to go to work," "You have to do this this way," without dialogue, without context and continuously calling our belief systems a myth was harmful. ~ Lydia-Joi Marshall

Vulnerability of BAC Frontline and Essential Workers: BAC communities were disproportionately represented in frontline and essential roles, where they faced higher exposure to COVID-19 due to limited opportunities for remote work. These workers were often in public-facing positions, increasing their risk of contracting the virus. Despite this heightened vulnerability, insufficient protective measures were put in place to safeguard these workers, exacerbating the health risks they faced during the pandemic.

Impact of Funding Changes: Many resources, including housing and social services, became less accessible during the pandemic due to shifts in funding priorities. Economic pressures, including inflation, worsened the availability of essential services, particularly those related to social determinants of health such as housing, employment, and social cohesion.

Service Interruptions & Delays: As the pandemic unfolded, numerous services were categorized as "non-essential" and temporarily suspended. This included non-urgent primary care, preventive services, and the management of chronic conditions like hypertension and diabetes. Critical preventive care, such as cancer screenings, was delayed, leading to worsened health outcomes for many individuals. Additionally, elective surgeries, which are scheduled in advance and are not emergencies, were postponed or canceled, further exacerbating the strain on the healthcare system and delaying essential treatments for patients.

Depletion of Healthcare Providers: The healthcare system experienced significant staffing shortages as many healthcare providers retired, left the profession, or faced burnout. This created a backlog in the workforce, slowing down the rate at which replacements could be made. As a result, primary care services became even more strained, and the ability for patients to establish or maintain ongoing care with healthcare providers significantly decreased.

Shift to Digital Healthcare: In response to the challenges posed by the pandemic, the healthcare sector rapidly transitioned to digital services, which played a crucial role in addressing the growing demand for healthcare. Virtual care became a vital tool in ensuring individuals could access medical consultations and follow-up care without the need to leave their homes or disrupt their work schedules. This shift allowed more people to receive timely care, particularly in areas where access to in-person services was limited.

TRUST BUILDING EFFORTS WITH BAC COMMUNITIES

Trust-building emerged as a key topic of discussion among experts, with differing views on its effectiveness. Some advocated for grassroots engagement, suggesting that meeting BAC community members in familiar spaces could help strengthen relationships and foster trust. Others, however, were skeptical of the emphasis on “building trust,” arguing that during the pandemic, it often felt performative and limited to COVID-related interventions, without addressing the deeper, systemic issues impacting BAC communities. This highlights the need for long-term, sustained engagement that goes beyond pandemic response and tackles the broader challenges these communities face.

Empowering Communities Through Community-Led Initiatives: The COVID-19 pandemic highlighted the essential role of community-based organizations in meeting the unique needs of racialized communities. Many organizations, like Roots Community Services, stepped up to ensure that their communities were not left behind. By providing culturally relevant support, these organizations made sure that the needs of BAC communities were met in ways that resonated with them. Initiatives like the High Priority Communities Strategy (HPCS), launched by the Ontario government in 2021, supported organizations in serving 15 high-risk neighbourhoods, deploying Community Health Ambassadors to deliver critical health education. These efforts emphasized the importance of community-driven solutions in addressing health inequities and building lasting trust.

> *In our organization [Roots Community Services], we were able to step up and fill that gap to ensure that our community was not left behind or ignored, and that we were able to meet their needs. The way they want their needs to be met. Embracing them and bringing them in and bringing them along with us. ~ Angela Carter*

Active, Community-Led Engagement: Trust-building requires consistent, active engagement with communities and their leaders to better understand their needs. This approach moves beyond passive communication methods like flyers, focusing on in-person interactions such as visiting homes, local businesses, and community spaces. Community feedback, especially during initiatives like vaccination campaigns, was essential in shaping tailored interventions. While this grassroots engagement fostered long-term relationships, challenges emerged, including the need to address diversity within communities, meet funder expectations, and overcome mistrust. Some experts pointed out that the focus on COVID-19 and vaccinations often overshadowed broader, long-term investments in addressing the deeper systemic issues facing these communities.

> *As community workers, we’re not going in with the notion that we know it better than you. It's more from that sort of humble perspective of “I want to learn how to solve this challenge you're having. I hear you. We see you. We don't have the solutions right now, but we can design something that works for us together. ~ Suleman Sule*

> *We even started a barber shop and beauty salon initiative. Those are spaces where people congregate and want to get access to those people in those establishments. The barbershop workers have an ear to the ground more than we do and use them to further reach in the community. ~ Angela Carter*

Flexible and Accessible Health Services: Flexibility in service delivery was essential for ensuring healthcare access without forcing individuals to choose between their health and other responsibilities. Mobile strategies, such as traveling health services and extended hours, allowed providers to meet communities where they were. A key example of this approach was the BAC Community Wellness Fairs in Peel region, which offered culturally relevant health education and services on topics like mental health, cancer prevention, and sexual health. Featuring community-based exhibitors, these fairs have been successfully replicated in regions like Durham and Toronto, proving their effectiveness in engaging and supporting BAC communities across multiple areas.

> *...working around the clock, so really being intentional with having interventions that extended beyond your traditional 9 to 5, so that people could access it when they were free and not have to take time away from work to access those services, as that would be another barrier for them. ~ Dr. Trudy McFarlane*

RECOMMENDATIONS FOR IMPROVEMENT

To address health disparities in BAC communities, a comprehensive approach is needed, including sustainable funding for healthcare programs, community-driven research, and events like the BAC Community Wellness Fairs. Policymakers, healthcare providers, and BAC-serving organizations must collaborate to allocate resources effectively and ensure community voices are heard. Disaggregated, race-based data collection is essential for developing targeted interventions, while a national Black health strategy can address systemic barriers to healthcare access. Additionally, increasing BAC representation in healthcare roles and updating medical curricula to focus on the unique health needs of BAC communities will help improve health outcomes and promote equity.

Sustainable Funding: Long-term funding is essential to support programs and services addressing healthcare, mental health, and social service needs for BAC communities, including those focused on chronic conditions like diabetes and hypertension. It is equally important to increase funding for community-based, qualitative research on health disparities in BAC populations, empowering communities to explore their own health outcomes through culturally responsive initiatives. Programs like the HPCS, which helped address health disparities and build trust during the pandemic, demonstrate the value of such funding. While the program's funding was initially set to end in 2024, it has now been extended under a new name with base funding to continue addressing health inequities.

We need to continue the attention the government placed on the communities during Covid to continue [after the pandemic]. COVID-19 might have abated, not gone, but doesn't mean the government's attention should be abated too. Attention should continue on these communities because there's gonna be other crises and we shouldn't wait until then to mobilize supports, throw money in and then take the money and attention back. ~ Angela Carter

Prevention is much cheaper than intervention. It will help reduce the impact on the ER and it would help to improve productivity within people. ~ Angela Carter

Collaboration between Communities, Policymakers, and Healthcare Providers: Policymakers and healthcare providers should engage directly with BAC-serving organizations and communities to ensure inclusive, meaningful, and respectful partnerships. This approach will help determine more effective funding allocations. Additionally, the pandemic underscored the need for social cohesion, as isolation and lockdowns significantly impacted mental health. Governments and funders should collaborate with community leaders to organize events like the BAC Community Wellness Fairs in Peel region, where members can connect, access resources, and improve their overall well-being. Such collaborative efforts can also break down silos in healthcare, fostering better communication and coordination across health programs and institutions.

We need more community things—more circles where people meet, gather where people get to share resources. Sometimes, you don't even know what services are available until you come to places...But I feel that social cohesion, that going back to the basics of how we interact as humans would be helpful. ~ Suleman Sulle

It's not in any of the mandates to say primary care should work together with mental health providers, with community and social services organizations. Even though we all purport to be working for the same populations, everybody feels like my deliverables are different. So it encourages a lot of siloed working. ~ Suleman Sule

Collect Race-based Disaggregated Data: Health data often overlooks the diverse needs within BAC communities, leading to generalized findings that fail to address the unique challenges faced by specific ethnic, cultural, and regional groups. By collecting race-based disaggregated data, we can better understand the distinct health inequities affecting different subpopulations within BAC communities. This data will enable the development of more targeted, effective public health interventions that address the specific needs of each group, ultimately improving health outcomes and ensuring more equitable care.

National Black Health Strategy: To foster the health and wellness of BAC communities, it is essential to address the far-reaching effects of anti-Black racism and its intersections with housing, education, and financial opportunity through a comprehensive national strategy. A national strategy is needed to confront these challenges head-on, ensuring that BAC communities receive the resources and support necessary for improved health outcomes. This strategy must include targeted policies that recognize the unique needs of BAC populations, promote social and economic empowerment, and create pathways for equitable access to care.

We need a national Black Health strategy. We have provincial frameworks, like the Ontario Black Health Plan, but it needs a framework that spans the country. ~ Dr. Ato Sekyi-Otu

BAC Representation in Healthcare and Policy Making: To create a healthcare system that truly serves all communities, it is crucial that it reflects the diversity of the regions it serves. Achieving meaningful BAC representation within healthcare roles is essential to ensure that the perspectives and needs of BAC communities are understood and addressed. Additionally, BAC representation must extend to policy-making tables where decisions are made, so that the voices of BAC communities are not only heard but actively influence the development of policies.

> *The structures of power of who we respect as experts, of who we allow to make decisions of what epistemologies of health that we value have not changed, but those we are serving has changed. We need to catch up, or we're going to continue to widen this gap. ~ Lydia-Joi Marshall*

Update Medical School Curricula: Medical education must evolve to address the unique health challenges faced by BAC communities. Curricula should include comprehensive training on conditions that disproportionately affect BAC populations, emphasizing how these conditions present and progress differently in BAC individuals. Additionally, integrating routine racial bias and cultural competency training is crucial to improve healthcare interactions and outcomes for BAC communities. By equipping future healthcare professionals with this knowledge, we can ensure more accurate diagnoses, earlier detection, and more effective treatment, ultimately leading to better health outcomes for BAC individuals.

5.3 LATINX HISPANIC COMMUNITIES

COMMUNITY SURVEY FINDINGS

This report analyzes survey data on access to health services, specifically family doctors and nurses, within the Latinx community in Toronto. The survey involved 40 participants and examined demographics, immigration status, education, and barriers to healthcare access. The findings are organized into three main themes: a) access to family doctors, b) access to primary healthcare, and c) access to specialized medical care (e.g., cardiologists, pediatricians, etc).

The survey recorded 40 responses between September and October 2024. Participants were required to be 18 years or older, reside within the GTA, and self-identify as LatinX or Hispanic. Data was primarily collected online, with paper surveys provided for participants facing connectivity issues or lacking digital access to ensure inclusivity.

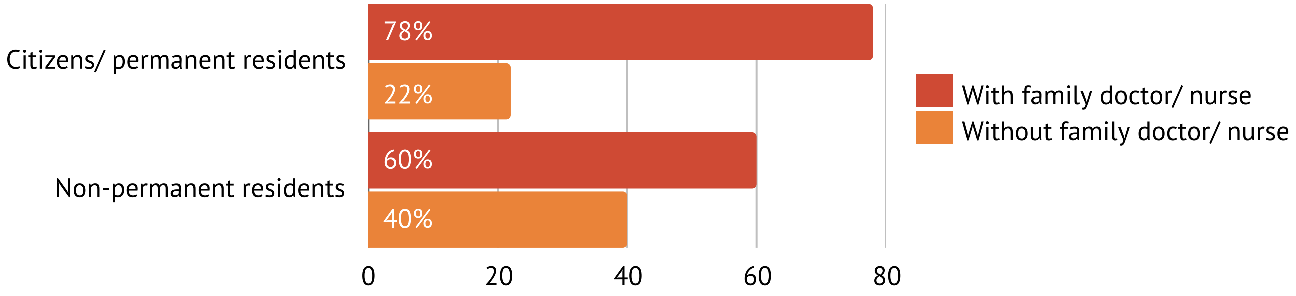
The survey explored several key areas, including:

- Demographics (refer to section 4.3)
- Access to Family Doctors
- Access to Primary Healthcare
- Access to Specialized Medical Care
- Recommendations for Government, Healthcare Providers, and Community Organizations

ACCESS TO FAMILY DOCTORS

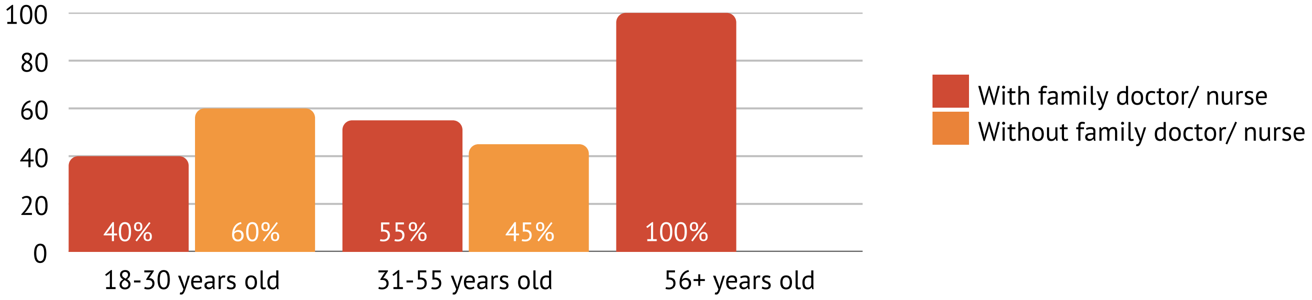
Among the 40 participants surveyed, 70% reported having access to a family doctor or nurse, while 30% did not. Having a family doctor is a critical entry point to the healthcare system, linked to better continuity of care, early intervention, and improved health outcomes. However, this access is not distributed equally. Among Citizens or Permanent Residents, 78% reported having a family doctor or nurse, compared to 60% of Non-Permanent Residents. Conversely, 22% of Citizens or Permanent Residents and 40% of Non-Permanent Residents reported lacking such access (Figure 68). These figures highlight systemic barriers—such as restrictive eligibility criteria, language barriers, and bureaucratic hurdles—that disproportionately affect Non-Permanent Residents. Targeted policy reforms are urgently needed to reduce these disparities and ensure equitable healthcare access for all.

Figure 68. Access to the family doctor or nurse by immigration status



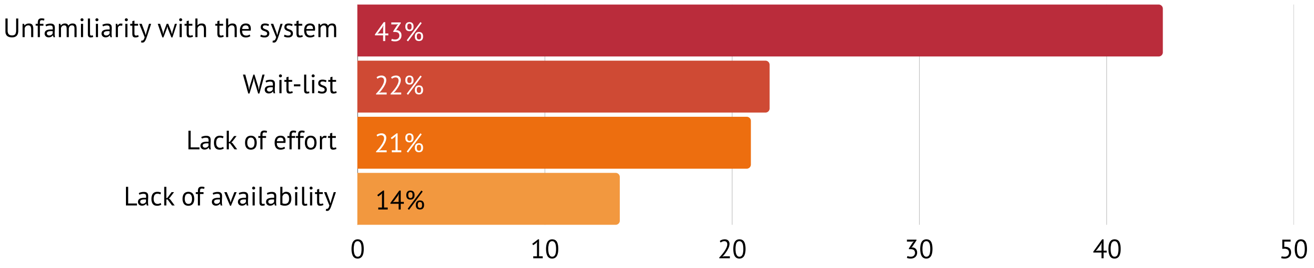
Access to a family doctor or nurse varies significantly across age groups (Figure 69). Among participants aged 18–30, 40% reported having access to a family doctor or nurse, while 60% indicated they did not. Within the 31–55 age group, 55% had access, compared to 45% who did not. In contrast, 100% of participants aged 56 and over reported having access, with no cases of lack of access in this age group. These results suggest that older adults, particularly those aged 56 and above, enjoy substantially greater access to primary healthcare services, while younger individuals, especially those aged 18–30, face higher barriers to securing consistent healthcare access.

Figure 69. Access to the family doctor or nurse by age group



The most common reasons for not having a family doctor were unfamiliarity with how the healthcare system works (43%), being on a waitlist for a doctor (22%), lack of effort to find a doctor (21%), and unavailability of accepting doctors in the area (14%) (Figure 70). These reasons reflect both systemic challenges, such as long waitlists and a shortage of available doctors, and individual barriers, including limited knowledge of how to navigate the healthcare system.

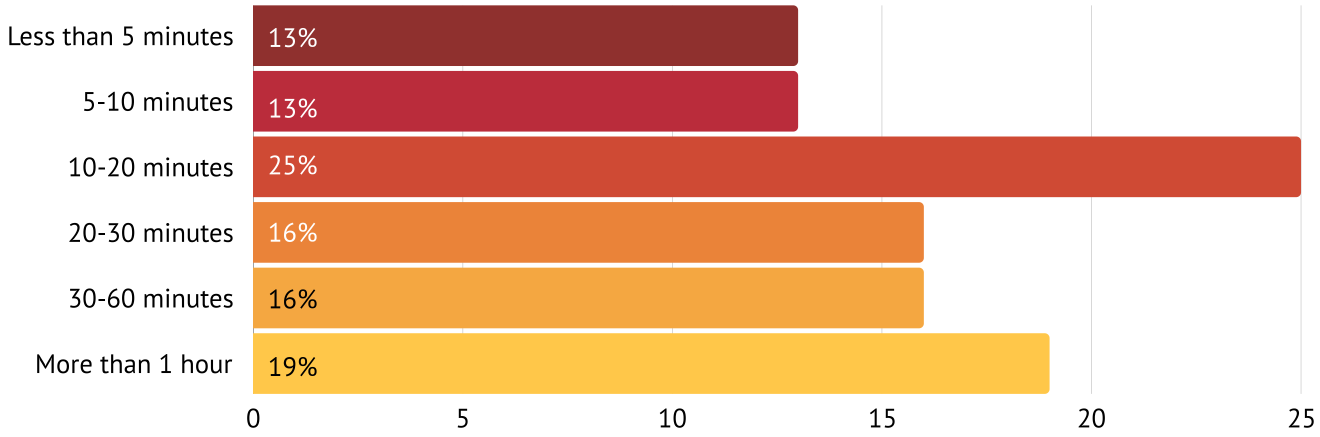
Figure 70: Reasons for not having a family doctor



ACCESS TO PRIMARY HEALTHCARE

Travel times to primary care services highlight significant geographic barriers. While 26% of participants report relatively short travel times of 10 minutes or less, a substantial 35% experience travel durations exceeding 30 minutes (Figure 71). Notably, 19% of participants travel for over an hour, underscoring the persistent challenge of geographic accessibility (Figure 71). These extended travel times can create considerable obstacles to timely care, particularly for individuals facing mobility challenges, limited transportation options, financial constraints, time limitations (such as work or caregiving responsibilities), or urgent healthcare needs. This lack of accessibility may discourage regular healthcare visits and worsen existing health inequities.

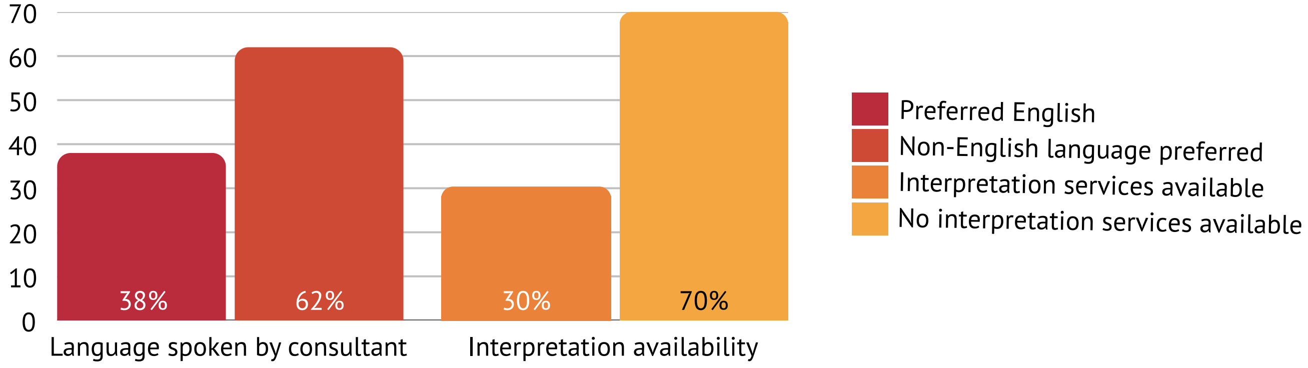
Figure 71: Travel time for accessing primary care services



When it comes to gender preferences for healthcare providers, only 3% of respondents expressed a preference, while 97% had no specific gender preference for their healthcare professional (Figure 72). This suggests that most individuals are open to receiving care from healthcare professionals of any gender, highlighting a low level of gender-specific demand in healthcare settings.

In terms of language accessibility within primary care services, there is a clear gap. 62% of respondents preferred consultations in a language other than English—primarily Spanish—yet only 30% were offered interpretation services (Figure 72). Furthermore, 70% of participants reported a lack of interpretation services, indicating structural limitations in healthcare access for non-English speakers (Figure 72). These barriers indicate that many individuals encounter communication challenges when seeking medical care, which can lead to patients misinterpreting the severity of their diagnosis, lower treatment adherence, reduced quality of care, and decreased patient satisfaction. To ensure equitable access to care, it is essential to expand language services, including professional interpreters, multilingual healthcare providers, and culturally tailored communication strategies. Proactive outreach to inform patients about available language services could also help improve healthcare accessibility for diverse linguistic communities.

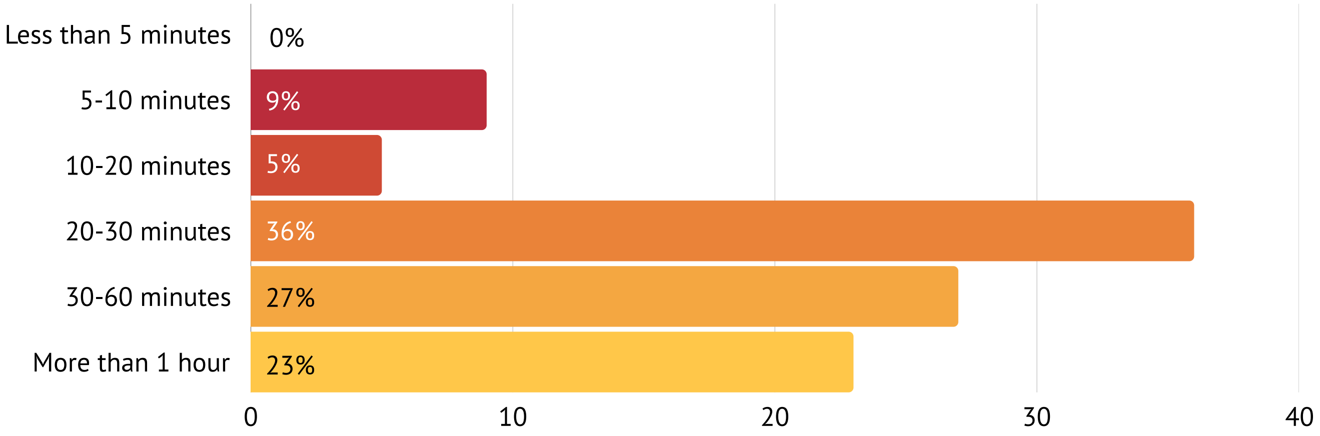
Figure 72. Language preferences and interpretation services for consultations



ACCESS TO SPECIALIZED MEDICAL CARE

Access to specialist medical care can involve significant travel times, as the data shows that many participants face considerable distances. Half of the respondents (50%) reported spending over 30 minutes to reach their appointments, with 23% traveling more than an hour (Figure 73). This suggests that geographic accessibility may be a significant challenge, potentially discouraging regular visits and complicating access to necessary care.

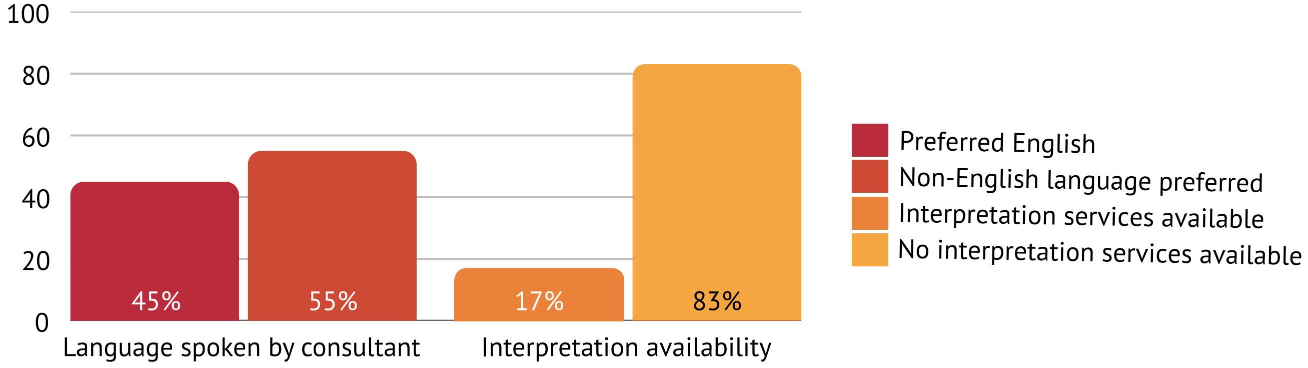
Figure 73: Travel time for specialist medical care access



Regarding provider selection, there was no gender preference—100% of respondents indicated that gender was not a factor in choosing a specialist.

Significant linguistic barriers exist in accessing specialist medical care. While 55% of respondents preferred interviews in a language other than English, only 17% were offered interpretation services, and 83% lacked access to such services (Figure 74). This gap in language accessibility poses challenges for patients with complex health needs who require clear communication. To address this, a comprehensive approach is needed, including improved referral and scheduling systems to reduce wait times, expanded specialist services in underserved areas, and increased availability of professional interpreters or multilingual healthcare staff. These measures will help ensure equitable access to specialist care for diverse linguistic communities.

Figure 74. Language preferences and interpretation services for specialist medical care



RECOMMENDATIONS FOR GOVERNMENT, HEALTHCARE PROVIDERS, AND COMMUNITY ORGANIZATIONS

To ensure equitable healthcare for LatinX Hispanic communities, it is essential to address barriers related to access, language, education, and travel. Expanding access to primary care and specialized services is crucial in improving overall health outcomes for these communities, particularly in underserved areas.

Expanding Access to Primary Healthcare: Ensuring equitable healthcare for LatinX Hispanic communities starts with expanding access to primary care. Governments should focus on increasing the availability of family doctors, particularly in areas with high LatinX Hispanic populations, and simplifying registration processes for newcomers, including non-permanent residents and younger individuals. In addition, developing community-based healthcare infrastructure—such as local health centers, mobile units, satellite clinics, and telemedicine—can alleviate the burden of long travel times and provide more timely access to care

Increase the number of family doctors accepting new patients in Latinx-populated areas.

Develop community-based health centers in Latinx neighbourhoods to ensure that residents can access healthcare services without significant travel burdens.

Strengthening Language Support and Interpretation Services: Language barriers significantly hinder effective healthcare delivery. To improve communication and ensure equitable access, healthcare facilities must enhance multilingual services for Spanish-speaking patients. This includes hiring bilingual healthcare professionals, offering interpretation services across primary and specialized care, and providing all medical materials in Spanish. These improvements will help ensure that LatinX Hispanic patients can fully understand their care plans and make informed decisions about their health.

Mandate interpretation services across primary and specialized healthcare settings and recruit Spanish-speaking healthcare providers to improve communication and care quality.

Improving Health Education and Navigation Support: Health education and system navigation support are essential for helping LatinX Hispanic individuals effectively navigate the healthcare system. Community organizations and healthcare providers should offer educational programs and resources in Spanish, guiding individuals on how to register for services and access care. Additionally, employing bilingual community health workers or navigators can further assist patients in scheduling appointments, understanding their treatment plans, and overcoming language or systemic barriers.

Launch educational campaigns tailored to the LatinX community, offering guidance on how to navigate healthcare services and access medical professionals.

Reducing Travel Barriers and Improving Timely Access: Long travel times are a significant barrier to healthcare access. To alleviate this, policies should focus on decentralizing services by establishing more specialized clinics in LatinX-populated areas. Additionally, telemedicine services should be expanded to allow remote consultations, further reducing the need for patients to travel. Providing transportation assistance, such as subsidized rideshare services or partnerships with transit authorities, can further ease travel challenges and help ensure timely access to healthcare.

Implement telemedicine services for specialist consultations to reduce travel barriers and ensure LatinX patients receive timely medical attention.

COMMUNITY FOCUS GROUP FINDINGS

Between September and October 2024, four focus groups were conducted with 28 participants from diverse subpopulations within the LatinX Hispanic community, including women (31-65 years), seniors (65+), youth (16-30 years), and LGBTQ2S+ individuals. The LGBTQ2S+ focus group was held in collaboration with Latinos Positivos and the People With AIDS Foundation (PWA). The discussions revealed a range of healthcare barriers faced by these groups, including language and cultural insensitivity, long wait times, financial constraints, limited access to specialized care, and stigma. These findings emphasize the need for more inclusive and accessible healthcare services.

DISTINCT BARRIERS AND NEEDS SPECIFIC TO EACH SUBPOPULATION

Women

Women face significant challenges in accessing healthcare, largely due to language barriers and culturally insensitive care. Many reported feeling dismissed or misunderstood by providers, which led to mistrust and, in some cases, avoidance of medical services. Systemic gaps in addressing reproductive, maternal, and mental health needs also worsened disparities, particularly for immigrant and racialized women. To overcome these challenges, participants emphasized the importance of collective dialogue and community-driven advocacy to push for culturally competent and accessible healthcare.

Challenges in Communication with Healthcare Providers: A critical barrier to accessing healthcare, as highlighted by women participants, was the difficulty in communicating effectively with healthcare providers. This challenge stemmed primarily from a lack of culturally sensitive and linguistically accessible services. For many women, this language barrier resulted in feelings of being unheard, misunderstood, or dismissed in medical settings. Additionally, the lack of interpreters or bilingual staff in medical facilities left many feeling isolated and alienated, contributing to an overall mistrust of the healthcare system. As a result, some participants reported avoiding medical care altogether to prevent these uncomfortable and potentially harmful experiences.

Limited Access to Specialized Services: Women participants expressed particular frustration with the limited availability and accessibility of specialized healthcare services, which are critical for their well-being. For instance, gynecological services, a significant area of concern, were often described as lacking culturally competent care and language accessibility, making it difficult for women to receive appropriate reproductive health care. In addition, mental health support was often either underfunded or not tailored to the unique needs of immigrant and racialized women, making it hard for them to access the help they required. These gaps in specialized services not only hinder access but also amplify existing health disparities, leaving women without the comprehensive care they need.

Systemic Gaps in Addressing Women's Health Needs: Participants also pointed out broader systemic issues that hindered the healthcare system's ability to address their specific health needs. Many women felt that the healthcare system failed to recognize or respond adequately to issues related to reproductive health, maternal care, and mental health. While these services are essential for all women, immigrant and racialized women often face compounded challenges in accessing them due to financial, cultural, and systemic barriers. Moreover, healthcare providers frequently lacked the training and cultural competence necessary to understand the unique health experiences of immigrant and racialized women. The system's inability to adapt to the diverse needs of women from different cultural backgrounds exacerbates health inequities and contributes to the persistence of these disparities.

> *We need a doctor who knows what we need.*

Importance of Collective Dialogue and Community Action: Throughout the discussions, participants emphasized the need for collective dialogue and community-driven action to address the systemic healthcare disparities they face. There was a shared desire for more spaces where women could openly discuss their healthcare experiences, exchange knowledge, and support each other in advocating for systemic change. Participants stressed the importance of coming together as a community to develop solutions informed by shared experiences and cultural perspectives. Strengthening community networks, providing culturally relevant health education, and advocating for systemic reforms were identified as key steps in transforming the healthcare system into one that is inclusive, responsive, and equitable for all women.

> *We need to get together and talk about health.*

Seniors

Seniors highlighted several barriers that hinder their access to quality healthcare. Many expressed frustration with rushed appointments, which left them unable to fully discuss their concerns. Physical accessibility issues, such as transportation challenges and digital literacy gaps, further restricted their ability to seek care. Additionally, they raised concerns over the affordability of dental care, vaccinations, and physiotherapy—services that are essential to their well-being. To address these issues, seniors called for longer consultations, improved accessibility, and more affordable healthcare services.

Challenges in Communication and Appointment Time Constraints: Senior participants expressed frustration with the limited time allocated for medical consultations. Many reported facing challenges due to accessibility constraints, cultural and language barriers, and the overall brevity of their appointments. They often felt mistreated and were particularly concerned about not having the opportunity to ask their doctors important questions. The short consultation time left them dissatisfied with the responses they received, leading to feelings of exclusion and miscommunication. As a result, some seniors struggled to articulate their concerns effectively, leaving them with unanswered questions and unmet healthcare needs.

> *No more than 15 minutes.*

Accessibility Barriers and Physical Constraints: Seniors encounter a range of accessibility challenges that go beyond mobility issues. These include physical barriers in healthcare facilities, such as inadequate seating and lack of wheelchair access, transportation difficulties in getting to appointments, and digital literacy gaps that make it hard for them to access online health resources. These challenges often lead to increased frustration, particularly when seniors also report insensitive or dismissive treatment from healthcare providers. The lack of adequate support in navigating these barriers further exacerbates their feelings of neglect and exclusion within the healthcare system.

Specific Healthcare Concerns: Seniors have expressed key concerns regarding the availability and affordability of healthcare services. Their priorities include improved access to vaccination services (e.g., flu and shingles vaccines), dental care—which is often costly and overlooked in healthcare coverage—and physiotherapy, which is essential for maintaining mobility and independence as they age. Addressing these gaps in service provision is critical to improving the overall healthcare experience for seniors.

Youth

Youth participants described a range of barriers that complicated their access to healthcare. Financial constraints, cultural stigmas, and limited family support often prevented them from openly discussing health concerns. With few trusted sources of information, many turned to the internet, which sometimes led to misinformation and confusion. Mistrust in the healthcare system was also common, as youth frequently felt dismissed by providers or struggled to find youth-friendly services. To improve access, they emphasized the need for comprehensive health education, culturally sensitive care, and accessible mental health support.

Challenges in Accessing Reliable Health Information and Support: Youth participants described significant challenges in accessing reliable health information and support. Many cited financial constraints, cultural stigmas, and a lack of open communication within their families as barriers to discussing health concerns. With limited guidance from trusted sources, they often turned to the internet—particularly Google—to seek answers about their well-being. However, this reliance on online information sometimes led to confusion or misinformation, complicating their ability to make informed health decisions. Without clear direction from trusted sources, youth found it difficult to navigate their health concerns effectively.

When we have any health problems, we Google.

Mistrust in the Healthcare System: Youth expressed a deep mistrust of the healthcare system, primarily due to a lack of accessible, youth-friendly health information and culturally competent care. Many felt that their concerns were dismissed or not taken seriously by healthcare providers, which discouraged them from seeking help. This mistrust was further exacerbated by an absence of comprehensive health education in schools. Without proper guidance, many young people felt unsupported and unsure about how to access the medical care they needed.

Lack of Support from Personal Networks: A significant number of youth participants reported feeling unsupported by their families, friends, or communities when it came to health discussions. Cultural and generational differences often made it difficult for youth to communicate openly with their parents, which left them to cope with health concerns alone. This lack of support from personal networks further isolated them, making it harder to seek guidance or professional care.

We cannot talk about health with our parents.

Need for Comprehensive Health Education and Support: Youth emphasized the need for more comprehensive sexual health education, which is currently inconsistent across regions and schools. Additionally, they highlighted the importance of bullying prevention programs, as many experienced mental health challenges related to harassment, discrimination, and social pressures. These gaps in education and support left many young people unprepared to handle their health issues, increasing the barriers to accessing the care they needed.

LGBTQ2S+

LGBTQ2S+ participants reported facing systemic inequities and discrimination when seeking healthcare. Long wait times, bureaucratic barriers, and a lack of culturally competent providers made it difficult to access necessary services. Many also described experiences of stigma, particularly regarding HIV-related care, which discouraged them from seeking treatment. Participants called for inclusive services, highlighting the need for equitable access to hormone therapy, PrEP, and LGBTQ2S+ affirming addiction treatment programs.

Systemic Inequities and Frustration with Healthcare Access: The LGBTQ2S+ community highlighted ongoing systemic inequities within the healthcare system. Participants shared their frustrations about long wait times, bureaucratic obstacles, and the constant struggle to access necessary care. These challenges were often compounded by stigma, language barriers, and the absence of healthcare providers trained in culturally competent care. Many participants expressed feeling overlooked or unprioritized, which led to a sense of vulnerability and exhaustion from constantly advocating for themselves in an unwelcoming system.

> *We are just a waitlist.*

> *We are tired of navigating the system; we want to access.*

Stigma and Discrimination in Medical Consultations: LGBTQ2S+ individuals reported experiencing persistent stigma in medical consultations, particularly related to HIV, which led to a reluctance to seek care. Many participants expressed fear of discrimination or judgment from healthcare providers, making it difficult to open up about their health concerns. The ongoing need to advocate for themselves in an unwelcoming system eroded trust in healthcare institutions, causing some individuals to delay or avoid care altogether. The absence of LGBTQ2S+ affirming care further compounded these issues, preventing individuals from receiving the appropriate treatment and reinforcing feelings of alienation.

Bureaucratic Obstacles and Administrative Challenges: Participants identified bureaucratic obstacles, such as difficulties updating medical records to reflect gender identity or finding healthcare providers who offered inclusive care. These administrative hurdles made it difficult to receive timely and appropriate care, leading to a sense of alienation. The lack of collaboration between healthcare providers and community agencies exacerbated these issues, preventing individuals from accessing services in a coordinated manner.

Specific Healthcare Needs and Access Issues: The LGBTQ2S+ community faces unique healthcare challenges that require specialized support. Participants expressed concerns about equitable access to pharmacies, particularly for medications such as hormone therapy and PrEP, which are critical for the health of many individuals in the community. Additionally, there was a recognition of the need for LGBTQ2S+ affirming treatment programs for substance use disorders and addiction, as many individuals in this community struggle with these issues and require tailored, supportive care.

SHARED BARRIERS AND NEEDS ACROSS SUBPOPULATIONS

Despite their unique experiences, all groups reported common barriers, including language challenges, long wait times, and financial constraints. The lack of professional interpreters and culturally competent care frequently led to miscommunication and feelings of exclusion. To address these widespread issues, participants stressed the need for affordable, timely, and culturally responsive healthcare.

Linguistic and Cultural Insensitivity: Many participants reported significant difficulties navigating the healthcare system due to inadequate language support and a lack of culturally appropriate care. Limited availability of professional interpreters, reliance on family members for translation, and healthcare providers' unfamiliarity with cultural nuances often led to miscommunication, frustration, and suboptimal care. These barriers not only hindered effective doctor-patient communication but also contributed to feelings of exclusion and distrust in the healthcare system.

Long Wait Times: Delays in accessing necessary healthcare services emerged as a widespread concern, pointing to systemic inefficiencies that disproportionately impact vulnerable populations. Participants expressed frustration with prolonged waitlists for specialist appointments, diagnostic tests, and treatment, often resulting in worsening health conditions. For many, these delays reinforced the perception that their healthcare needs were not a priority, further discouraging them from seeking timely medical assistance.

Financial Challenges: The high cost of healthcare services—including medication, treatments, and specialized care—posed a significant obstacle across all groups. Many participants cited financial constraints as a major barrier to receiving adequate medical attention, with some having to forgo essential treatments due to affordability concerns. Out-of-pocket expenses, lack of adequate insurance coverage, and the financial burden of chronic illness management further exacerbated disparities in healthcare access. These challenges underscored the need for more affordable and equitable healthcare solutions.

RECOMMENDATIONS FOR GOVERNMENT, HEALTHCARE PROVIDERS, AND COMMUNITY ORGANIZATIONS

To reduce healthcare inequities, governments, healthcare providers, and community organizations must implement targeted, culturally responsive solutions. For women, expanding access to specialized services/training and creating community-led health groups would address their unique needs. Seniors would benefit from improved accessibility, longer consultations, and greater access to preventive care. Youth require tailored health education, financial support for uninsured individuals, and safe, stigma-free spaces. The LGBTQ2S+ community needs affirming care, better access to specialized services, and streamlined administrative processes. Across all groups, fostering culturally competent, accessible, and inclusive healthcare is essential.

Women

Expand Access to Comprehensive Women's Healthcare Services: Policies must prioritize the availability of culturally competent care by increasing the number of healthcare providers who are trained to address the specific needs of immigrant and racialized women. This includes expanding access to gynecological, reproductive, and other healthcare services, ensuring that appointments are thorough, and that patient concerns are taken seriously.

> *It's difficult to find a gynecologist who understands our needs, and even when we do, appointments feel rushed, and our concerns are often dismissed.*

Establish Community-Led Health Discussion Groups: Government and community organizations should invest in peer-led programs that allow women to engage in knowledge-sharing, mutual support, and open discussion about their health needs. These groups would offer safe spaces where women can voice concerns, share experiences, and develop solutions informed by their cultural perspectives.

> *Having a space to talk with others who understand our struggles makes a huge difference —it helps us feel less alone and more informed.*

Train Healthcare Professionals to Be More Responsive to the Needs of Immigrant and Racialized Women: It is critical to implement ongoing cultural competence training for healthcare providers to address the unique medical, mental health, and emotional needs of immigrant and racialized women. This would help reduce systemic barriers like language barriers, discrimination, and lack of understanding of cultural practices, ensuring that these women are given appropriate, respectful care.

> *Racialized women face so many barriers—language, discrimination, and fear of not being believed. We need doctors who truly listen and understand our experiences.*

Seniors

Improve Accessibility in Healthcare Facilities: Healthcare providers should enhance accessibility by offering transportation assistance for seniors and ensuring that healthcare facilities are fully equipped to accommodate mobility limitations. This includes wheelchair access, ramps, and elevators in all relevant areas, so seniors can easily access the care they need.

Extend Consultation Times for Seniors: Given the complex health concerns that many seniors face, it is essential that doctors allocate sufficient time during consultations to fully discuss their health needs. Short consultations that rush through critical concerns often result in misdiagnosis or unmet healthcare needs.

Once you turn 80, it seems like doctors don’t care about the patient or their needs.

I can’t find a doctor who will treat me—some doctors make patients responsible for their own healthcare.

Increase Access to Preventive Care: There should be a greater emphasis on preventive care for seniors, particularly in areas like vaccination (e.g., flu, shingles), dental services, and physiotherapy. Accessible and affordable preventive services can significantly improve seniors' overall health and well-being, reducing unnecessary hospitalizations and improving quality of life.

Youth

Develop Youth-Friendly Health Education Initiatives: Governments and healthcare providers should create educational programs specifically tailored to youth, focusing on sexual health, mental well-being, and guidance on navigating the healthcare system. These programs should provide accessible, non-judgmental, and accurate information, empowering youth to make informed decisions about their health.

Talking about sexual health is important.

We don’t always know where to turn for help, and when it comes to sexual health, no one really talks to us—we need real information and a place to ask questions without judgment.

Provide Financial Assistance for Uninsured Youth: Establish subsidized programs that offer affordable healthcare services for youth without insurance coverage. This would ensure that young individuals can access essential medical services, including mental health care, sexual health services, and other preventive care, regardless of their financial situation.

Create Safe Spaces for Youth: It is crucial to provide confidential, stigma-free environments where young people can openly discuss their health concerns. These spaces would encourage youth to seek care and ask questions they may otherwise avoid due to fear of judgment or lack of understanding from peers and adults.

LGBTQ2S+

Implement LGBTQ2S+ Affirming Training Programs for Healthcare Providers: Healthcare providers must undergo specialized training to provide inclusive care to LGBTQ2S+ individuals. This training should focus on reducing stigma, promoting understanding, and ensuring that LGBTQ+ individuals feel respected and supported in medical consultations.

> *Stigma plays a negative and crucial role. You feel judged.*

> *I felt the doctor was invasive with their questions.*

Improve Access to Specialized Services: It is essential to expand access to healthcare services that are specifically tailored to the LGBTQ2S+ community. This includes services like HIV prevention, hormone therapy for transgender individuals, and specialized support for substance use disorders. These services should be delivered in an LGBTQ2S+ affirming environment to ensure that individuals feel safe and supported in their care.

> *Doctors treat patients without looking them in the eye. They are like robots.*

> *Doctors treat patients without looking them in the eye. They are like robots.*

Reduce Bureaucratic Barriers: Governments and healthcare systems must streamline procedures to make healthcare more accessible for LGBTQ2S+ individuals, particularly in terms of updating medical records to reflect gender identity and ensuring that care providers are aware of and responsive to LGBTQ2S+ needs. Clear communication and guidance about how the system works are essential to reduce confusion and facilitate smoother access to care.

> *They should explain how the system works—clearly and calmly—so we know how to overcome barriers.*

SUBJECT MATTER EXPERT INTERVIEW FINDINGS

The LatinX Hispanic community in Toronto faces significant barriers to accessing healthcare services, including language barriers, immigration status, and economic constraints, all driven by systemic challenges and cultural dynamics. The COVID-19 pandemic further exposed and exacerbated these inequities, highlighting the need for more inclusive policies, increased language support, and greater investment in community-led healthcare initiatives to better serve the unique needs of LatinX Hispanic populations.

These insights are based on six SME interviews with healthcare professionals and community workers, selected for their expertise and hands-on experience in addressing the needs and challenges of the LatinX Hispanic population.

- **Anonymous SME** – Community Legal Advocate, Center for Spanish-Speaking People
- **Anonymous SME** – Health Outreach Coordinator, Scarborough Centre for Healthy Communities
- **Anonymous SME** – Youth and Women's Empowerment Facilitator, Jane and Finch Community and Family Centre
- **Anonymous SME** – Senior Services Specialist, Family Service Toronto
- **Anonymous SME** – Refugee Support Coordinator, FCJ Refugee Centre
- **Anonymous SME** – Community Housing Advocate, Center for Spanish-Speaking People

BARRIERS TO HEALTHCARE ACCESS

The LatinX Hispanic community in Toronto faces significant healthcare access barriers due to language, immigration status, economic instability, cultural practices, and systemic challenges. Limited access to Spanish-speaking providers leads to miscommunication, misdiagnoses, and reduced trust in care. Immigration status further complicates access, with undocumented migrants and those without OHIP relying on emergency services as their only option. Financial constraints force individuals to prioritize basic needs over healthcare, often leading to self-medication and neglected chronic conditions. Cultural reliance on traditional remedies and limited knowledge of the Canadian healthcare system delay medical intervention. Addressing these barriers requires culturally responsive policies, expanded language services, and improved health education.

Language Barriers: Limited access to Spanish-speaking healthcare providers significantly hinders effective communication during medical consultations. Patients often struggle to describe symptoms accurately without a shared language, resulting in misdiagnoses or inadequate treatment. Although interpretation services are available, they can disrupt the patient-provider relationship, creating a sense of detachment and reducing trust and continuity of care.

As a newcomer, it is very difficult to explain your symptoms without a doctor who speaks Spanish.

Consulting a therapist with an interpreter disrupts the connection between client and professional.

Immigration Status and Bureaucratic Challenges: Immigration status creates substantial barriers to healthcare access, particularly for individuals without permanent residency or legal status. Lengthy and complex OHIP application processes cause delays in obtaining essential care, leaving many without coverage. Undocumented migrants face the most severe challenges, often forced to rely on emergency services as their only healthcare option. Bureaucratic obstacles and long wait times frequently result in untreated conditions, increasing the risk of preventable complications. Limited access to affordable or community-based care further marginalizes this group, deepening existing health inequities.

These processes can be lengthy and complex, leaving individuals with untreated illnesses.

E**conomic Constraints:** Economic instability forces many LatinX Hispanic individuals to prioritize basic survival needs, such as housing and food, over healthcare. Financial strain often results in self-medication or dependence on informal medication sources, particularly for managing chronic conditions like diabetes or hypertension. Preventive care and early interventions are frequently neglected due to affordability concerns, increasing the likelihood of severe health complications. The inability to afford regular medical visits or prescription medications worsens health outcomes, making it harder for individuals to manage existing conditions effectively.

Cultural Practices and Delayed Care: Many LatinX Hispanic individuals rely on traditional remedies, home treatments, or informal community consultations before seeking formal medical care. This cultural preference often leads to delayed intervention, as individuals may wait until conditions become severe before visiting a healthcare provider. While traditional healing practices are deeply valued, the absence of integration with formal healthcare systems can result in missed opportunities for early diagnosis and treatment.

In our culture, health is often managed through community interviews or traditional remedies before going to a hospital.

Systemic Challenges and Navigation Issues: Limited knowledge of the Canadian healthcare system creates significant navigation barriers, preventing Latinx individuals from accessing appropriate services. Complex referral processes, unclear eligibility requirements, and a lack of culturally sensitive support services contribute to confusion and frustration. Systemic biases, including discriminatory practices and lack of culturally competent care, further discourage individuals from seeking formal healthcare.

Health Education Gaps: Limited access to preventive health education contributes to delayed diagnoses of serious conditions, such as cancer and cardiovascular diseases. Misconceptions about the importance of regular check-ups and preventive screenings are widespread, leaving many individuals unaware of early warning signs. This gap in knowledge leads to missed opportunities for early detection and treatment. Culturally relevant health education campaigns are essential to promote health literacy, increase awareness of available services, and encourage proactive healthcare practices within the LatinX Hispanic community.

STRATEGIES AND COLLABORATIVE EFFORTS FOR COMMUNITY ORGANIZATIONS

Community health centers, educational programs, referral networks, and inter-organizational collaborations are key in addressing healthcare access challenges within the LatinX Hispanic community. While community health centers provide essential services, their capacity is often stretched, limiting their ability to serve new clients. Educational initiatives help overcome cultural misconceptions about healthcare, promoting regular check-ups and early detection. Proactive outreach efforts and referral networks connect individuals with Spanish-speaking providers and resources, ensuring better access to care. Additionally, collaboration between organizations and public health services strengthens efforts to address systemic challenges and improve healthcare outcomes for underserved populations.

Community Health Centers and Access to Care: Community health centers are crucial in providing vital services, such as interpretation, referrals, and preventive care, to the LatinX Hispanic community. However, many centers are often overwhelmed, operating at full capacity, which limits their ability to accept new clients. This strains the resources available for those in need and creates a backlog in care.

These centers are often at full capacity and unable to accept new clients.

Educational Programs and Cultural Misconceptions: Educational programs are essential in addressing cultural misconceptions about healthcare and encouraging regular check-ups. Many community members, especially newcomers, may not fully understand the importance of preventive care. These programs will bridge the knowledge gap, emphasizing the importance of early detection and consistent health maintenance to mitigate the impact of chronic diseases like diabetes and hypertension.

> *Some people have been here two or three years and have never visited a doctor. They think, "if I'm not sick, I don't need to go," which can delay the detection of serious illnesses.*

Referral Networks and Outreach Efforts: Referral networks and proactive outreach efforts are vital in connecting underserved populations with Spanish-speaking providers and available community resources. Community health workers work to engage the LatinX Hispanic community directly, often reaching out through events and partnerships with local businesses.

> *Instead of waiting for the community to come to us, we go to the community.*

Inter-Organizational Collaboration and Systemic Change: Addressing the systemic challenges that limit healthcare access for the LatinX Hispanic community requires inter-organizational collaboration. Joint efforts between community organizations, public health services, and hospitals have resulted in initiatives such as vaccination clinics with interpreters and mental health commissions to serve specific populations. Collaborative initiatives like these help to bridge gaps in service provision and ensure that the LatinX Hispanic community receives culturally appropriate care tailored to their unique needs.

> *We developed a mental health commission with different organizations, each one works with specific populations.*

RECOMMENDATIONS FOR GOVERNMENT AND HEALTHCARE PROVIDERS

To better serve the LatinX Hispanic community, healthcare systems must foster inclusive, culturally sensitive environments. This involves not only providing language support, such as bilingual staff and translated materials, but also ensuring that healthcare providers are trained in LatinX Hispanic cultural values and health practices through formal education. Educational initiatives in Spanish should address misconceptions and promote preventive care, while legal and financial barriers—especially for undocumented migrants—must be tackled through expanded care provisions and referral networks. Furthermore, subsidizing essential treatments will also enhance accessibility, ultimately leading to improved health outcomes for the community.

Establish Dedicated Liaison and Language Support Services: To ensure effective communication within healthcare settings, language support must be embedded across all healthcare services. This includes not only multilingual signage and Spanish-language written materials but also having interpreters or bilingual staff available during medical visits. Spanish-speaking staff, both professional and volunteer, should be recruited and trained to assist with appointment registration, medical guidance, and providing clear health explanations.

Recruit and train Spanish-speaking staff, and volunteers to assist with appointment registration, medical guidance, and health explanations, ensuring effective communication.

Cultural Sensitivity and Training for Healthcare Providers: Healthcare providers should undergo comprehensive training to better understand LatinX Hispanic cultural values, traditional health practices, and the health concerns prevalent in the community. Such training would foster better patient-provider relationships, ensuring that healthcare providers can engage with patients in a culturally respectful and responsive manner. Training sessions should cover areas such as the importance of family in medical decision-making and the reliance on traditional remedies.

Organize training sessions for healthcare providers on LatinX cultural customs, including reliance on traditional remedies and family involvement in medical decisions.

Targeted Health Education and Promotion: Healthcare institutions must create health education materials that are tailored to the LatinX Hispanic community, specifically in Spanish, addressing common misconceptions and promoting preventive care practices. These materials —ranging from posters and brochures to videos—should cover topics like symptom identification, prevention, and treatment options for common illnesses. Additionally, providing one-on-one medical resource navigation services helps individuals better understand and access available healthcare options. This approach ensures that the LatinX Hispanic community is not only aware of health risks but is also empowered to take proactive steps toward maintaining their well-being.

Produce culturally relevant health promotion materials covering symptoms, prevention, and treatment of common diseases in Spanish.

Provide LatinX community residents with detailed information on local healthcare resources, including hospital locations, available services, and operational hours.

Addressing Legal and Migration-Related Barriers: Undocumented migrants face significant challenges in accessing healthcare, primarily due to legal status and financial limitations. Expanding emergency care services and supporting initiatives that offer healthcare regardless of immigration status are critical for ensuring equitable access. Community organizations are key in bridging these gaps by strengthening referral networks and connecting undocumented individuals with essential services, including Spanish-speaking providers. It is also important to note that the stress of migration can exacerbate existing health conditions, highlighting the need for targeted support to address both the physical and mental health impacts of migration.

Recognize that migration-related stress can exacerbate chronic conditions such as diabetes, and provide targeted healthcare support accordingly.

If someone already had prediabetes in their home country, the stress of immigration can make their condition worse. The system must acknowledge and address this reality.

Develop partnerships between community organizations, hospitals, and public health agencies to create referral systems for undocumented individuals.

Addressing the Cost of Specialized Medical Examinations and Treatments: To alleviate the financial strain on LatinX Hispanic individuals, particularly seniors, governments should ensure that essential medical exams—such as cataract screenings and diabetes tests—are fully covered under public healthcare programs. Additionally, expanding financial assistance programs for low-income seniors who struggle with out-of-pocket expenses for essential treatments can prevent financial barriers from worsening health outcomes. Subsidizing critical diagnostic tests and procedures will reduce the burden on individuals, particularly seniors, who may otherwise avoid seeking medical attention due to cost concerns.

Subsidize critical diagnostic tests and procedures for chronic conditions, reducing the financial burden on seniors with limited pensions.

Integrating Traditional Practices in Modern Healthcare: Recognizing the role of traditional LatinX Hispanic health practices in healthcare delivery can enhance patient care. While evidence-based medicine remains a cornerstone of healthcare, integrating traditional practices, when appropriate, allows for a more culturally competent and inclusive approach. For example, incorporating family participation in healthcare decisions aligns with the cultural importance of family involvement in the Latinx community. Adjusting medical service models to accommodate such cultural preferences can improve trust, engagement, and overall health outcomes.

Adjust medical service models to reflect Latinx cultural values, such as incorporating family participation in healthcare decisions.

Strengthening Medical Curricula: Medical schools must include training on health conditions that disproportionately affect LatinX Hispanic communities, paying particular attention to how these conditions may manifest differently among LatinX Hispanic individuals. Such training will ensure that healthcare professionals are equipped to understand the nuances of Latinx patients' health needs. Additionally, actively recruiting, supporting, and training LatinX Hispanic students in medical schools is critical to increasing diversity within the healthcare workforce. LatinX Hisapnic medical professionals can provide culturally competent care that better addresses the needs of their community, creating an environment where both patients and providers can build rapport more effectively.

Doctors often overlook how conditions like diabetes or hypertension progress in LatinX patients. We need training that acknowledges these differences.

Having more LatinX doctors would make a huge difference. They understand the culture, the language, and the struggles of our community.

If we want better healthcare for LatinX patients, we need more LatinX professionals in the field. Representation matters.

5.4 MIDDLE EASTERN AND NORTH AFRICAN COMMUNITIES

COMMUNITY SURVEY FINDINGS

The survey recorded 3,115 responses between September 23, 2024 and October 23, 2024. Participants were required to be 18 years or older, reside within Ontario, speak either English or Arabic, and self-identify as Arab. The data collection was conducted entirely online, with the survey available in both languages to ensure accessibility.

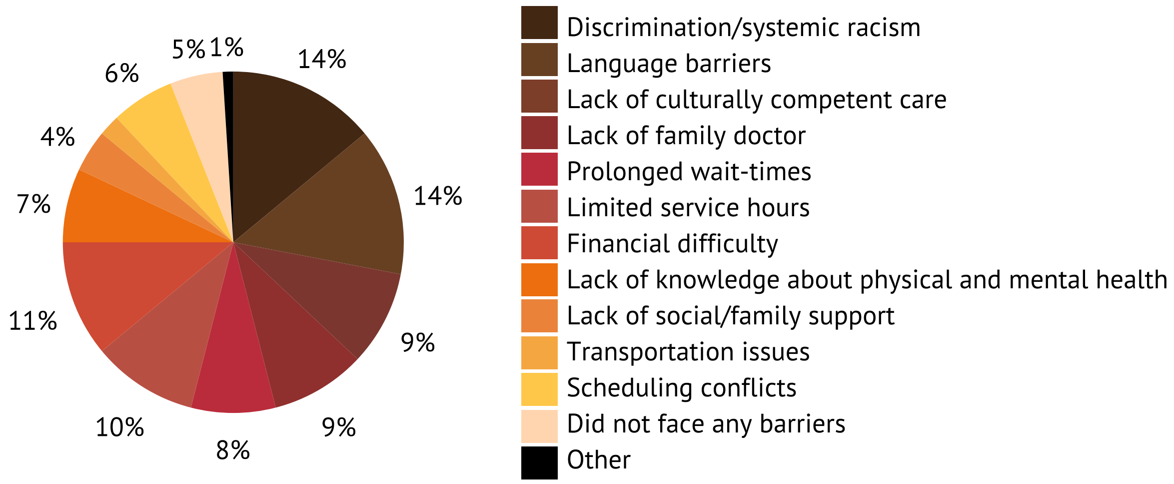
The survey was created to improve the understanding of the health needs of the Arab community in Ontario and help improve our knowledge of the challenges the community faces in accessing healthcare. It explored several key areas, including:

- Demographics (refer to section 4.3)
- Healthcare Access and Barriers
- Chronic Health Conditions and Mental Health Challenges
- Chronic Disease Management and Health Literacy & Promotion

HEALTHCARE ACCESS AND BARRIERS

Healthcare accessibility remains a significant issue within the MENA community. While 67% of participants reported having a family doctor, 79% faced barriers when attempting to access healthcare, including discrimination (14%), language difficulties (14%), limited service hours (10%), financial challenges (11%), and lack of culturally competent care (9%) (Figure 75).

Figure 75: What is the top barrier you face in accessing healthcare?



When asked specifically about their experiences, 62% of respondents reported feeling discriminated against or uncomfortable due to their cultural background. Additionally, 13% noted that healthcare providers did not understand their cultural context or healthcare needs. These challenges contribute to a broader mistrust of the healthcare system, underscoring the need for more inclusive and culturally competent care to improve health outcomes for the MENA community.

Navigating the healthcare system was highlighted as a major challenge, with respondents pointing to several key difficulties:

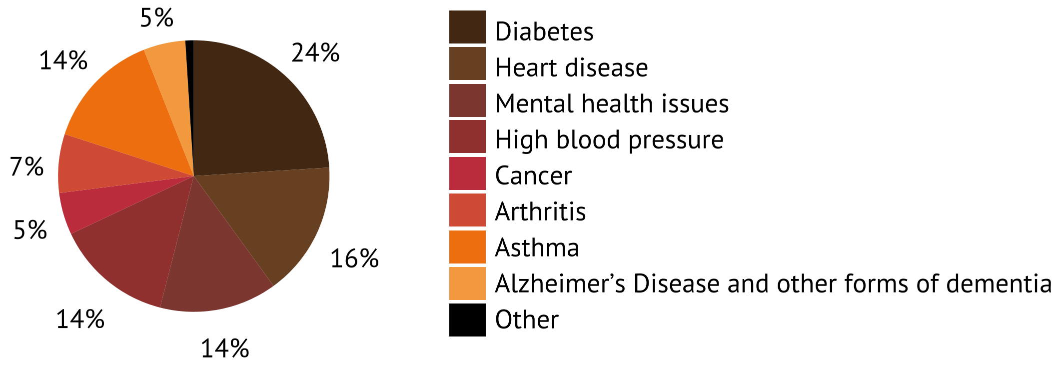
- **Lack of Clear Guidance on Accessing Specialized Care:** Many participants reported confusion around the referral process, specialist appointments, and follow-up care. This lack of clarity led to delays in treatment and dissatisfaction with the healthcare services.
- **Long Wait Times for Appointments:** Respondents highlighted prolonged wait times, especially in walk-in clinics and emergency rooms, which were the least satisfactory services. These delays could have contributed to worsening health conditions and discouraged individuals from seeking timely care.
- **Limited Availability of Arabic-Speaking Healthcare Providers:** 31% of respondents expressed a greater need for more Arabic-speaking professionals. Language barriers, particularly for seniors and recent immigrants, hindered effective communication of symptoms, understanding of diagnoses, and adherence to medical advice.
- **Gaps in Culturally Responsive Healthcare:** Many participants were frustrated by the lack of culturally competent care, with some reporting that their concerns were dismissed or misunderstood. Healthcare providers often overlooked cultural sensitivities, particularly in mental health and dietary considerations for chronic disease management.
- **Difficulty Accessing Preventative and Primary Care Services:** Although most respondents had a family doctor, barriers to regular check-ups and preventative care persisted. Some individuals only sought medical attention when absolutely necessary, which could result in undiagnosed conditions and delayed interventions.

The findings highlight the urgent need for systemic improvements in healthcare accessibility, greater availability of Arabic-speaking professionals, and expanded outreach programs to ensure that MENA community members receive equitable, timely, and culturally sensitive care.

CHRONIC HEALTH CONDITIONS AND MENTAL HEALTH CHALLENGES

While participants generally reported feeling positive about their overall health and well-being, chronic conditions were notably prevalent within the MENA community. Forty percent of respondents reported living with a chronic condition. The most common conditions were diabetes (24%), heart disease (16%), and mental health issues (14%), followed by high blood pressure and asthma, each affecting 14% of participants (Figure 76). These findings underscore the considerable health challenges faced by the community, despite their general sense of well-being.

Figure 76: What chronic health conditions do you currently have?



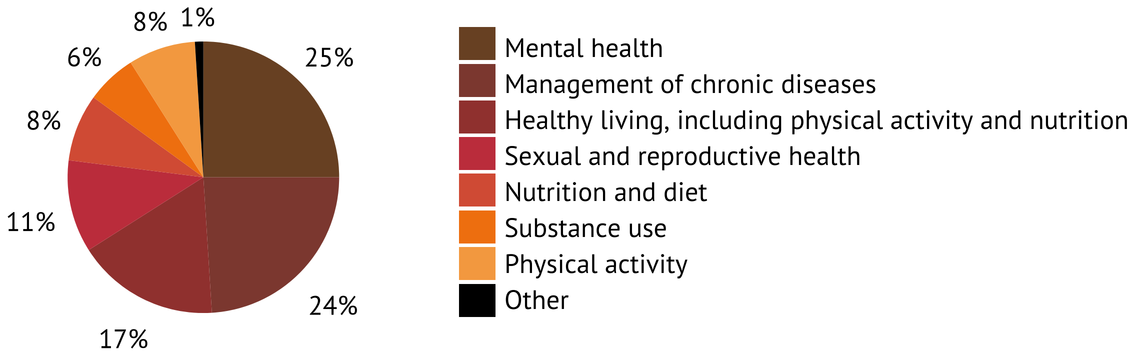
Among these challenges, mental health issues stand out as particularly concerning. The MENA community faces significant barriers to mental health care, which are exacerbated by stigma, language barriers, and a lack of culturally relevant resources. Many participants reported low levels of knowledge and confidence in managing mental health, which only worsens the difficulties they experience.

Further interviews with SMEs revealed a critical gap in culturally competent mental health services tailored to the specific needs of the MENA community. The stigma surrounding mental health continues to discourage open discussion and the pursuit of professional help, leaving many individuals without the necessary support to effectively manage their conditions.

CHRONIC DISEASE MANAGEMENT AND HEALTH LITERACY & PROMOTION

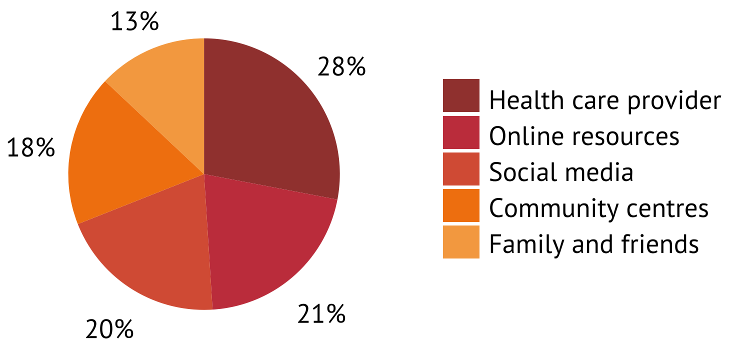
Preventative care and self-management of chronic conditions were identified as key areas for improvement, with participants expressing low confidence and knowledge in managing chronic illnesses, mental health, and disease prevention. The top areas where they felt more information was needed included mental health (25%), chronic disease management (24%), healthy living, including physical activity and nutrition (17%), and sexual and reproductive health (11%) (Figure 77). These findings highlight a significant gap in health education and emphasize the need for targeted education and support to empower individuals to better manage their health, reduce the burden of chronic conditions, and improve overall well-being.

Figure 77: Which health topic are you least familiar with?



When asked about where they get their health information, the findings show that many participants rely on healthcare providers (28%), online resources (21%), and social media (20%) (Figure 78). However, despite using these sources, they still feel underprepared to effectively manage their chronic conditions. This suggests that current health education efforts may not be adequately aligned with the unique needs of the MENA community. Furthermore, the absence of culturally relevant resources and Arabic-language health education materials likely exacerbates these knowledge gaps.

Figure 78: What is your primary source for health information?



SMEs echoed these concerns, stressing that health education programs specifically tailored to the MENA community are crucial for enhancing health literacy and preventing chronic diseases. Without proper education on managing conditions like diabetes and heart disease, the community faces heightened risks of complications and poorer health outcomes. Developing community-driven awareness campaigns, patient-centered workshops, and culturally relevant health materials in Arabic could help bridge these gaps, empowering individuals to take a more proactive approach to managing their health.

SUBJECT MATTER EXPERT INTERVIEW FINDINGS

MENA communities in Ontario face significant healthcare challenges, including language barriers, limited culturally competent care, mental health stigma, low participation in preventative care, and inadequate elder care support. Key solutions include expanding Arabic-language resources, increasing interpreter access, reducing stigma through community outreach, enhancing preventative care education, and strengthening elder care services. Culturally tailored, community-driven approaches are essential to bridging these gaps and ensuring equitable healthcare access for MENA populations.

These insights are drawn from five SME interviews with healthcare professionals and advocates who offered valuable insights into the healthcare experiences, challenges, and priorities of MENA residents in Ontario.

- **Anonymous SME** – Executive Director; expert in newcomer community support.
- **Anonymous SME** – Executive Director; expert in newcomer community support.
- **Anonymous SME** – Family Doctor and Business Owner
- **Anonymous SME** – Hospital Media Manager
- **Anonymous SME** – Professor and Nurse

BARRIERS TO HEALTHCARE ACCESS

MENA communities in Ontario face significant healthcare barriers, including a shortage of Arabic-speaking professionals, limited interpreter services, and a lack of Arabic-language resources. Many newcomers are also unfamiliar with the Canadian healthcare system, particularly the referral process for specialists. To address these challenges, efforts should focus on recruiting more Arabic-speaking providers, improving interpreter service access, expanding Arabic-language resources, and educating the community about the healthcare system.

Increase Arabic-Speaking Healthcare Professionals: There is a critical shortage of Arabic-speaking healthcare providers in Ontario, leading to miscommunication and unmet health needs. For example, on SME, a practicing nurse and professor, described a situation in a long-term care facility where Arabic-speaking residents could not communicate their needs due to the unavailability of interpreters on weekends. This highlights the importance of recruiting and training more Arabic-speaking healthcare professionals to improve patient-provider communication and ensure essential care is provided.

Improve Accessibility and Promotion of Interpreter Services: Interpreter services are available but not always well-publicized or easy to access. It is crucial to make these services more visible to patients, especially in high-demand settings like long-term care facilities, where language barriers can severely hinder healthcare delivery. Efforts should include improving awareness of interpreter availability and ensuring that services are accessible during all hours, including weekends.

Develop and Scale Arabic-Language Resources: Community organizations have created Arabic-language health resources, but these efforts are not sufficient to meet the demand. Expanding these resources and making them more widely available could help bridge the language gap and better inform Arabic-speaking patients about healthcare options, treatment, and prevention.

Provide Education on the Canadian Healthcare System: Many newcomers, especially those from countries with different healthcare systems, are unfamiliar with Canada's structure, particularly the need for referrals from family physicians before seeing specialists. Several experts noted that many MENA immigrants come from systems where direct access to specialists or walk-in care is common. Educational campaigns should be developed to inform the MENA community about how the Canadian healthcare system works, including the role of family physicians and the referral process.

Address Wait Times and Access to Specialists: Long wait times and the Canadian system’s gatekeeping model of requiring family physician appointments before seeing specialists create additional barriers for MENA immigrants. Streamlining access to care and reducing wait times should be a priority, possibly through initiatives to increase the availability of family physicians or offering more walk-in care options for those unfamiliar with the referral process.

Many are unfamiliar with the need to see a family physician before accessing specialists. ~ Anonymous SME

MENTAL HEALTH & CULTURAL STIGMA

Mental health challenges in MENA communities, particularly among youth and women, are often met with cultural stigma, making it difficult for individuals to seek help. Emotional suffering is not always seen as a legitimate health concern, and mental health issues are often viewed as shameful. To address this, education initiatives should raise awareness and reduce stigma, while culturally sensitive, peer-led programs should be developed for individuals to navigate conflicting cultural expectations.

Increase Mental Health Awareness in the Arab Community: Mental health challenges are growing, especially among youth and women, yet stigma prevents many from acknowledging their struggles or seeking help. Community-based education initiatives should raise awareness about mental health issues, emphasizing that emotional suffering is a legitimate health concern and reducing the stigma associated with mental health in Arab culture.

Challenge Cultural Stigma Surrounding Mental Health: The cultural norm that frames mental health issues as private, shameful, or non-existent continues to be a significant barrier. Emotional suffering can have profound physical consequences, yet many MENA individuals, especially older generations, do not recognize mental health as a legitimate health concern. Mental health programs should be designed to challenge these deep-rooted cultural beliefs, promoting open conversations and normalizing mental health struggles within families and communities.

> *"Sorrow kills your heart" (quoting a renowned Egyptian cardiologist) [...] Mental health in our culture is a stigma ~ Anonymous SME*

Target Mental Health Support for Youth: Youth from MENA backgrounds are often hesitant to seek professional mental health support, even when they are aware of available resources. Many find themselves caught between conflicting expectations from their Canadian social environment and traditional Arab upbringing, with the fear of being labeled or misunderstood by family often silencing them. To address this, programs targeting youth should focus on reducing this fear, incorporating peer-led initiatives or mentorship from community role models who understand the cultural tensions, alienation, and identity crises they face. These programs should be youth-friendly, culturally sensitive, and designed to help youth navigate both cultural and personal expectations.

Address Gender-Specific Mental Health Needs: MENA women, particularly those balancing caregiving and provider roles, experience emotional exhaustion but often lack culturally safe avenues for support. Mental health programs should specifically target the needs of MENA women, offering services that acknowledge their unique challenges and providing them with accessible, culturally sensitive support options. Without targeted intervention, these women continue to carry the burden in silence.

Create Culturally Tailored and De-Stigmatizing Mental Health Programs: Mental health programming must go beyond simply translating services into Arabic. Programs should be culturally tailored, community-driven, and de-stigmatizing, involving trusted facilitators from within the community. The format should be informal and interactive to create a safe, non-judgmental space for individuals to seek help and discuss mental health openly.

LACK OF PREVENTATIVE CARE CULTURE

Preventative care remains under-utilized within the MENA community, with a variety of cultural, logistical, and informational barriers preventing individuals from prioritizing their health. The concept of regular check-ups and preventative screenings is not deeply ingrained, as many come from healthcare systems that do not emphasize these practices. To overcome this, a comprehensive approach is needed to shift cultural perceptions and make preventative care more accessible, relevant, and empowering.

Promote Preventative Care as Empowerment: Shift the perception of preventative care from being reactive to empowering individuals to take control of their health. Educational campaigns should reframe preventative care as a proactive, community-driven effort that benefits everyone, emphasizing the importance of early intervention and routine screenings.

Increase Culturally Tailored Education on Preventative Health: Many MENA community members, particularly newcomers, come from healthcare systems that don't prioritize regular check-ups or preventative screenings. Even when aware of risks like high blood pressure or cholesterol, cultural beliefs, time constraints, lack of urgency, and informal practices—such as relying on home remedies or advice from family and social media—often lead to delays in seeking care. To address these barriers, culturally relevant education campaigns should be created and delivered in familiar languages and settings, focusing on the importance of routine screenings and preventative care. These efforts should aim to correct misconceptions and encourage individuals to prioritize their health before issues escalate.

> *We don't have the culture of doing a general checkup on an annual or bi-annual basis. ~ Anonymous SME*

Address Misinformation from Informal Sources and Social Media: Misinformation, especially from social media, is a growing and dangerous influence on health decisions within the MENA community. Experts have noted that older adults, in particular, often consume and act upon unverified health tips shared online, leading to a high degree of trust in informal sources. This reliance on unverified sources fosters reluctance to engage with professional healthcare services unless absolutely necessary. Educational initiatives should aim to address the risks of relying on unverified health advice, emphasize the importance of professional guidance, and include campaigns to help individuals identify credible health information.

Simplify Access to Preventative Health Services: Logistical barriers, such as complicated referral processes, appointment scheduling, and unclear eligibility for screenings, often prevent individuals from accessing preventative care. While initiatives like a breast cancer awareness campaign targeting newcomer women—which resulted in an 80% increase in screening rates—demonstrate the potential of culturally tailored approaches, challenges like language barriers and skepticism remain. To overcome these obstacles, health services should streamline access by providing clear instructions, reducing bureaucratic hurdles, and offering walk-in clinics for screenings, especially for high-risk populations. These services should be available in familiar, community-based settings to encourage broader participation.

Engage Men in Preventative Health Efforts: Men in the MENA community often disengage from preventative care, even when aware of their chronic health conditions. They tend to avoid follow-up appointments and resist committing to necessary lifestyle changes. Cultural norms surrounding masculinity, privacy, and self-reliance contribute to this reluctance. Targeted educational campaigns should address these barriers by reframing health maintenance as a strength and a personal responsibility, encouraging men to view prioritizing their well-being as a vital part of their strength and resilience.

Leverage Trusted Community Organizations for Health Education: Effective health promotion efforts must involve trusted community leaders and organizations to deliver health education. Programs should utilize familiar settings, such as mosques or community centers, to foster a sense of comfort and trust. These organizations can act as intermediaries to guide individuals toward professional healthcare services and ensure greater participation in preventative health initiatives.

Develop Long-Term, Community-Driven Health Education Programs: Short-term initiatives have demonstrated success, but long-term, sustained efforts are needed to shift cultural attitudes towards preventative care. Community-driven programs should be designed to engage individuals over time, with follow-up efforts to maintain momentum and encourage ongoing participation in preventative healthcare.

ELDER CARE CHALLENGES

Elder care is a particularly sensitive and complex issue within the Arab community, deeply influenced by cultural values and traditional family expectations, with women bearing the majority of the burden. There is a strong consensus that caring for elderly family members is viewed as both a moral and familial responsibility, and placing elders in long-term care institutions is often seen as an act of abandonment or failure. However, many community members are not aware of the services they are entitled to or what is available to them. Furthermore, even when these services are accessible, they often lack the cultural sensitivity and language support needed, making it difficult for those in need to fully utilize them.

Promote Culturally Sensitive Elder Care Education: Increase awareness in the MENA community about available elder care services through culturally appropriate education. Focus on the importance of understanding what services are available, such as home care, personal support workers, and how to navigate the healthcare system. Educational materials should be available in Arabic and tailored to the community's cultural values.

Provide Support for the "Sandwich Generation" (MENA Women Caregivers): MENA women often face significant pressure as they balance the responsibilities of childrearing and elder caregiving, a dynamic rooted in cultural values of respect and filial duty. This situation, known as the "sandwich generation," refers to individuals who are caught between caring for their aging parents and raising their own children, often without sufficient support or resources. This dual caregiving role can lead to emotional, physical, and financial strain. To address these challenges, it is crucial to create targeted support programs specifically for MENA women caregivers. These programs should include respite care, counselling services, and peer support networks to provide relief and build a sense of community. Recognizing the unique pressures of the "sandwich generation" is essential to developing solutions that ensure women have the necessary resources and support to navigate these demanding responsibilities.

Increase Awareness of Long-Term Care Alternatives: Address the cultural stigma surrounding placing elders in long-term care facilities by promoting awareness of alternative care options such as in-home care, day programs, and community-based services. Focus on dispelling myths that suggest using such services equals failure in family responsibilities.

Placing elderly in institutions is seen as failing family responsibilities. ~ Anonymous SME

Remove Language Barriers in Elder Care Services: Ensure that all elder care services, including home care and transportation assistance, are accessible to the Arab community by providing language support. Offer services in Arabic, use interpreters where necessary, and ensure healthcare providers understand the importance of effective communication with non-English-speaking patients.

Improve Outreach Through Trusted Community Networks: Utilize community organizations, faith-based spaces, and family networks to effectively disseminate information about available elder care services. These trusted networks can help bridge the knowledge gap and make resources more accessible to individuals who may feel overwhelmed or disconnected from the formal healthcare system. As experts have noted, many newcomers are unaware of their entitlements or how to access the services available to them. By tapping into these familiar, trusted channels, we can ensure that vital information reaches those who need it most.

Expand Culturally Relevant Home Care Models: Develop and promote home care models that are culturally sensitive to the needs and values of the MENA community. These models should incorporate traditional caregiving practices, respect for family involvement, and understanding of cultural norms, ensuring that elderly individuals feel comfortable and supported in their homes.

EFFECTIVE OUTREACH, EDUCATION & ENGAGEMENT STRATEGIES

To ensure meaningful and impactful health outreach within the MENA community, strategies must be culturally responsive, trust-driven, and community-centered. Beyond translation, campaigns should reflect the social and cultural realities of the community, addressing both language and lived experiences.

Adopt a Culturally Nuanced and Community-Driven Approach: Health outreach campaigns must go beyond simple translation and be deeply embedded in the social and cultural fabric of the MENA community. Tailor messages to reflect cultural values, customs, and practices to resonate with both newcomers and established residents. Ensure campaigns are linguistically accessible and delivered in ways that align with the community's preferences and expectations.

Build Trust with Community-Led Outreach: Trust is essential in health outreach efforts. To foster trust and credibility, health education campaigns should be led by trusted figures from the MENA community, such as Arabic-speaking healthcare professionals, cultural leaders, or well-known community workers. These individuals should have lived experience or cultural understanding to effectively address sensitive health topics like mental health, preventative care, and chronic illness.

Meet People Where They Are (Physically and Digitally): Conduct health outreach activities in locations where community members naturally gather, such as mosques, community centers, schools, and women's groups. Instead of relying solely on traditional healthcare channels, this will increase the reach and impact of health messages. Additionally, leverage digital platforms to deliver accurate health information. Utilize social media channels like Facebook, YouTube, and TikTok to provide accessible and culturally relevant content, especially for the younger generation.

> *We need to meet them where they are... if people can't reach us, we should reach out to them. ~ Anonymous SME*

Leverage Social Media for Health Information: Acknowledge that social media is a primary source of health information for many in the MENA community, especially older adults. While misinformation is prevalent, social media can also be used to deliver accurate, culturally appropriate healthcare content. Create multimedia content in Arabic (and other relevant languages) featuring healthcare professionals who understand both the Canadian healthcare system and Arab cultural norms.

University of Facebook ~ Anonymous SME

People need fast info ~ Anonymous SME

YouTube library, TikTok lives with doctors—that's the way. ~ Anonymous SME

Create Gender-Sensitive Outreach Spaces: Ensure health outreach efforts are gender-sensitive, especially when addressing sensitive topics like reproductive or mental health. Create separate spaces for men and women to discuss health issues, and ensure that facilitators share the same gender identity as participants to improve comfort and engagement.

Ensure Sustained and Systematic Outreach: Health outreach must be ongoing, not just one-off campaigns. Implement sustained efforts through collaboration between community organizations and health authorities. Engage community members from the outset to co-create campaigns and interventions, ensuring that they are relevant, culturally appropriate, and supported over time.

Nothing about us without us. ~ Anonymous SME

Involve the Arab Community in Campaign Design and Evaluation: Involve Arab community members in every step of health outreach campaigns—design, implementation, evaluation, and policy decisions. Ensure campaigns are created "by Arabs, for Arabs" to foster trust, cultural relevance, and meaningful engagement. Without this involvement, even well-intentioned initiative risks being irrelevant, mistrusted, or underutilized. To maximize impact, health education efforts should be community-driven, ensuring they address real needs and resonate with those they aim to serve.

In Arabic, by Arabs, for Arabs. ~ Anonymous SME

Focus on Culturally Familiar and Interactive Formats: Deliver health messages through interactive, community-driven formats that align with cultural norms. Ensure that health education is not just informational but also engaging and participatory. This can include group discussions, workshops, and culturally appropriate health screenings that encourage active participation and build community trust.

5.5 EAST ASIAN COMMUNITIES

COMMUNITY SURVEY FINDINGS

This survey recorded 29 responses between September 2024 and October 2024. Participants were required to be 18 years or older, reside within the GTA, and identify as Chinese. The survey was conducted entirely online via Google Forms, the survey was bilingual, allowing responses in Traditional Chinese, Simplified Chinese, and English. However, to accommodate seniors requiring assistance with digital input, one in-person survey session was held, during which nine seniors provided their responses with support.

The survey explored several key areas, including:

- Demographics (refer to section 4.3)
- Healthcare Concerns, Issues, and Experiences
- Impacts on Health and Healthcare Access During the Pandemic
- Recommendations to Improve Equitable Health Access and Outcomes

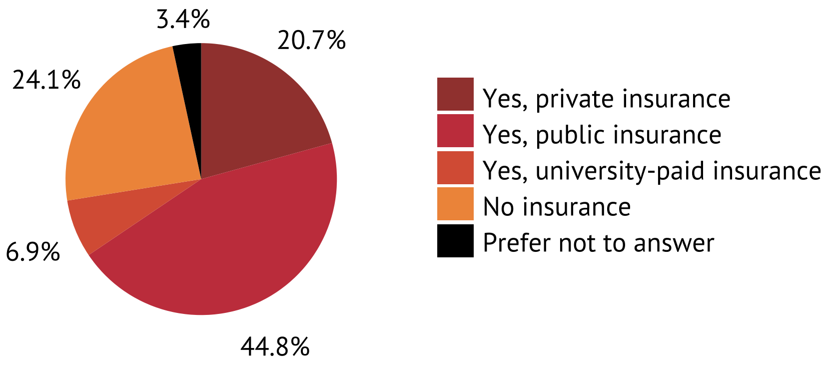
A total of 38 questions were included.

HEALTHCARE CONCERNS, ISSUES, AND EXPERIENCES

Findings in this category showed that racism and discrimination, lack of information and knowledge, and accessibility (cultural responsiveness, financial, geographic, etc) were central themes among all respondents' concerns, issues, and experiences.

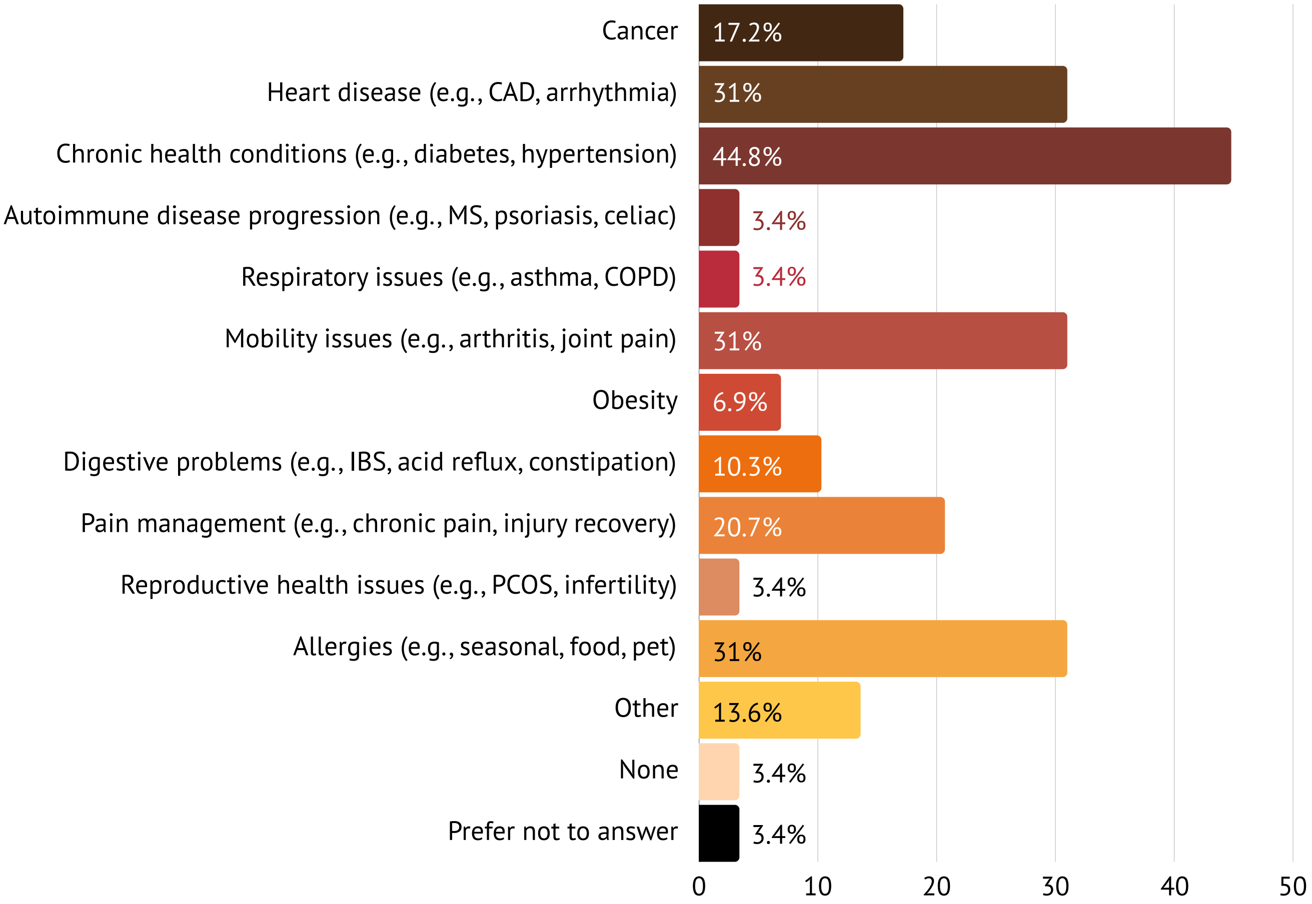
86.2% of participants reported having a family doctor, and 68.9% had some form of health insurance (Figure 79). This indicates that while most participants had access to primary care and some level of coverage, a significant portion (31.1%) lacked health insurance, potentially limiting their access to specialized services and increasing financial barriers to care.

Figure 79: Do you have health insurance?



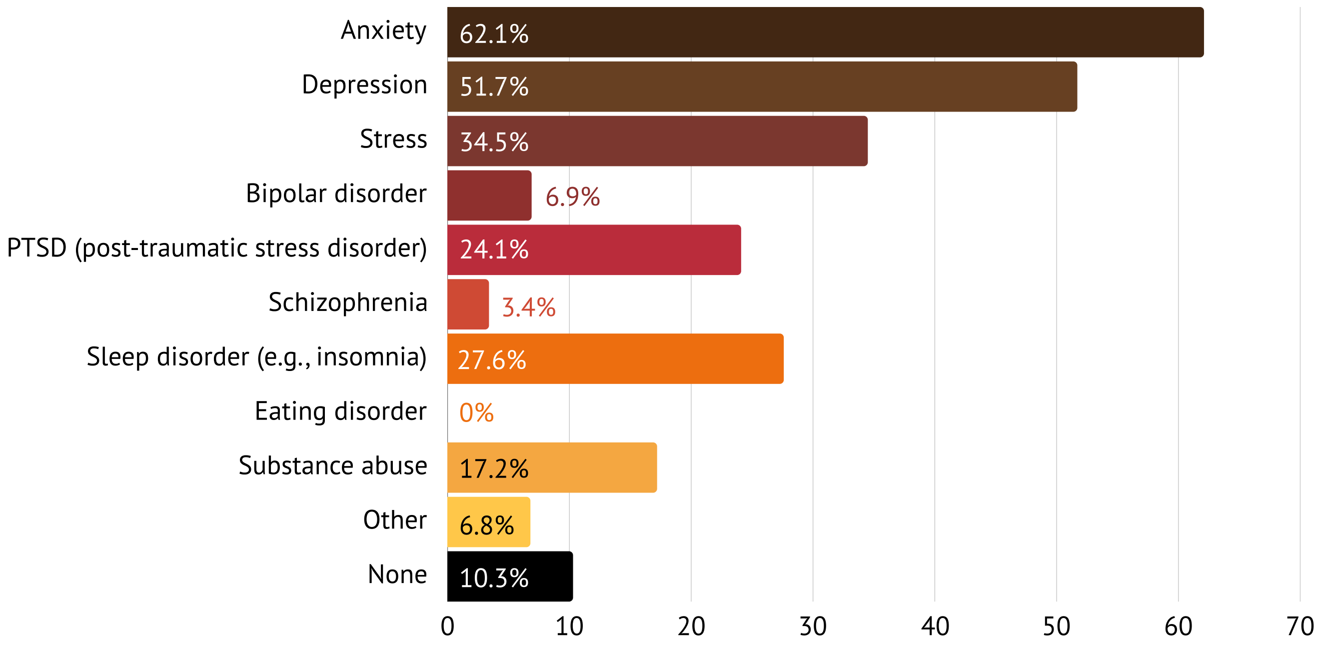
When asked about their top healthcare concerns, most respondents (69%) prioritized physical health over mental health. The most common issues cited were chronic illnesses such as diabetes and hypertension (44.8%), heart disease (31%), allergies (31%), mobility challenges like arthritis and joint pain (31%), and pain management related to chronic pain or injury recovery (20.7%). (Figure 80)

Figure 80: What are your main physical health concerns. (Select all that apply)



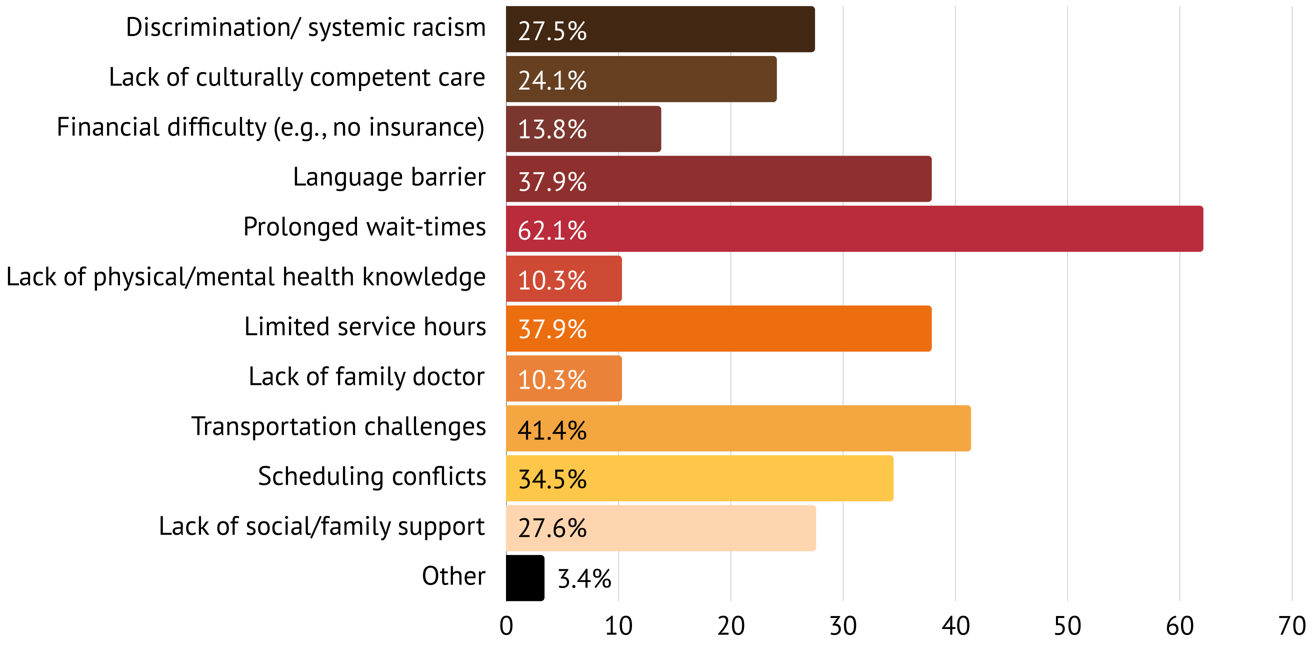
While most respondents prioritized physical health, 24.1% were equally concerned about both their physical and mental well-being. The most common mental health concerns reported were anxiety (62.1%), depression (51.7%), and stress management (34.5%) (Figure 81) . These findings align with the survey demographics (refer to section 4.3), where the largest proportion of respondents (37.9%) were aged 65 and older, followed by a significant share (31%) in the 18-29 age group. Physical health concerns were more prevalent among senior respondents, while both physical and mental health issues were reported across all age groups.

Figure 81: What are your main mental health concerns. (Select all that apply)



The key barriers to accessing doctor's appointments, as reported by respondents in a select-all-that-apply format, included prolonged wait times (62.1%), transportation challenges (41.4%), limited service hours (37.9%), and language barriers (37.9%). Other significant obstacles included scheduling conflicts, lack of social and family support, discrimination/systemic racism, and a lack of culturally competent care. These issues will be explored further in the next sections. (Figure 82)

Figure 82: Do any of the following barriers affect your ability to visit the doctor? (Select all that apply)



Discrimination an Systemic Racism

A key barrier identified by respondents when accessing healthcare was discrimination and systemic racism. This was defined in the survey as situations where healthcare providers treat individuals differently based on factors such as race, ethnicity, immigration status, age, or other aspects of identity. For example, a patient who receives less attention or is denied care due to their status as a newcomer or lack of permanent residency may experience discrimination or systemic racism in healthcare. In response, 27.5% of participants noted this as a barrier to accessing a doctor (Figure 82).

To gain further insight into the experiences of community members, survey respondents were prompted to elaborate on how their identity may impact the services they or other Chinese community members receive, as well as their personal health outcomes. This open-ended question revealed how racism and discrimination affected healthcare access and the overall quality of care within the community.

Respondents shared powerful accounts of how racism and discrimination shaped their healthcare experiences, particularly how their visible or invisible identities influenced the care they received. Many described the anxiety and emotional toll of perceiving that healthcare providers may treat them unfairly based on these identities. This suggests that the stress of potential discrimination can harm health outcomes, adding an emotional burden that negatively affects overall well-being.

> *Healthcare providers may be reluctant or treat Chinese community members with less care due to discrimination. It is extra stress to be concerned about how they may treat me due to my visible identity, or invisible aspects of my identity reflected through the impact of activities of my daily life on my health.*

Others highlighted disparities in how healthcare services are promoted across communities, revealing a critical gap in outreach and accessibility. When services are not equally represented or promoted in different areas, it can further marginalize racialized groups, limiting their access to necessary healthcare information. These disparities contribute to unequal access, leading to worse health outcomes for these communities.

> *Different types of services may be advertised more in the communities I am in, compared to services advertised in non-Chinese communities.*

Additionally, some respondents reflected on how their identities led to serious harm and abuse in healthcare settings. This reflects a deep-seated concern that individuals from certain racialized communities are more likely to experience negative treatment in healthcare spaces, leading to physical, emotional, or psychological harm. Such experiences can seriously affect their health and erode trust in the healthcare system.

Serious harm and abuse (translated response when asked how their identity impacts the care they receive and their health outcomes)

Ageism was another form of discrimination commonly reported, particularly by older respondents. Many shared how their physical health concerns were dismissed or ignored because of their age, without any appropriate follow-up or investigation into their symptoms. This added another layer of inequity to the challenges they already faced as racialized individuals.

Respondents also identified sexism as a barrier to receiving adequate healthcare, particularly in relation to advocating for reproductive health. One respondent shared how their gender had a greater impact on the quality of care they received than their visible minority status, especially due to their fluency in English. They expressed concern about how elderly Chinese women might face even greater challenges in advocating for their health.

Honestly, my gender as a woman has a larger impact on the quality of care I receive than the fact that I'm a visual minority because my English is fluent. I have to really push and advocate for my reproductive health all the time. I can't imagine how this would impact elderly Chinese women

Another respondent highlighted that Western doctors may assume the Chinese community is already familiar with preventative healthcare measures, likely due to cultural stereotypes or a generalized belief that individuals from certain communities have access to the same level of health education. This assumption can create a disconnect, as it may prevent doctors from providing clear explanations about important practices, such as pap smears, mammograms, blood pressure checks, and vaccinations—practices that many individuals from this community may not be aware of due to cultural and systemic gaps in health education.

> *I do think there are a lack of awareness on preventative healthcare among the Chinese community. And because Western doctors assume we do take preventative healthcare measures, when asked about this, we don't really know what it is (e.g. pap smear). I think this is worse around sexual health due to the cultural taboo.*

Survey respondents were asked to rate on a scale of 1-10 how various factors impacted the quality of healthcare they or others in their community received. The most frequently cited factor was language proficiency, with 57.1% of respondents ranking it as 10, indicating a strong belief that language proficiency significantly impacts healthcare quality (Figure 83). Working or economic status received more mixed responses, with 17.1% of respondents ranking it as both 1 and 8, suggesting a split perception of its impact on healthcare (Figure 84). Similarly, citizenship or immigration status was rated as 10 by 20.7% of respondents, reflecting a moderate to strong belief that immigration status influences healthcare access (Figure 85).

Figure 83: On a scale of 1-10, how much do you believe that language proficiency (English) impacts the quality of healthcare you or others in your community receive?

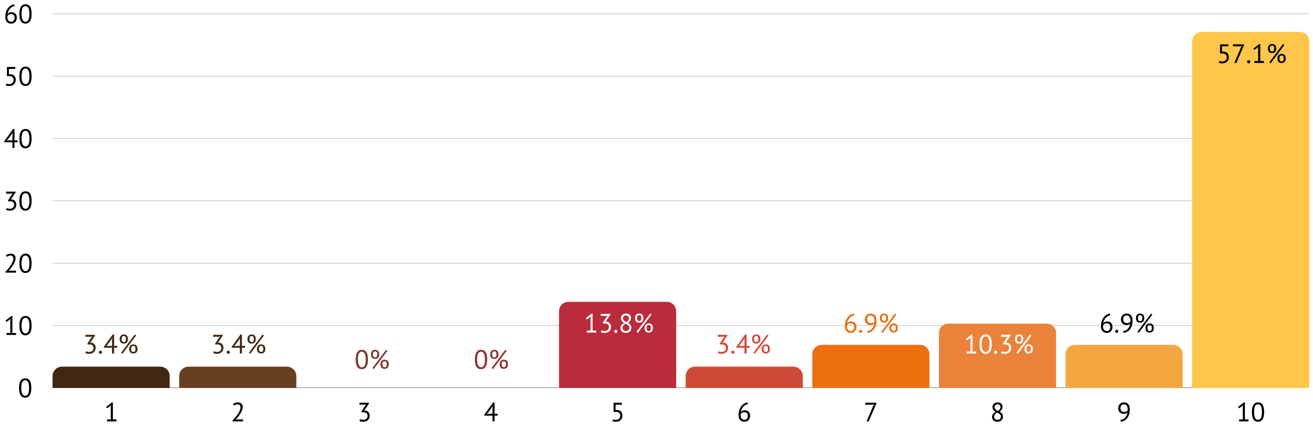


Figure 84: On a scale of 1-10, how much do you believe that employment or economic status impacts the quality of healthcare you or others in your community receive?

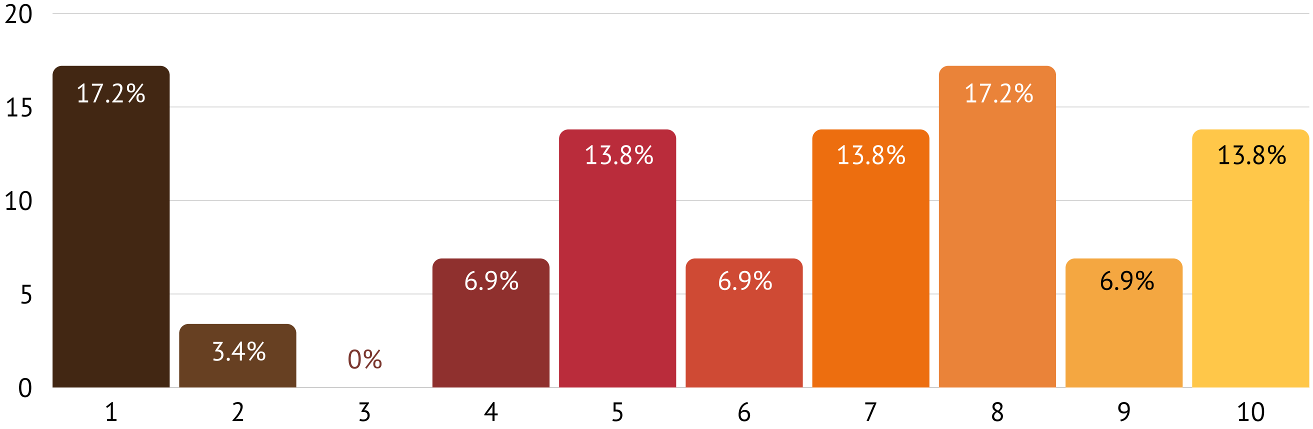
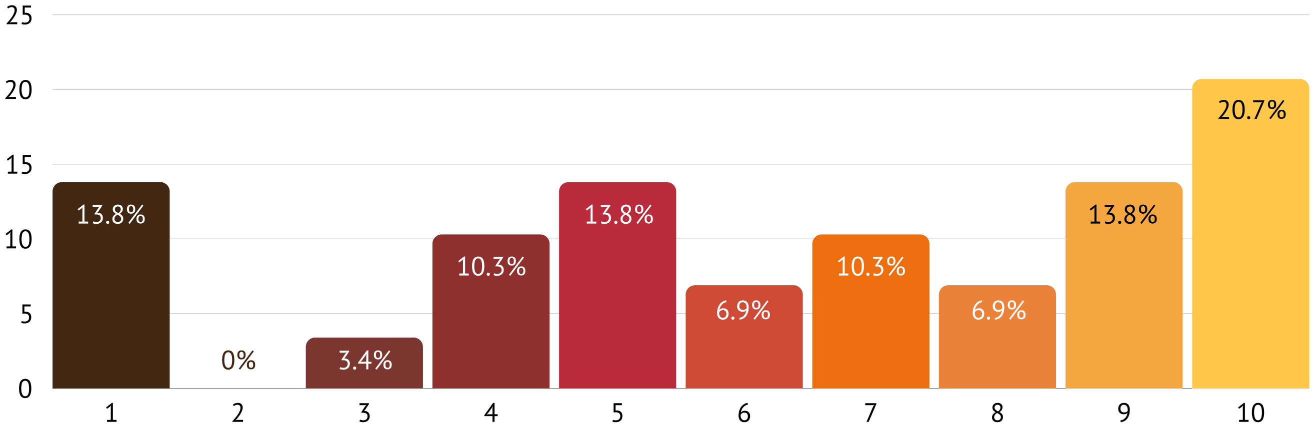


Figure 85: On a scale of 1-10, how much do you believe that citizenship or immigration status impacts the quality of healthcare you or others in your community receive?



Several respondents, particularly students and those with precarious immigration status, provided additional context, explaining how the lack of healthcare insurance after graduation, combined with the high cost of medical expenses, created severe barriers for those without permanent immigration status or insurance coverage. These individuals felt particularly vulnerable to discrimination, both for their racialized identity and their immigration status, contributing to their limited access to quality healthcare services.

Lack of Information and Knowledge

10.3% of respondents identified a lack of knowledge about physical and mental health as a significant barrier when seeking healthcare (Figure 82). While this percentage was not particularly high among survey participants, it emerged as a central theme during focus group discussions and subject-matter expert consultations, and it was subsequently included in our research recommendations.

Survey respondents were also asked to rate their knowledge of community health services and health promotion initiatives on a scale of 1-10. In terms of community health services, 20.7% of respondents rated their knowledge as either 1 (very limited) or 8 (relatively high), suggesting a significant disparity in awareness within the community (Figure 86). While some individuals feel well-informed, a notable portion of the community reports limited understanding of available healthcare resources. Similarly, 27.6% of respondents rated their knowledge of community health promotion initiatives as a 6, indicating a moderate level of awareness (Figure 87). These findings highlight the uneven distribution of knowledge and suggest that while some individuals have access to relevant information, there is a clear opportunity to improve outreach and education efforts.

Figure 86: On a scale of 1-10, how would you rate your knowledge of community health services?

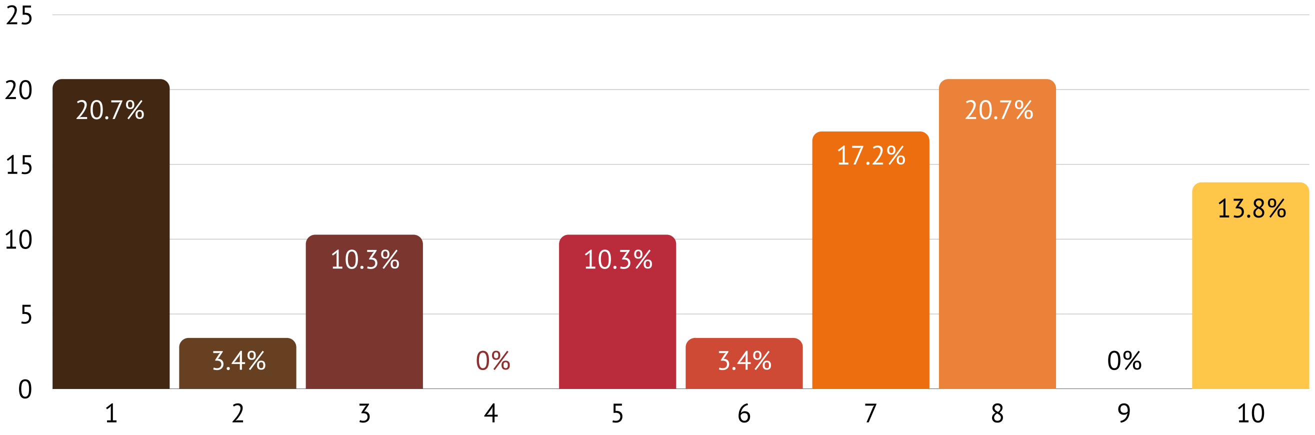
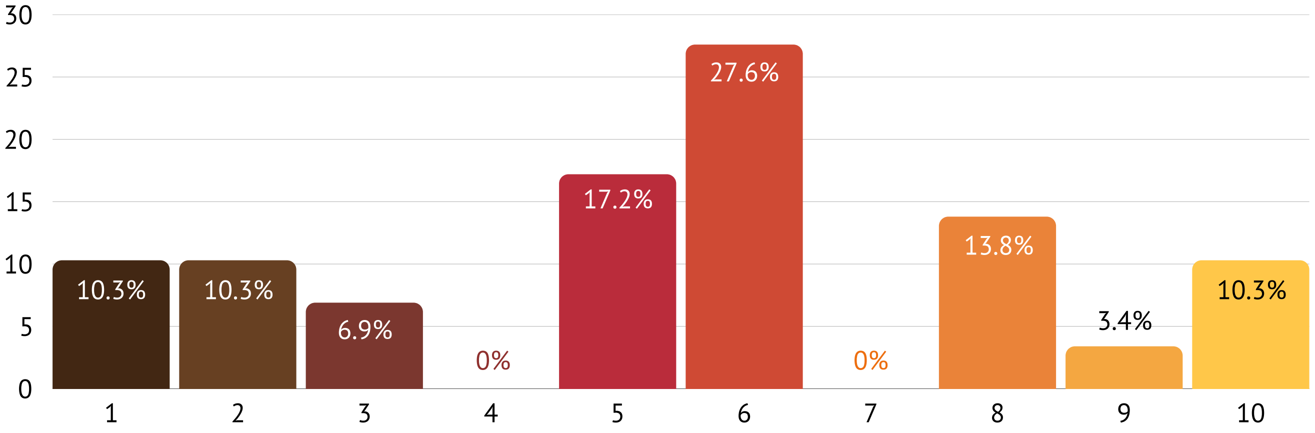


Figure 87: On a scale of 1-10, how would you rate your knowledge of community health promotion initiatives?



A key concern raised by respondents was the prevalence of misinformation within Chinese communities, particularly regarding physical and mental health. This is further exacerbated by cultural stigma surrounding certain health conditions, which limits individuals' understanding and access to care. Additionally, the knowledge gap is not only present within the community but also among healthcare providers, who often lack the cultural competence needed to adequately address the unique needs of Chinese patients. This issue will be explored further in the following section on accessibility.

> *Health outcomes can be adversely affected by limited health literacy if educational materials are not culturally relevant or accessible.*

Accessibility

Accessibility emerged as a central theme affecting the quality of healthcare, with respondents highlighting several key factors that impede their ability to receive adequate care. One of the most significant challenges was prolonged wait times (62.1%) for appointments, which delayed access to essential healthcare services. Additionally, limited service hours (37.9%) of healthcare providers posed a barrier, as many respondents found it difficult to schedule appointments (34.5%) outside of their work or personal commitments. The shortage of family doctors (10.3%) further compounded the issue, as a lack of available primary care providers made it difficult to secure consistent, quality care. (Figure 82)

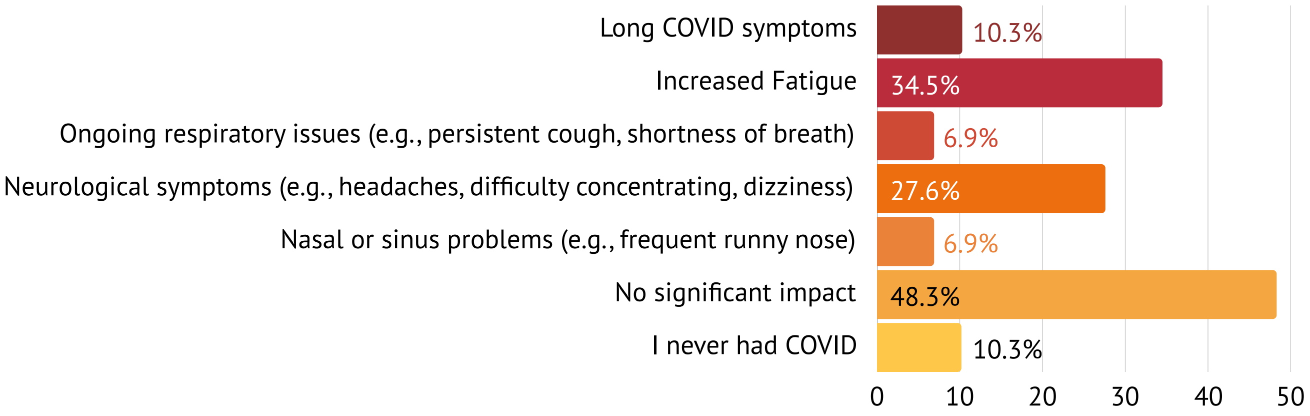
Respondents also highlighted the lack of culturally competent healthcare providers (24.1%) as a major concern. The absence of healthcare professionals who could effectively address the specific cultural needs of patients led to feelings of disconnection and dissatisfaction with the care provided. Language barriers (37.9%) were another challenge, particularly for individuals who faced difficulties communicating with healthcare providers, impacting their ability to fully understand diagnoses, treatment options, and medical instructions. These barriers not only affected the quality of care but also increased the stress and anxiety of navigating the healthcare system. (Figure 82)

Economic factors played a significant role in healthcare access as well. Financial constraints (13.8%), including the lack of insurance or limited financial resources, prevented many respondents from seeking necessary care or affording prescribed treatments. Transportation issues (41.4%) were also a common problem, particularly for individuals living in underserved areas or with limited access to reliable transportation. These logistical challenges added an additional layer of difficulty for those already facing other barriers to healthcare. (Figure 82)

IMPACTS ON HEALTH AND HEALTHCARE ACCESS DURING THE PANDEMIC

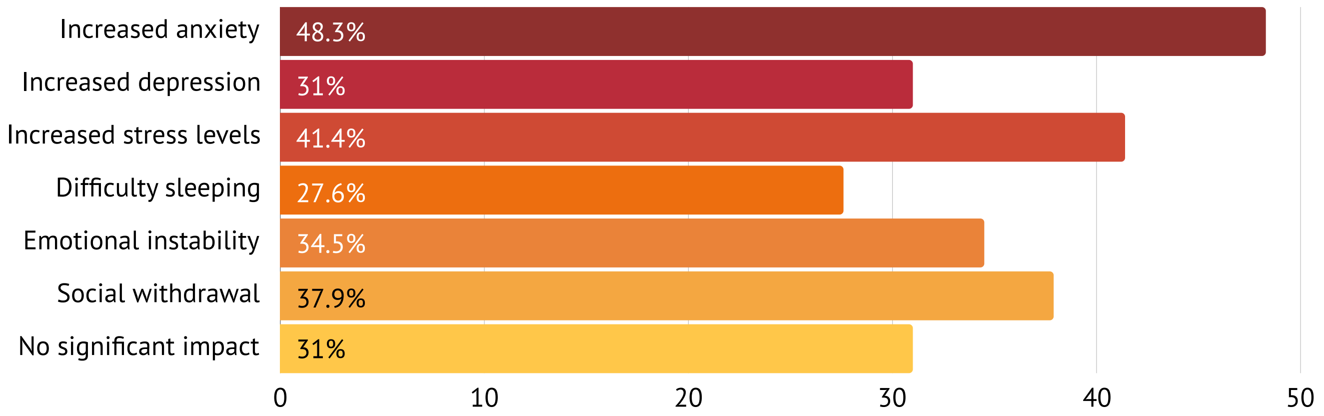
COVID-19 had a profound impact on both physical and mental health in the community. When asked how the pandemic affected physical health, 48.3% of respondents reported no significant impact. However, others reported experiencing various symptoms, with 34.5% indicating increased fatigue, and 27.6% experiencing neurological symptoms such as headaches, difficulty concentrating, and dizziness. (Figure 88)

Figure 88: How has COVID-19 impacted your physical health? (Select all that apply)



The mental health effects of the pandemic were more pronounced. 48.3% of respondents noted increased anxiety, while 41.4% experienced heightened stress levels (Figure 89). Other common mental health impacts included social withdrawal (37.9%), increased depression (31%), and emotional instability (24.5%) (Figure 89). Several open-ended responses highlighted significant psychological challenges, including paranoia, distrust of medical institutions, and heightened fear, all of which were exacerbated by prevalent anti-Asian racism and sinophobic rhetoric. Economic strain further intensified these psychological burdens, leading to increased stress, anxiety, and a sense of insecurity. Participants also reported social isolation and withdrawal, feeling disconnected from both healthcare systems and their communities, which compounded their mental health struggles.

Figure 89: How has COVID-19 impacted your mental health? (Select all that apply)



My maternal grandfather got pneumonia and seeing people unmasked at the hospital was extremely frustrating. Especially since we were all masked and would get dirty looks. I think the lack of community support and understanding makes this a struggle.

The whole Mandarin speaking community was in panic. Not only because of the Pandemic, but also the tensions between our home country and the Western world. We felt being torn by some forces.

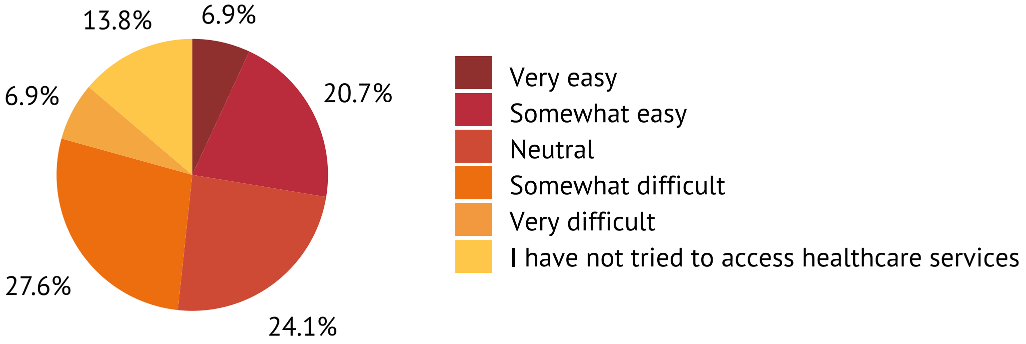
The economic fallout from COVID-19, including job losses and financial instability, disproportionately affected many within the community. This economic strain further impacted health by limiting access to necessary health resources and services.

Public health measures, such as social distancing and lockdowns, led to increased social isolation, which negatively affected both mental and physical health. Community members experienced reduced social support, which is crucial for overall well-being.

Alot of social withdrawal and increased aggression.

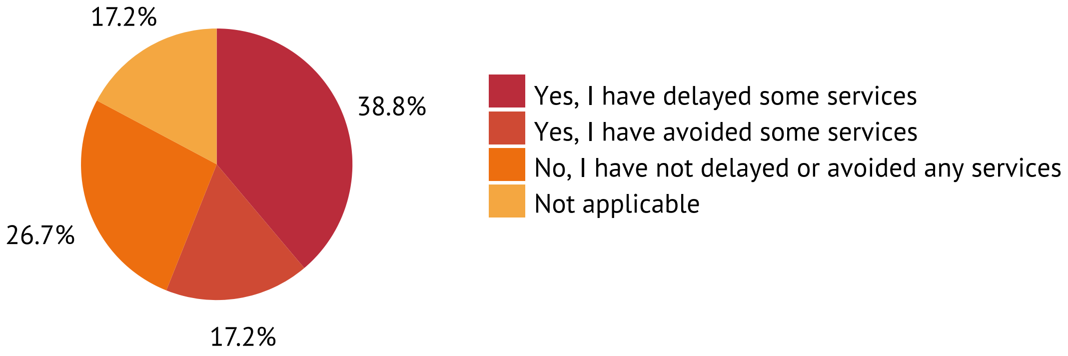
Access to healthcare services during the COVID-19 pandemic was reported as challenging for many respondents. When asked about ease of access, 27.6% found it somewhat difficult, 24.1% were neutral, and 20.7% considered it somewhat easy (Figure 90). This indicates that a significant portion of individuals faced difficulties in accessing necessary healthcare, with a notable group reporting moderate ease in navigating healthcare services during the pandemic.

Figure 90: How easy was it for you to access healthcare services during the COVID-19 pandemic?



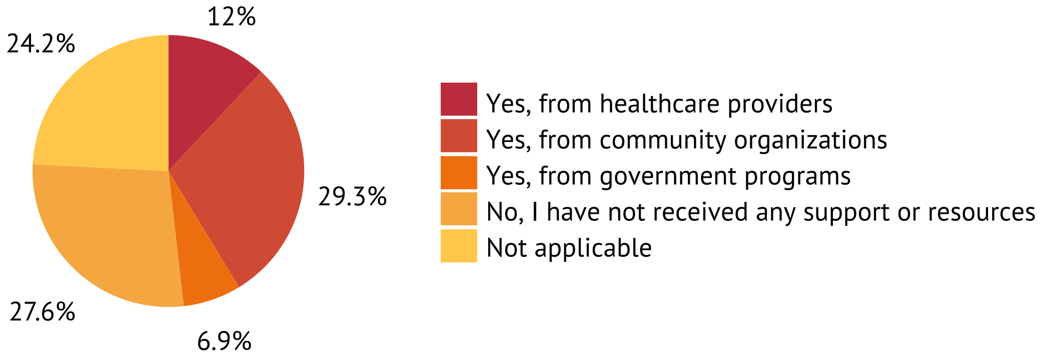
In terms of delaying or avoiding healthcare services, 38.8% of respondents indicated that they had delayed some services, while 17.2% had avoided services altogether (Figure 91). In contrast, 26.7% of participants reported that they had not delayed or avoided any healthcare services (Figure 91). This suggests that a large number of individuals either felt unable or unwilling to seek healthcare during the pandemic, possibly due to concerns about exposure to COVID-19, disruptions to regular healthcare services, or other barriers such as financial or logistical challenges.

Figure 91: Have you delayed or avoided accessing any healthcare services because of the COVID-19 pandemic?



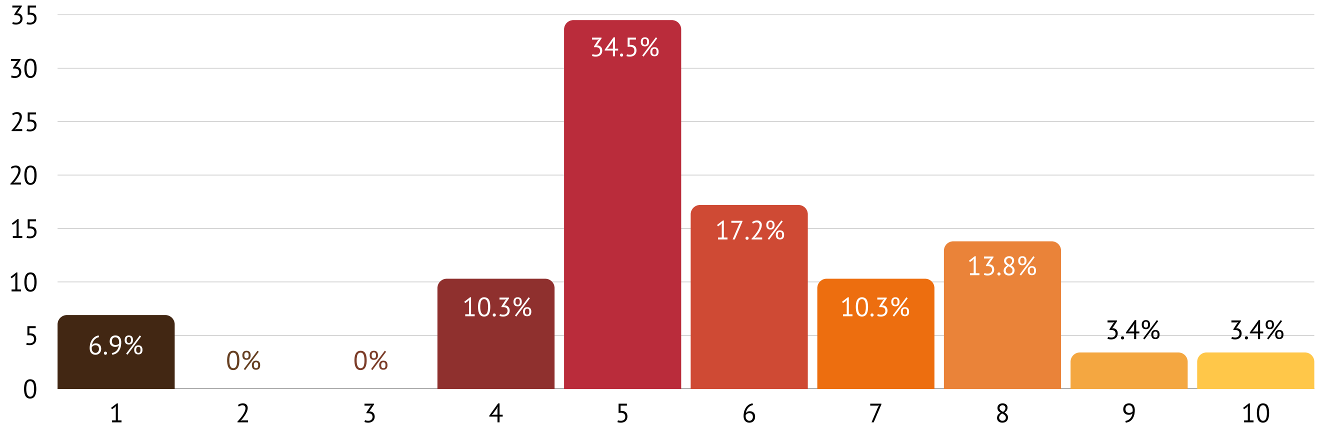
Support from healthcare providers and community organizations played a role in helping individuals manage their health during this period. 29.3% of respondents received support from community organizations, while 12% received assistance from healthcare providers. However, 27.6% reported not receiving any support or resources (Figure 92). This highlights a disparity in access to support, with some individuals benefiting from resources, while others were left without the necessary assistance to manage their health effectively during the pandemic.

Figure 92: Did you receive any support or resources to help manage your health during the COVID-19 pandemic?



When asked to rank how access to healthcare services has changed since the COVID-19 pandemic, 34.5% of respondents gave a neutral score of 5, indicating that, on balance, the changes in healthcare accessibility were neither overwhelmingly positive nor negative for them (Figure 93). This suggests that while some saw improvements, others faced continued or even exacerbated challenges in accessing care. Several quotes illustrate the dual nature of healthcare accessibility during the pandemic:

Figure 86: On a scale of 1-10, how has your access to healthcare services changed since the COVID-19 pandemic?



I noticed that masks are often required in healthcare settings. I believe this is very beneficial as it slows the spread of viruses, not only COVID.

There's a lot more accommodations for telehealth and that's been great because hours for seeing a doctor are so limited.

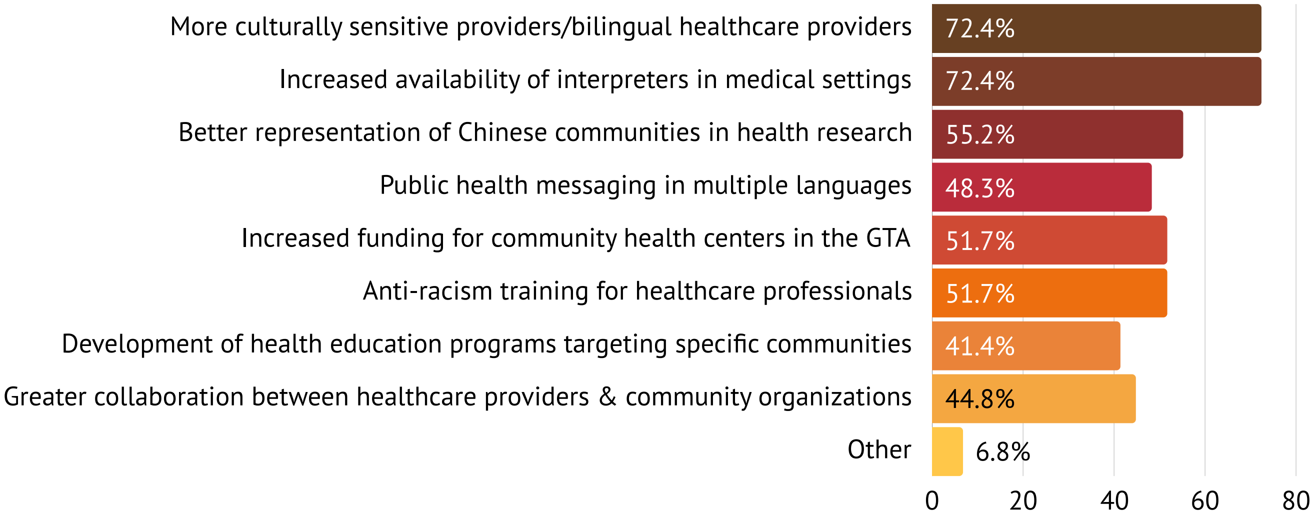
COVID-19 significantly impacted healthcare accessibility, with both personal and community effects. On a personal level, the shift to virtual care and telemedicine increased accessibility, allowing for convenient and timely consultations without the need for in-person visits. For many, this meant easier access to healthcare services, especially amid pandemic-related restrictions. However, the community at large faced challenges such as limited digital literacy and inadequate access to technology, which hindered the adoption of telemedicine for some. Additionally, the surge in demand for healthcare services strained systems and highlighted disparities, as those with limited internet access or technology faced barriers to care. Despite these issues, the increased use of virtual care offered a valuable alternative, improving access for individuals who could benefit from it.

Discouraged routine check-ups due to fear around higher likelihood of getting sick from other patients in medical settings. Increased use of virtual care helped accessibility.

RECOMMENDATIONS TO IMPROVE EQUITABLE HEALTH ACCESS AND OUTCOMES

Respondents identified several key areas for improving healthcare services for the Chinese Canadian community. A significant number, 72.4%, suggested the need for more culturally sensitive and bilingual healthcare providers, along with increased availability of interpreters in medical settings. Over half (55.2%) called for better representation of Chinese communities in health research, while 51.7% advocated for increased funding for community health centers in the GTA. Additionally, 51.7% emphasized the importance of anti-racism training for healthcare professionals to foster a more inclusive and equitable healthcare environment. (Figure 94)

Figure 94: What specific changes in healthcare, health education, or strategies do you think healthcare providers, clinics, or the government could implement to better support the Chinese Canadian community? (Select all that apply)



Anti-Asian Racism and Health Equity Programs: Develop and implement more targeted anti-Asian racism and health equity programs to address the unique healthcare challenges faced by Asian communities. These programs should focus on improving access to culturally competent care, addressing mental health concerns related to discrimination, and promoting awareness of health disparities. Additionally, providing resources and support for navigating the healthcare system will help ensure better health outcomes for Asian individuals.

Try to have more anti-asian program.

Better understanding of Asian mental health.

Enhance Language Access and Translation Services: To address language barriers, healthcare providers should prioritize offering robust Chinese language services, including translation and interpretation, to ensure that individuals can effectively communicate complex medical conditions and understand treatment plans. This will help bridge the gap in healthcare accessibility for those with limited English proficiency.

> *I think Chinese language services and translation services are the most critical because the English level of Chinese people (or my own level) is not enough to describe complex disease conditions. (translated)*

Incorporate Traditional Chinese Medicine (TCM) into the Healthcare System: There is a clear desire for greater recognition of TCM alongside the Canadian biomedical healthcare model. Healthcare providers should consider integrating TCM practices, where appropriate, and creating a more holistic approach to care that values both Eastern and Western medical perspectives. This would help foster a healthcare system that is more inclusive and culturally competent.

> *The Canadian biomedical healthcare model overlooks eastern medical practices, this stigmatization/lack of recognition reduces the legitimacy of practices whose goals are simply to support human life. A well rounded, multi-cultural individual will benefit from a healthcare model that nourishes both the body and mind by any means.*

Strengthen Collaboration Between Healthcare Providers and Community Organizations: Establishing more initiatives that bring together healthcare providers and community organizations trusted by Chinese immigrants is essential. These partnerships can help bridge cultural gaps, promote health education, and advocate for improved health services. Community organizations can serve as effective channels for outreach and engagement, increasing trust and participation in healthcare.

> *More initiatives between healthcare providers with community organizations which Chinese immigrants have trust and regularly access in order to advocate and promote health education.*

Improve Accessibility to Healthcare Services: To address accessibility challenges, we need to expand the availability of healthcare providers, offer flexible appointment times, and open more clinics and health centers in racially diverse neighborhoods. Additionally, expanding OHIP to fully cover services like vision, dental, and mental health, without the need for additional insurance, would significantly reduce barriers to care. Making healthcare more convenient and accessible will encourage individuals to seek timely care.

Better/easier accessibility in terms of locations, available doctors nearby, and available appt time.

Increase funding for community health centres in Toronto.. (translated)

If healthcare was actually fully free without insurance. vision, dental, mental health, and so on.

Implement Comprehensive and Personalized Care Coordination: The integration of medical, mental, and social health aspects through a personalized care coordination model would address gaps in care and improve health outcomes. Providers should work towards ensuring that different healthcare professionals communicate effectively, reduce unnecessary tests, and streamline access to services. This approach would be particularly beneficial for individuals managing chronic conditions and seeking continuous, holistic care.

The one change in the healthcare system that would make the greatest impact on my health would be the implementation of comprehensive and personalized care coordination. This would involve a holistic approach where all aspects of an individual's health—medical, mental, and social—are integrated and managed cohesively. Improved care coordination would ensure that different healthcare providers communicate effectively, reduce redundant tests and treatments, and address gaps in care. It would also enhance the management of chronic conditions, streamline access to necessary services, and improve overall health outcomes by providing a more personalized and continuous care experience.

COMMUNITY FOCUS GROUP DISCUSSIONS FINDINGS

Between September 2024 and October 2024, five focus groups were conducted with a total of 35 participants. All participants were required to be 18 years or older, reside within the GTA, and identify as Chinese. The breakdown of focus group participant demographics can be found in section 4.3. The majority of focus group participants were adults aged 25-54.

Out of the five focus group discussions were conducted as part of the project, three were hosted by CCNC-TO, with two held online and one in person at their Scarborough office. To expand the project's reach, two additional focus groups were held in collaboration with Friends of Chinatown Toronto (FOCT) in downtown Toronto and 105 Gibson Center in Markham, as both organizations serve marginalized Chinese workers and seniors. Staff from FOCT and 105 Gibson Center were onboarded and trained to facilitate the focus groups, ensuring effective community engagement.

LANGUAGE AND CULTURAL BARRIERS TO HEALTHCARE ACCESS

Participants identified several barriers related to language and cultural differences that hindered healthcare access. These included a lack of adequate translation and interpretation services, the diminishing availability of Chinese-speaking healthcare providers, and geographical disparities in language support. Additionally, cultural taboos and the perceived incompatibility between Eastern and Western medical models, contributed to reluctance in seeking care and difficulties in communication within the healthcare system.

Limited Translation and Interpretation Services: Many participants pointed out that healthcare facilities often lack adequate translation services, hindering their ability to accurately convey symptoms and medical concerns. This resulted in difficulty fully communicating conditions, increasing the risk of misdiagnoses or improper treatment. Complex medical terminology, procedures, and critical aspects of patient care—such as follow-up questions, pain descriptions, and prescriptions—were often inadequately translated. Participants also noted a lack of patience from providers in ensuring that patients with language barriers fully understood care instructions and had their questions answered. This insufficient support led to feelings of disconnection and dissatisfaction with healthcare services.

> *Even interpreters in hospitals aren't always capable of conveying what we are sharing about our symptoms when we go, such as the difference between throbbing pain and shooting pain and dull aching pain. Just being an interpreter isn't always enough to convey medical information without the right training.*

Lack of Chinese-speaking Healthcare Providers: Participants expressed concerns about the diminishing number of family doctors who speak Cantonese or Mandarin, leading to challenges in accessing care. For many, language remains a significant barrier in finding a healthcare provider they can trust, especially in communities where Chinese is the primary language spoken. The lack of linguistic compatibility can create discomfort, making it harder for patients to express their needs or fully understand medical advice.

> *There are fewer and fewer family doctors who speak Cantonese or Mandarin. Language barrier is my main concern when finding a family doctor.*

Geographical Disparities in Interpreter Services: There were differences in the availability and quality of language support across different healthcare settings. Larger hospitals in urban areas often had better resources for translation, while those in smaller or rural areas struggled to offer adequate support. This disparity created challenges for individuals in underserved regions, as they may have been forced to travel long distances or endure subpar translation services, hindering their ability to receive proper healthcare.

> *Some people have more access than others, such as having more competent translators in larger hospitals; there's geographical differences—some people won't move to better living circumstances because they fear having to find new doctors.*

Stigma and Taboos Around Healthcare: A significant number of younger participants shared that certain health topics, especially those related to sexual or reproductive health, were difficult to discuss, particularly in the presence of family members. These taboos often led to people avoiding necessary healthcare services or failing to seek guidance on important health matters. This was especially true for individuals who were raised in more traditional households where healthcare discussions were often seen as private or even inappropriate to bring up.

Perceived Incompatibility Between Eastern and Western Medical Models: Beliefs such as Falun Gong, a spiritual practice combining meditation and exercises, and the use of TCM, are central to the health practices of some within the Chinese community. These practices are often viewed as vital to well-being, yet the Canadian healthcare system may not fully understand or accept them. Healthcare providers may dismiss or undermine these practices, contributing to a reluctance to seek care or a sense of disconnection from the system. Additionally, the lack of insurance coverage for TCM further discourages engagement with the Canadian healthcare system, as many in the community turn to these traditional practices as alternatives.

THE FINANCIAL BARRIERS TO HEALTHCARE ACCESS

Cost emerged as a significant barrier to healthcare access, especially for recent graduates, part-time workers, and newcomers without insurance. Many participants faced challenges in affording healthcare, with some prioritizing basic needs over medical expenses. Cultural reluctance to spend on healthcare, particularly among seniors, further exacerbated this issue. These financial challenges often led to individuals avoiding necessary care or seeking it only in emergencies, which worsened their health outcomes.

Cost of Healthcare for Recent Graduates and Families: Cost was a significant barrier for many participants in accessing adequate healthcare, particularly among those who were recently graduated or without insurance. Some shared the compounded difficulty of not having a designated family or university doctor, making it harder to navigate the healthcare system. Respondents noted that they were often left covering 20-30% of healthcare costs, which was not financially feasible for them. When faced with decisions between immediate needs like food or shelter and healthcare, participants shared that healthcare often became a lower priority.

> *At some point, they could not get medication for my kid with a fever because the fever was not above 40 Celsius. But we waited till my son's situation got worse...The healthcare provider said buying the specialty medication would be very expensive but it turned out to be covered by insurance [...] Care should be more flexible and available for children and seniors.*

Financial Challenges Faced by Newcomers: Newcomers to Canada also experienced difficulties accessing healthcare due to high costs. Many shared how, as part-time workers, it was hard to apply for OHIP and had to either purchase expensive health insurance or pay out-of-pocket for medical services. This financial strain led many to avoid seeking healthcare unless it was an emergency, which only worsened health problems.

Cultural Reluctance to Spend on Healthcare: Cultural values played a role in how individuals approached healthcare costs. Senior participants expressed that they didn't want to burden their families by spending money on their own care, including medication. This led them to avoid seeking treatment, even when it was necessary, resulting in worse health outcomes. This reluctance was also heightened by the cultural stigma associated with spending money on healthcare, especially for mental health services.

> *Seniors don't want to burden their children.*

THE NEED FOR CULTURALLY RESPONSIVE MENTAL HEALTH CARE

Many participants expressed a need for mental health services tailored to the Chinese community, noting the lack of culturally relevant care. Language barriers, cultural stigmas surrounding mental health, and cost were significant deterrents. Addressing these barriers could encourage more individuals to seek mental health support and improve their well-being.

Lack of Culturally Relevant Services: Many participants emphasized the absence of mental health services tailored to the Chinese community. They expressed a willingness to access care but cited language, cultural, and cost barriers as significant deterrents. This was especially true for new immigrants facing stress, anxiety, and depression due to unfamiliarity with the Canadian healthcare system and the lack of culturally sensitive services.

Cultural Stigma Around Mental Health: Cultural stigma surrounding mental health is a significant barrier, particularly for older adults and seniors. In Chinese culture, mental health issues are often seen as shameful, leading many individuals to avoid seeking help. However, participants indicated that this stigma could be reduced by reframing mental health services in a way that aligns with cultural values, such as referring to “family counseling” instead of “therapy.” While seniors expressed resistance to traditional therapy, they were more open to receiving support from a “family expert,” suggesting that professional mental health care would be more acceptable if framed within the context of family support and cultural norms.

GAP IN HEALTH LITERACY AND PROMOTION

Participants highlighted key gaps in health literacy and promotion within the Chinese community, especially among new immigrants and seniors. These challenges included a limited understanding of the Canadian healthcare system, language and digital literacy barriers, and a lack of culturally appropriate resources. Widespread of misinformation further complicated healthcare beliefs. Participants also expressed difficulty advocating for their healthcare needs and accessing reliable health information, which compounded the issues they faced in navigating the healthcare system.

Challenges in Understanding Healthcare Services and Access: Many participants identified a lack of knowledge about the healthcare system as a significant barrier to better health outcomes in the Chinese community. New immigrants faced challenges in understanding the Canadian healthcare system, and older adults and seniors struggled with limited English proficiency and digital literacy. As a result, many were hesitant to seek or invest in healthcare, not understanding its long-term benefits. This gap in awareness contributed to a widespread reluctance to prioritize routine check-ups or preventative care, with some seniors perceiving visits to the doctor as unnecessary or even an indication of poor health.

> *Often seniors talk about how they haven’t seen a doctor in 15 years and they brag about this to their friends.*

Barriers to Accessing Health Information and Promotion: Health promotion efforts were often inadequate, and many participants struggled to access relevant health information. One senior participant explained that in China, preventative health procedures and supports like dental care and mental health care were not commonly discussed, influencing why many newcomers here didn't recognize their importance. The absence of Chinese-language resources, along with difficulty finding Chinese-speaking healthcare providers, made it even more difficult for both new immigrants and seniors to access essential health information.

> *It's not easy to obtain promotional materials related to medical information, such as brochures. Much of the information relies on word of mouth, and people don't know where to access healthcare or health information.*

Impact of Misinformation on Healthcare Beliefs: While younger participants were more tech-savvy and able to access online resources, translation tools, and telehealth services, some shared how their families' belief in TCM and the spread of health misinformation through Chinese-language media—often on platforms like WeChat and Xiaohongshu/ 小红书 (The Little Red)— created tensions. These differences in healthcare beliefs hindered the sharing of accurate health information between generations.

Difficulty Advocating for Healthcare Needs: FGDs allowed participants to share strategies for overcoming barriers and advocating for better healthcare. While some suggested that all healthcare professionals should have access to interpretation services, many still felt challenged to advocate for themselves or their family members during medical visits. This highlighted ongoing struggles with self-advocacy in healthcare settings.

WIDESPREAD EXPERIENCES OF DISCRIMINATION AND RACISM

Participants described experiencing widespread discrimination and racism within healthcare settings, often due to their race, age, sex, immigration status, or perceived financial standing. This discrimination took multiple forms, including overt racism, microaggressions, and systemic biases, all of which contributed to poorer health outcomes in the community. Discrimination was felt not only from healthcare providers but also from Chinese-speaking and identifying staff, showing how deeply embedded these issues are in the healthcare system.

Discrimination in Healthcare Settings: Participants across various age groups shared that they had been discriminated against within healthcare environments. Many seniors, students, and working adults mentioned having faced bias from healthcare professionals based on their immigration status, financial standing, or appearance. A recurring theme was the feeling of being treated differently or unfairly because of their race, which made accessing care more stressful and uncomfortable.

Impact of Anti-Asian Sentiment: Anti-Asian sentiment, which was especially prevalent during the COVID-19 pandemic, was reported as having a long-lasting negative effect on participants. Many individuals shared that they faced discrimination and verbal abuse in public spaces, including healthcare settings, because they were perceived to be Asian or because they wore masks. This racialized treatment compounded the emotional toll participants experienced and led to a mistrust in the healthcare system.

Systemic Racism and Health Outcomes: The lack of cultural sensitivity and understanding of systemic racism among healthcare providers was noted as a major issue, particularly for seniors who had prior medical records from their home countries. For example, one senior participant shared how their healthcare records from China were dismissed as invalid by Canadian healthcare providers, forcing them to undergo re-testing at additional costs to show the same results. This led to frustration and financial strain.

Distrust in Canadian Healthcare: A general mistrust in the Canadian healthcare system was prevalent, particularly among older generations who had prior healthcare experiences that were dismissed or invalidated. This created a sense of alienation and reluctance to engage with the Canadian system, as participants felt their cultural backgrounds and previous healthcare experiences were not respected or acknowledged. This mistrust, coupled with racist experiences, made it harder for individuals to feel comfortable seeking care.

INSIGHTS ON HEALTHCARE ACCESS THROUGHOUT THE PANDEMIC

The COVID-19 pandemic created significant barriers to healthcare access, especially for seniors, who were disproportionately affected by the rapid shift to digital healthcare services. These barriers were compounded by the racism experienced during the pandemic, making it a particularly stressful time for participants.

Transition to Digital Healthcare: The shift to digital healthcare during the COVID-19 pandemic had contrasting impacts on different groups. For many younger people, pivoting to online healthcare appointments was relatively easy. However, seniors faced significant challenges due to their limited digital literacy, making it difficult for them to access essential services like booking appointments, assessing test results, and viewing medical results. This digital divide led to increased social isolation and worsened healthcare access for seniors, particularly those with language barriers. While the shift to digital care made sense during the pandemic, many seniors felt that its continued use post-COVID only exacerbated their difficulties.

Rise of Anti-Asian Racism: The pandemic saw a rise in anti-Asian racism, with many participants sharing their painful experiences of being targeted simply for wearing masks. Public racism and derogatory comments became more frequent, adding to the strain of an already difficult time. Participants expressed frustration with the delayed government response, feeling that the attention to anti-Asian hate came too late, only after the damage had been done, *There was a lot of racism towards Asians who wore masks.*

People called me disgusting in public.

The government response felt very delayed (亡羊补牢)*. This was injustice. And now after the fact, they talk about Stop Asian Hate.*

Deterioration of Healthcare Quality: Seniors noted that their healthcare quality significantly deteriorated with the shift to online care, especially for those facing language barriers. The move to digital healthcare during the pandemic left them feeling excluded and distrustful, as they no longer had the face-to-face interactions they valued for building rapport and clarity in medical consultations. This deterioration in care quality has continued even as the pandemic has waned, making it more difficult for seniors to seek and receive adequate support.

RECOMMENDATIONS TO IMPROVE EQUITABLE HEALTH ACCESS AND OUTCOMES

The recommendations focus on addressing barriers to healthcare for diverse communities, particularly Chinese-speaking populations. Key strategies include increasing cultural sensitivity and bilingual healthcare providers, enhancing collaboration between healthcare services and community organizations, and integrating TCM into mainstream healthcare. Expanding OHIP coverage is also crucial to reducing financial barriers and improving access.

Enhancing Cultural Sensitivity and Accessibility in Healthcare: Participants highlighted the need for more bilingual family doctors and healthcare providers who are culturally sensitive and trained to understand the unique needs of diverse communities. They suggested that healthcare services be made more accessible through partnerships with community organizations that have established trust with immigrant and racialized communities. In addition, healthcare providers should receive ongoing cultural competence training to improve patient-provider interactions, particularly in community health centers that can collaborate with organizations that already serve these groups.

The government should also provide increased training opportunities for medical personnel and implement improved policies to support healthcare workers. They should recommend encouraging more young people to pursue careers in health and medical fields.

Supporting Community Organizations for Health Education and Awareness: Community organizations such as CCNC-TO, FOCT, and 105 Gibson Center have been instrumental in providing healthcare information and support to Chinese-speaking populations. Many participants expressed the desire for greater funding and collaboration between these organizations and healthcare providers to promote awareness on key topics like mental health, preventive care, and routine check-ups. Strengthening these partnerships would help ensure healthcare information is accessible, culturally relevant, and better received by the communities they serve.

Promoting Education on Traditional Chinese Medicine (TCM) within the Healthcare System: To improve health outcomes and reduce misinformation, participants recommended that healthcare providers and the Chinese community engage in a dialogue about the role of TCM in a way that doesn't dismiss it entirely but addresses harmful myths. Healthcare materials and public health campaigns should acknowledge the benefits of TCM while clarifying its limitations and dispelling common misconceptions. This approach would help bridge the perceived divide between Eastern and Western medical practices and make the healthcare system more inclusive.

Expanding OHIP Coverage for Comprehensive Healthcare: Participants strongly advocated for the expansion of OHIP coverage to include essential services like dental, podiatry, and mental health care. Many emphasized that the lack of coverage for these services creates unnecessary financial barriers, especially for newcomers, students, and precariously employed individuals. Expanding insurance to cover these areas would alleviate some of the financial strain and improve access to necessary care. The idea of "Healthcare for All" was particularly resonant among participants, with many suggesting that extending coverage would help reduce disparities and improve overall health outcomes in the community.

Dental and podiatry should be covered under basic insurance and not private insurance. Why are some services covered and some not? These issues can cause burden and suffering for the patient.

If these issues were covered by insurance, people will have less problems.

This is very important—it gets harder and harder to walk [with age]...[Podiatry care is] not less important than oral health.

SUBJECT MATTER EXPERT INTERVIEW FINDINGS

Between September 18-24, 2024, five SMEs participated in one-on-one virtual interviews. The interviews, which lasted between 60 to 90 minutes, were conducted in Cantonese (1), English (1), and Mandarin (3). The experts, with two to 20 years of experience in various health-related roles, primarily supported Chinese community members. It is important to note that most SME interviews were conducted in Chinese (Cantonese or Mandarin), and as such, many quotes have been translated into English for this report.

These insights are drawn from five SME interviews with healthcare professionals and experts who offered valuable insights into the healthcare experiences, challenges, and priorities of the East Asian community in Ontario.

- **Anonymous SME –** Expert in healthcare promotion, self-management of chronic conditions, and mental health wellness.
- **Anonymous SME –** Expert in newcomer community support, integration, and services for immigrant populations.
- **Anonymous SME –** Expert in mental health case management
- **Hannah Xu –** Lead of Youth and Family Services at Hong Fook Mental Health Association
- **Tin Man Cheung (RSW) –** Newcomer Youth Mental Health Worker at the Centre for Immigrant and Community Services

ADDRESSING CULTURAL, LINGUISTIC, AND SYSTEMIC BARRIERS

Chinese community members in Ontario face a range of challenges in accessing healthcare, exacerbated by language barriers, cultural stigma, and limited service availability. These barriers hinder timely care, contribute to health disparities, and create reluctance to seek preventative services. Key recommendations include enhancing language accessibility, reducing cost barriers, promoting culturally competent care, and addressing stigma surrounding mental and sexual health. Additionally, expanding healthcare services outside urban centers and improving service hours can provide equitable access for individuals across Ontario

Enhancing Language Accessibility: To mitigate language barriers, healthcare services must prioritize the recruitment and retention of Chinese-speaking practitioners and offer consistent, easily accessible interpretation services. This includes expanding interpretation support across all healthcare settings, from family practices to specialist services.

> *Language is a significant barrier to accessing mental health services. Even young immigrants who graduated from U of T prefer counselling in their mother tongue, as counsellors from other ethnic backgrounds may not be able to provide effective assistance.*
> *~ Anonymous SME*

Even though some family doctors may speak Chinese, when patients are referred to specialists, language issues often make communication more complicated and difficult. This leads to misunderstandings in medical information and affects treatment outcomes. ~ Tin Man Cheung

Chinese individuals with legal status find it easier to access healthcare services, especially at Scarborough General Hospital, where Chinese-speaking staff are specifically hired to support them. However, language barriers remain the major challenge for Chinese community members in the healthcare system. ~ Anonymous SME

Reducing Cost Barriers: To improve affordability, governments and health institutions should expand healthcare coverage for uninsured or precarious status individuals, including international students and temporary workers. Increasing access to free or low-cost mental health services is essential. Additionally, outreach initiatives should promote preventative healthcare, addressing both financial barriers and cultural reluctance. For example, some Chinese community members may avoid spending money on preventive care due to cultural norms that prioritize treatment over prevention. Tackling this stigma through culturally sensitive education campaigns can encourage earlier healthcare engagement, reducing the financial burden of late-stage treatments.

Many Chinese community members do not have OHIP (Ontario Health Insurance Plan), and they must pay out of pocket for healthcare, particularly new immigrants whose status complicates access to services. ~ Tin Man Cheung

International students and work permit holders face financial barriers to healthcare because they cannot apply for Ontario's OHIP health insurance […] Counseling services must often be paid for out-of-pocket […] Even if they (students/workers) have commercial insurance, only permanent jobs offer full coverage, and it is difficult for many to secure permanent positions. This makes it difficult for many Chinese community members to obtain sufficient healthcare coverage. ~ Hannah Xu

Promoting Culturally Competent Care: Healthcare providers should receive cultural competency training to better understand Chinese cultural practices, values, and preferences. This includes integrating TCM into care models and ensuring hospitals respect cultural customs (e.g., preferences for warm water or traditional health practices). The lack of insurance coverage for TCM also highlights the insufficient recognition of culturally relevant care, despite many Chinese community members relying on it for their physical health and well-being. Expanding coverage and promoting culturally safe environments will foster trust and reduce hesitancy.

For example, Chinese people prefer drinking hot or warm water, but nurses sometimes impolitely refuse these requests. These cultural differences leave patients feeling misunderstood and increase their anxiety. ~ Anonymous SME

Many Chinese community members have more trust in TCM, but the information from TCM and Western medicine often conflicts, which also hinders trust in Western medicine. ~ Anonymous SME

More inclined to use traditional methods of health management, such as practicing "Ba Duan Jin" (a traditional Chinese exercise) to maintain their wellness. ~ Anonymous SME

Addressing Stigma Around Mental and Sexual Health: To address cultural stigma and misunderstandings, healthcare campaigns should promote mental and sexual health awareness in ways that are sensitive to both cultural norms and language barriers. This includes offering discreet services, community-based outreach, and public education to normalize discussions on mental health, sexual health, and preventative screenings (e.g., pap smears). Involving community leaders can improve message effectiveness.

In Chinese culture, there is a belief that family shame should not be made public, leading many families to be reluctant to share their issues with external institutions like schools. ~ Tin Man Cheung

Due to cultural influences, Chinese community members often do not actively seek mental health services, leading to mental health issues being under-addressed in the community. ~ Anonymous SME

In the Chinese community, mental health is often viewed as a secondary issue. ~ Tin Man Cheung

Improving Geographical Access: Healthcare services need to be expanded in areas outside of Toronto, Markham, and Scarborough to improve access for Chinese community members in remote regions. This includes establishing more multilingual healthcare services, mobile clinics, and telehealth options to reduce the need for long-distance travel.

In remote areas like Newmarket and Aurora, it is very challenging to find family doctors. Even places as far away as Quebec and Hamilton are visited because they lack adequate healthcare services. ~ Hannah Xu

Some older clients move to rural areas for economic reasons and find it difficult to get a family doctor. They often have to drive long distances to the city for treatment, making consistent care more challenging. ~ Tin Man Cheung

Reducing Wait Times and Expanding Service Hours: Long wait times are a common challenge in healthcare, but they are often worsened when individuals need language-accessible and culturally relevant services. These services are frequently in limited supply, creating additional delays for patients who require both linguistic support and culturally appropriate care. To resolve this, healthcare providers should prioritize reducing wait times by increasing the availability of these specialized services. Expanding service hours, including evenings and weekends, will further help accommodate working individuals and families, ensuring timely and equitable access to care.

Schools often refer students with mental health issues to Chinese service organizations, but the wait times for these services are very long, delaying access to care. ~ Hannah Xu

Many elderly people visiting family lack experience living in Canada and face significant difficulties due to language and cultural differences. Their children often cannot accompany them to appointments due to work. Since the Canadian healthcare system operates on an individual basis rather than a family unit, this creates inconveniences for elderly Chinese who are accustomed to family-based support. ~ Anonymous SME

ADDRESSING THE BENEFITS AND DOWNFALLS OF DIGITALIZATION IN HEALTHCARE

The expansion of digital healthcare during the COVID-19 pandemic improved access to medical services, especially for those in remote areas. However, it also exposed disparities, as seniors and individuals with lower digital literacy were often excluded. To promote equitable access, healthcare systems should expand digital services with flexible hours, offer multilingual interpretation, and promote hybrid care models that combine digital and in-person options. Targeted digital literacy programs and multilingual tech support will help seniors and non-English speakers navigate healthcare platforms. Maintaining non-digital alternatives will further prevent marginalized groups from being excluded from essential care.

Expanding and Optimizing Telehealth Services: To maximize the benefits of digital healthcare, telehealth services should be expanded and made more accessible. The pandemic highlighted the value of telehealth by making healthcare and support services more convenient, especially for individuals in remote areas. Increasing access to video and audio interpretation services will better support patients with language barriers, while expanding telehealth hours beyond regular office times—including evenings and weekends—will benefit precarious workers and students unable to take time off for medical appointments. Additionally, promoting telehealth in underserved regions, where access to in-person specialists is limited, will help bridge geographical gaps and improve healthcare access.

Before the pandemic, online healthcare services were rare, but during the pandemic, many services transitioned online, such as parent support groups shifting from in-person to virtual formats. This made participation easier for adults, especially patients in remote areas, such as in Hamilton, where psychologists provided services via telehealth. By shifting knowledge-sharing and peer support activities online, patients were able to access help more conveniently. Online medical consultations and psychological counseling have gradually been accepted by more community members, and this model will likely become more common during future health crises.” ~ Hannah Xu

Improving Digital Literacy and Access for Seniors: To reduce the negative impact of digitalization on seniors, targeted digital literacy programs should be introduced. These programs can teach seniors how to navigate healthcare portals, schedule telehealth appointments, and access online interpretation services. Additionally, providing multilingual tech support can enhance accessibility for non-English speakers.

Combining Digital and In-Person Services to Prevent Social Isolation: During the COVID-19 pandemic, many Chinese community members reduced their social interactions due to fears of virus exposure and discrimination, leading to increased isolation. This was particularly harmful for seniors, who experienced heightened anxiety, depression, and physical decline as a result. To prevent social isolation, hybrid healthcare models should be promoted, offering both in-person and digital options. This ensures seniors can still access face-to-face care and engage with their healthcare providers, reducing the risk of isolation-induced health issues.

Addressing Disparities in Digital Healthcare Access: Younger individuals with higher digital literacy found it easier to navigate online healthcare platforms during the pandemic, while many seniors struggled with tasks like logging into portals for virtual appointments. As a result, older adults often benefited less from the shift to digital healthcare. To prevent these disparities, healthcare systems should offer alternative non-digital options for seniors and individuals with low digital literacy. Additionally, telehealth platforms should be accessible in multiple languages to ensure equitable access for diverse communities.

ADDRESSING LACK OF KNOWLEDGE AND FAMILIARITY WITH CANADIAN HEALTHCARE SYSTEMS

Limited knowledge of the Canadian healthcare system, compounded by language barriers and misinformation, significantly impacts health outcomes for Chinese community members. To address this, multilingual healthcare education initiatives should provide clear, accessible information about healthcare processes and services. Additionally, culturally competent mental health campaigns can reduce misconceptions and promote early access to support services. Targeted outreach efforts, particularly for vulnerable groups like international students, can improve mental health literacy and reduce reliance on emergency rooms for initial care.

Enhancing Multilingual Healthcare Education and Outreach: To overcome language barriers, healthcare organizations should provide multilingual educational materials, including flyers, pamphlets, and online content. These resources should clearly explain healthcare processes, services, and preventive care options. Community outreach programs, led by trusted local organizations, can further promote accurate healthcare information.

> *While many are concerned about mental health, the information they receive may be inaccurate, particularly information obtained from online sources. ~ Anonymous SME*

Many Chinese community members were unable to understand the information on English flyers, making it difficult for them to identify and verify correct information. ~ Anonymous SME

Increasing Access to Culturally Competent Mental Health Information: To reduce misinformation and improve mental health literacy, culturally tailored public health campaigns should be introduced. These campaigns can address common misconceptions, such as the need for referrals to access psychologists, and promote the availability of mental health services at walk-in clinics. Additionally, targeted outreach programs should focus on improving early access to mental health services for vulnerable groups, including international students, by raising awareness of available support and reducing reliance on emergency rooms for initial mental health care.

Many parents believe they need a family doctor's referral to see a psychologist. In reality, walk-in clinics can also provide mental health assessments, but due to this misunderstanding, timely help is often missed. ~ Anonymous SME

Young people in the Chinese community often have overly high expectations for themselves. International students suffer from poor mental health due to a lack of friends and social support, and they usually first encounter mental health services through emergency rooms. ~ Hannah Xu

RECOMMENDATIONS TO IMPROVE COMMUNITY HEALTH OUTCOMES

Primary Concerns and Future Healthcare Needs for the East Asian Community

Increasing Cultural Sensitivity and Accessibility in Healthcare: SMEs unanimously emphasized the urgent need to increase the number of healthcare providers—such as doctors, nurse practitioners, and mental health professionals—who possess both language and cultural competence to effectively serve the Chinese community. With many Chinese-speaking healthcare providers retiring since the onset of COVID-19, there is a significant gap in services that must be filled. To address this gap, it's crucial to not only train more healthcare professionals but also to ensure that existing resources are allocated effectively to support this need. Cultural competency training for healthcare workers, particularly those serving marginalized and racialized populations, is essential to ensure that providers can respond effectively to the unique needs of the community.

Existing resources are very limited, with only a few organizations specifically serving the Chinese community. ~ Anonymous SME

Expanding Mental Health Care Access and Support: Mental health care tailored to the Chinese community is critically underdeveloped, with the negative impact of COVID-19 on mental well-being being especially pronounced among youth and seniors. Mental health services remain underutilized due to stigma and lack of awareness. Prioritizing mental health as a key component of healthcare, particularly for vulnerable groups, will improve access and outcomes for those in need.

Mental health has not been sufficiently prioritized. Whether during the pandemic or not, mental health has never been given enough attention in the overall healthcare system. ~ Anonymous SME

Fostering Mutual Support Within the Community: The importance of strengthening community-based support networks was emphasized, particularly within the Chinese community. Building volunteer programs to offer mental health services, medical accompaniment, and interpretation support can reduce barriers to accessing care. Initiatives like music therapy, meditation, and pen pal/mentorship programs for seniors could also provide valuable emotional support.

Bridging the Digital Divide for Seniors: While digital healthcare tools such as videoconference, audio/video interpretation services, and telehealth are valuable, many seniors face challenges in utilizing these services. Offering targeted digital literacy workshops, simplifying telehealth technology, and ensuring access to interpreters can significantly improve seniors' ability to navigate digital healthcare platforms. Providing interpreters for non-English speaking seniors, for instance, can further enhance communication and understanding during virtual consultations. Equipping seniors with the necessary skills and tools will help them engage more effectively with remote healthcare services, improving both access and health outcomes.

In the current telehealth system, the wait times for interpreter services are very long, especially for elderly patients who have to wait for extended periods before being connected with an interpreter. Reducing wait times and increasing the availability of interpreter services would significantly improve the efficiency and patient experience in telehealth. ~ Tin Man Cheung

Strengthen[ing] technology training or provid[ing] simpler telehealth devices to help these groups engage better with remote healthcare. ~ Anonymous SME

Investing in Healthcare Workers and Social Services: There is a critical shortage of community mental health workers, social workers, and interpreters who are essential for serving the Chinese community. Many of these roles face limited job opportunities and insufficient pay, making it difficult to meet the growing demand for services. It is essential to improve working conditions, increase access to training programs, and allocate more funding to these roles. Doing so will help expand the pool of trained professionals and ensure more community members can receive early intervention, preventing issues from escalating and reducing the need for reactive healthcare responses.

Resources for preventive healthcare in the Chinese community remain insufficient, particularly in mental health and social work services. The number of mental health service providers and social workers is limited, unable to meet the growing demand. It is recommended to increase investment in preventive healthcare, particularly in the mental health field, to help more community members receive early intervention and prevent problems from escalating. ~ Hannah Xu

Revise Provincial Criteria for Foreign-trained Healthcare Professionals: To address the shortage of healthcare professionals in Ontario, it is recommended to revise provincial criteria to allow more foreign-trained doctors to practice in Canada. Implementing easier bridging pathways for foreign-trained doctors to gain accreditation would help alleviate current shortages and improve access to culturally competent healthcare.

Increasing Access to Healthcare Education and Resources: The availability of Chinese-language health education and resources is currently insufficient, limiting access to critical health information and services. Investing and expanding access to health promotion materials, such as brochures, websites, and workshops, will help improve community knowledge on preventive healthcare, combat misinformation, increase mental health awareness, and help with navigating the healthcare system. These resources should be widely distributed in community centers, schools, and healthcare clinics.

Strengthening Collaboration Between Healthcare Providers and Community Organizations: New immigrants, especially those unfamiliar with the Canadian healthcare system, often face significant barriers to accessing care. Strengthening partnerships between healthcare providers and community organizations can help deliver more accessible and culturally responsive services—such as health check-ups, mental health workshops, and needs assessments—tailored to the needs of immigrants and marginalized groups. Sustained funding for collaborative programs and demographic-specific outreach is essential to expand these efforts. Targeted investments in culturally tailored services, multilingual resources, and community-driven outreach will help bridge gaps in care and reduce health disparities.

> *Community organizations can engage directly with community members by organizing more client-centered health activities, such as health check-ups and mental health workshops, to raise awareness of health and preventive measures. Additionally, community organizations can conduct needs assessments to ensure that healthcare services effectively meet the needs of community members. ~ Hannah Xu*

Simplify Access to Mental Health Services: Allow patients to access mental health services at walk-in clinics to reduce unnecessary barriers, such as referral requirements and complex insurance processes. This would ensure more timely and accessible mental health support, improving overall care delivery.

Expanding Mental Health Coverage Under OHIP: Currently, many individuals, particularly low-income or grassroots workers, are unable to access mental health services because they are not covered under OHIP. Expanding OHIP coverage to include mental health services will allow individuals to seek help early, preventing mental health issues from escalating.

> *Mental health needs of grassroots workers and low-income groups often go unmet because OHIP does not cover mental health services, and individuals can only seek help when the problem becomes severe. This situation needs improvement, with more resources allocated to mental health services. ~ Anonymous SME*

COMPARATIVE ANALYSIS

6.1 COMMON BARRIERS AND SHARED EXPERIENCES ACROSS ALL COMMUNITIES

The findings of this report reveal that, despite differences in culture, language, and lived experiences, racialized communities in Ontario encounter many of the same systemic barriers when trying to access healthcare services. These barriers are not isolated incidents but are indicative of broader structural issues that continue to disadvantage marginalized populations. The COVID-19 pandemic further magnified these disparities, exposing cracks in the healthcare system that have long existed but were often overlooked or normalized. The following section outlines shared barriers that point to the urgent need for systemic reform, equity-focused policies, and community-informed care.

Linguistic and Cultural Insensitivity
Many individuals faced significant difficulties navigating the healthcare system due to inadequate language support and a lack of culturally appropriate care. Limited availability of professional interpreters, reliance on family members for translation, and healthcare providers' unfamiliarity with cultural nuances led to miscommunication, frustration, and suboptimal care.

Discrimination, Implicit Bias, and Mistrust in Healthcare Institutions
Historical and ongoing discrimination, racism, and systemic neglect have fostered deep mistrust in healthcare among many racialized groups. Implicit bias often results in dismissive treatment, misdiagnoses, or inadequate pain management, discouraging patients from seeking care and eroding trust in providers.

Financial Barriers to Care
The high cost of uninsured healthcare services—including medication, treatments, and specialized care—posed a significant obstacle across all groups. Many participants cited financial constraints as a major barrier to receiving adequate medical attention, with some having to forgo essential treatments due to affordability concerns.

System Navigation and Access Barriers
System navigation challenges and long wait times often left individuals struggling to access timely care. A lack of clear guidance on referrals, follow-up care, and specialist consultations—combined with prolonged waitlists—led to treatment delays, worsening health outcomes, and reinforcing the perception that racialized communities' healthcare needs are deprioritized.

Limited Access to Mental Health Services

Mental health stigma within racialized communities, along with a shortage of culturally competent professionals, creates significant barriers to care. This stigma discourages individuals from seeking help, while the lack of cultural understanding leads to ineffective treatment. Financial constraints and long wait times further limit access, perpetuating a cycle of unmet mental health needs in these communities.

Immigration Status-Related Challenges

Many racialized individuals, particularly newcomers and undocumented individuals, faced barriers such as lack of access to health insurance, uncertainty about available healthcare services, and difficulty obtaining a family doctor. These obstacles often hinder their ability to receive timely and effective care.

Underrepresentation in Healthcare Leadership

The underrepresentation of racialized healthcare professionals and decision-makers has significantly contributed to gaps in culturally competent care. This lack of diversity has limited the healthcare system's ability to effectively respond to the unique needs of diverse communities, resulting in less personalized care, poor understanding of cultural nuances, and challenges in addressing systemic barriers.

Addressing Gaps in Preventive Care Knowledge

Many racialized communities identified a gap in knowledge about preventive care, which contributed to late diagnoses and worsened health outcomes. There was a strong recommendation for increased investment in community-based healthcare initiatives to provide localized, culturally competent care, and to address this knowledge gap by promoting education and awareness about preventive measures.

Limited Integration of Traditional and Holistic Medicine

Many communities incorporate traditional remedies alongside Western medicine, but healthcare providers frequently overlook, dismiss, or even discourage these practices. By fostering greater integration of holistic approaches, healthcare systems can build stronger trust with patients, leading to improved adherence to treatment plans and better overall health outcomes.

Digital and Technological Barriers

The increasing reliance on virtual healthcare has created challenges for individuals with limited digital literacy, poor internet access, or discomfort using telehealth services. This has led to disparities in access, particularly among older adults and low-income individuals.

6.2 UNIQUE BARRIERS AND DISTINCT HEALTHCARE EXPERIENCES OF EACH COMMUNITY

While many common barriers were observed across all communities, some challenges were more pronounced for certain racialized groups, while others were entirely unique to specific communities, reflecting their distinct healthcare needs, cultural practices, historical experiences, and social determinants of health that shaped their interactions with and access to healthcare systems.

South Asian Communities

South Asian participants identified several unique barriers to healthcare, including gaps in healthcare literacy, difficulty navigating the system, and a lack of awareness of available services. Chronic disease management, particularly for conditions like diabetes and cardiovascular diseases, was a key concern, as dietary recommendations and treatment plans often failed to account for cultural and religious needs. Mental health stigma within the community also discouraged individuals from seeking support. The strong influence of family in healthcare decisions sometimes prevented individuals from seeking professional care, while a preference for traditional healing practices, such as herbal treatments and spiritual healing, often conflicted with conventional medical approaches.

Black and African Caribbean (BAC) Communities

BAC individuals revealed significant challenges accessing healthcare during the COVID-19 pandemic, including overcrowded facilities, resource shortages, and systemic racism. Many felt the healthcare system ignored their needs, with experiences of unconscious bias and cultural insensitivity. Participants also expressed distrust in the vaccine and the healthcare system due to historical oppression and injustices. For many, the pandemic exacerbated mental health issues, especially due to isolation and lack of support. Communication from government and healthcare bodies was seen as inconsistent, confusing, and not culturally responsive.

LatinX Hispanic Communities

Language barriers were a significant challenge for LatinX Hispanic individuals, particularly among non-English-speaking immigrants. Limited access to Spanish-speaking healthcare providers and interpreters led to miscommunication and suboptimal care. Additionally, undocumented migrants faced severe healthcare access restrictions, relying primarily on emergency services due to lack of insurance coverage. Cultural stigma around mental health also prevented many from seeking necessary support. Access to maternal and reproductive healthcare was another area of concern, with many reporting inadequate culturally competent services.

Middle Eastern and North African (MENA) Communities

MENA individuals face significant barriers in accessing healthcare, including high levels of discrimination, language barriers, and a lack of culturally competent care. Challenges navigating the healthcare system—such as long wait times, unclear referral processes, and limited Arabic-speaking providers—impact timely and effective treatment. Chronic conditions like diabetes, heart disease, and mental health issues are common, with many community members expressing low confidence in managing these illnesses due to gaps in health education and limited culturally relevant resources. Mental health remains a critical concern, with stigma and a lack of culturally appropriate services discouraging people from seeking support.

East Asian Communities

The exclusion of Traditional Chinese Medicine (TCM) from mainstream healthcare, along with the lack of insurance coverage for TCM services, led many individuals to feel their cultural practices were not supported by the system, discouraging them from seeking conventional medical care. Experiences of racism and discrimination during the COVID-19 pandemic also deepened mistrust in the healthcare system, making individuals hesitant to seek care. Additionally, many respondents preferred healthcare providers who understood their cultural dietary habits and incorporated traditional healing practices. Elderly individuals in these communities faced increased social isolation, exacerbating age-related health issues like dementia and mobility concerns, which made accessing appropriate care even more difficult.

This comparative analysis emphasizes the need for a deeper understanding of the diverse and often complex barriers that racialized communities face in accessing healthcare. The unique challenges encountered by each group reflect a combination of cultural, historical, and systemic factors that must be addressed through more targeted, culturally competent approaches. To achieve meaningful progress, healthcare policies and interventions must be reformed to prioritize inclusivity, ensuring that services are not only accessible but also respectful of the intersectionality and lived experiences of individuals. The following section will outline key recommendations for improving healthcare delivery, strengthening community involvement, and exploring future areas of research to better address the needs of racialized communities.

RECOMMENDATIONS

7.1 POLICY RECOMMENDATIONS FOR HEALTHCARE SYSTEMS

To address the healthcare disparities faced by racialized communities, the following policy recommendations are proposed to ensure equitable, accessible, and culturally competent healthcare services. These recommendations are especially relevant to key healthcare institutions, including Ontario Health, medical schools such as the University of Toronto Faculty of Medicine, hospitals, and community health centers. Additionally, public health agencies like Public Health Ontario, healthcare professional organizations such as the College of Physicians and Surgeons of Ontario and Ontario Nurses Association, as well as research institutes like the Canadian Institutes of Health Research, play an essential role in shaping and implementing these policies. The Ontario Ministry of Health is also critical in guiding these initiatives and supporting their integration across the healthcare system.

ENHANCE LANGUAGE ACCESSIBILITY AND COMMUNICATION

- **Recruitment and Training:** Increase the number of healthcare providers who speak languages spoken within diverse communities, such as Arabic, Bengali, Spanish, Mandarin, and others, to break down language barriers. Additionally, offer language training programs for existing healthcare staff to improve communication and reduce reliance on interpretation services.
- **Digital and Printed Resources:** Expand the availability of multilingual health portals and distribute translated health materials to ensure accurate and accessible information for patients with limited English proficiency.

RACE-BASED DISAGGREGATED DATA COLLECTION AND REPORTING

- **Disaggregated Data for Health Outcomes**: Collecting detailed, race-based disaggregated data is critical for understanding the nuances of health disparities. This data should be used not only to measure outcomes but to guide funding decisions and resource allocation. The lack of race-based data often hinders the development of targeted policies.
- **Patient-Reported Outcome Measures (PROMs)**: Include measures that reflect how patients from racialized communities experience care, including their sense of dignity, trust in providers, and satisfaction with cultural competency.

CULTURAL COMPETENCY, ANTI-RACISM EDUCATION, AND INTEGRATION OF TRADITIONAL HEALING PRACTICES

- **Mandatory Cultural Competency Training:** Implement mandatory cultural competency training for healthcare providers to ensure they not only understand but also respect the diverse cultural beliefs and practices of their patients. This includes recognizing cultural health practices, addressing biases that may affect care delivery, and adapting care approaches to meet the unique needs of diverse populations.
- **Anti-Racism, Anti-Oppression, and Anti-Discrimination Education:** Require healthcare professionals to undergo regular training on recognizing and addressing racial bias, systemic racism, and other forms of oppression to reduce disparities and discrimination in care. This should include specific modules addressing the unique health challenges faced by Black, Indigenous, and racialized communities.
- **Integration of Evidence-Based Traditional and Holistic Healing in Healthcare:** Ensure healthcare education includes the integration of evidence-based traditional and holistic healing practices alongside Western medical approaches. This will equip healthcare providers with the knowledge to understand, respect, and work collaboratively with patients who prefer traditional or holistic care, while ensuring patient safety and enhancing care effectiveness.

INCLUSIVE HEALTH COVERAGE AND FINANCIAL SUPPORT

- **Insurance Coverage Expansion:** Expand insurance coverage to include a broader range of services, such as traditional medicine and mental health support, particularly for marginalized groups like immigrants, students, and individuals with precarious status.
- **Financial Support Programs:** Create subsidized healthcare programs for low-income and uninsured individuals, especially for chronic conditions that require long-term management. This includes ensuring that health benefits are extended to those without permanent status, such as international students and temporary workers.
- **Insurance for Mental Health:** Ensure that mental health services, including therapy and counseling, are covered under basic healthcare insurance for all, to address the significant gap in mental health support for marginalized groups.

STREAMLINE HEALTHCARE ACCESS AND REDUCE WAIT TIMES

- **Expand Healthcare Infrastructure:** Increase the availability of healthcare services by expanding community health centers, introducing mobile clinics, and improving the recruitment of bilingual healthcare providers to reduce wait times and increase service accessibility in underserved areas.
- **Operational Reforms:** Implement reforms within clinics and hospitals to streamline appointment scheduling, reduce wait times, and improve resource allocation, ensuring timely care for all patients, particularly those with urgent health needs.
- **Access to Digital Health Tools**: Expand programs to ensure equitable access to digital health platforms and virtual care, particularly in underserved areas. Promoting digital literacy in racialized communities can ensure these populations are not excluded from modern healthcare services.

PROMOTE HEALTH EDUCATION AND PREVENTATIVE CARE

- **Community-Based Health Education Programs:** Launch programs that focus on chronic disease prevention, mental health awareness, and nutrition, with a particular focus on addressing health risks prevalent in racialized communities.
- **Cultural Sensitivity in Health Campaigns:** Design health education initiatives that address cultural misconceptions about healthcare and promote the importance of regular check-ups, early intervention, and vaccination.
- **Age-Specific Health Education:** Tailor health education programs for different age groups, focusing on youth empowerment in areas like sexual health and mental health, and provide seniors with age-sensitive care education.

STRENGTHEN MENTAL HEALTH SERVICES

- **Culturally Competent Mental Health Support:** Expand access to mental health services tailored to the cultural needs of racialized communities, addressing issues like stigma and trauma, and integrating these services into primary care settings to normalize access.
- **Promote Mental Health Literacy:** Launch mental health literacy campaigns to educate individuals and families about recognizing symptoms and seeking help, aiming to reduce stigma and encourage earlier intervention.

ADDRESS WORKFORCE REPRESENTATION AND TRAINING

- **Increase Representation in Healthcare Professions:** Recruit and support more professionals from racialized and marginalized communities in healthcare fields, particularly in roles like family physicians, mental health professionals, and healthcare leadership, to ensure more culturally informed care and improve community trust in the healthcare system.
- **Develop Mentorship and Scholarship Programs:** Create mentorship opportunities and scholarships for racialized students pursuing healthcare careers, with an emphasis on bilingual medical training and early career exposure through internships or workshops.

BUILD COMMUNITY PARTNERSHIPS AND TRUST

- **Engage Community Leaders:** Actively involve trusted community leaders in shaping healthcare policies and outreach efforts. Building strong relationships between healthcare systems and community organizations is crucial for improving health outcomes and increasing trust in healthcare institutions.
- **Community Feedback Mechanisms:** Develop systems that encourage community members to provide feedback on healthcare services, ensuring that policies and programs are continuously adapted to meet the evolving needs of racialized communities.

TACKLE STRUCTURAL HEALTH INEQUITIES

- **Implement National Health Strategies for Racialized Groups:** Develop coordinated, national health strategies to address the specific health challenges faced by racialized communities. This includes initiatives focused on improving access to care, education, and culturally relevant interventions.
- **Focus on Equity in Health Research:** Ensure that healthcare research reflects the experiences and needs of marginalized communities by prioritizing funding for research on diseases and conditions disproportionately affecting racialized populations, and ensuring that healthcare providers are trained to recognize how these conditions manifest in different demographic groups.

By addressing these interconnected policy areas, healthcare systems can ensure that all individuals, regardless of race, ethnicity, or background, have equitable access to high-quality, culturally sensitive care. This comprehensive approach will help eliminate barriers to healthcare and improve overall health outcomes for marginalized populations.

7.2 COMMUNITY-BASED INTERVENTIONS AND SOLUTIONS

To reduce healthcare barriers in racialized communities, community-based interventions should focus on enhancing accessibility, addressing systemic gaps, and empowering individuals through culturally appropriate and preventive healthcare. These recommendations are intended for community leaders, grassroots organizations, faith-based groups, local advocacy groups, and racialized individuals who play an active role in their communities. The goal is to support communities in addressing their own healthcare needs, ensuring solutions are culturally relevant and driven by those who are directly impacted. The recommendations include:

ADDRESS LANGUAGE BARRIERS

- **Expand Multilingual Healthcare Services**: Hire bilingual/multilingual staff and provide translation services to improve patient-provider communication, reduce reliance on interpreters, and build trust.
- **Community-Led Interpretation Programs**: Train community members as interpreters for non-urgent healthcare settings to ensure culturally sensitive and trust-building interpretation services.
- **Language Support in Outreach**: Develop multilingual materials (brochures, online content, and campaigns) to inform individuals about available healthcare services, health rights, and how to navigate the system.

SIMPLIFY HEALTHCARE ACCESS

- **Healthcare Navigation Assistance:** Partner with legal aid organizations to assist immigrants, undocumented individuals, and low-income populations with navigating healthcare-related documentation and processes.
- **Mobile Health Clinics:** Develop mobile healthcare clinics to serve underserved areas, providing essential services like screenings, immunizations, and preventative care.
- **Reducing Economic Barriers:** Advocate for subsidies and expand access to affordable healthcare services, including sliding-scale fees, free or low-cost clinics, and partnerships with pharmaceutical companies to reduce medication costs.
- **Health Insurance Advocacy:** Work to expand public healthcare coverage to include uninsured or underinsured individuals, particularly those dealing with chronic conditions or complex health needs.

CULTURAL SENSITIVITY AND INTEGRATION IN HEALTHCARE

- **Culturally Tailored Health Education:** Develop workshops and educational campaigns that align with community cultural values and practices. These initiatives should focus on preventive care, vaccinations, mental health awareness, chronic disease management, and the importance of regular check-ups to empower individuals with relevant and accessible health information.
- **Bridge Traditional and Modern Healthcare:** Recognize the role of traditional and alternative healing practices in many racialized communities. Fostering collaboration between conventional healthcare providers and traditional healers can build trust, enhance patient engagement, and improve overall health outcomes.

BUILD COMMUNITY-CENTERED HEALTH ACCESS AND EDUCATION

- **Train and Expand Community Health Workers & Ambassadors:** Provide funding and training for community health workers and trusted community leaders who understand the cultural and linguistic needs of racialized populations. These individuals can serve as both health navigators and ambassadors, promoting awareness, facilitating connections to healthcare services, and encouraging proactive health behaviors.
- **Enhanced Referral Networks:** Strengthen referral systems between healthcare providers, community organizations, and public health agencies to ensure access to culturally competent care for racialized communities. Partnerships with grassroots organizations can streamline referrals to multilingual providers and specialized services, improving access for those hesitant to engage with mainstream healthcare.
- **Joint Health Initiatives:** Organize regular information sessions, webinars, and health events in partnership with local businesses, cultural organizations, and healthcare providers, pooling resources to increase access and outreach. These initiatives will educate individuals on navigating the healthcare system, understanding their rights, and offering free screenings, vaccinations, and health education.
- **Public Awareness Campaigns:** Develop and launch community-centered campaigns that deliver accurate, accessible, and culturally relevant health information. These campaigns should cover key topics such as preventive care, mental health, chronic disease management, and navigating healthcare systems, including insurance. In addition to dispelling myths and misconceptions, they should promote proactive health behaviors and increase awareness of available services.

SELF-GOVERNANCE AND EMPOWERMENT

- **Community-Led Research and Policy Development:** Empower communities to lead health research and policy initiatives related to their own health outcomes. This ensures that decision-making is led by those with lived experience, promoting more relevant and effective interventions.
- **Collect Disaggregated Data:** Collect and analyze race-based disaggregated and cultural data to identify disparities within specific subpopulations. This data should guide the development of targeted interventions and inform public health priorities.
- **Qualitative Research for Contextualization:** Use qualitative research methods to collect insights on health disparities and experiences within the healthcare system, including focus groups, interviews, and community-based storytelling.

REDUCE MISTRUST AND IMPROVING ENGAGEMENT

- **Build Trust through Community Healthcare Ambassadors:** Deploy trusted members of the community as healthcare ambassadors to help individuals navigate the healthcare system, reduce mistrust, and improve engagement with healthcare services. With training in effective communication and cultural competence, ambassadors can foster meaningful connections, address barriers to care, and promote proactive health-seeking behaviors within their communities.
- **Build Trust Through Cultural Competency:** Healthcare providers should receive ongoing training in cultural humility, anti-racism practices, and ethnocentric biases. This will ensure that care providers are better equipped to serve diverse populations and address systemic barriers to care.
- **Collaborative Health Education and Outreach:** Partner with healthcare providers and trusted community leaders to create health initiatives that address systemic racism and resonate with community values. Working with faith leaders, grassroots organizers, and other trusted figures can help deliver messages that build trust, reduce mistrust, and improve engagement by making healthcare more accessible and culturally relevant.

EXPAND HEALTHCARE ACCESS BEYOND THE TRADITIONAL SYSTEM

- **Expand the Role of Non-Physician Providers:** Increase the roles of nurse practitioners, pharmacists, and other non-physician providers to alleviate the burden on family doctors and ensure access to care, especially in areas with a shortage of physicians.
- **Utilize Technology for Healthcare Delivery:** Use telemedicine and virtual care options to expand access to healthcare, particularly in remote or underserved areas. This allows individuals to receive consultations, prescriptions, and follow-up care without the need for physical visits.
- **Home-Based Healthcare Initiatives:** Implement home visit programs, where healthcare professionals are paired with community volunteers to provide culturally competent care, conduct wellness checks, and offer preventative services in patients' homes.

CREATE TAILORED MENTAL HEALTH SUPPORT

- **Culturally Relevant Mental Health Services:** Develop mental health programs and resources that are culturally specific and linguistically accessible. Services should aim to reduce stigma, educate communities about mental health, and offer therapy options that align with cultural norms and practices.
- **Community-Based Support Networks:** Create peer-led support groups, including faith-based groups, for individuals dealing with mental health issues, substance abuse, or trauma. These networks should focus on providing a safe space for dialogue and mutual support.
- **Trauma-Informed Care:** Integrate trauma-informed care practices into community health programs to address the mental and physical health consequences of historical and systemic violence, including the effects of racism, displacement, and discrimination.

These community-based interventions and solutions aim to strengthen healthcare access, improve trust in the system, and reduce health disparities in racialized communities. By focusing on culturally relevant care, empowering communities, and fostering collaborations across healthcare and community organizations, these recommendations seek to create a more equitable healthcare system for all.

7.3 FUTURE AREAS OF RESEARCH

While the findings from this study offer valuable insights, further research is needed to address the remaining gaps in healthcare disparities. The following areas should be prioritized to enhance the understanding of healthcare disparities and improve access to services for marginalized populations:

UNDERSTAND THE LONG-TERM HEALTH IMPACTS OF DELAYED CARE

Research should explore the long-term health outcomes associated with delayed care, particularly regarding chronic conditions such as diabetes, hypertension, and mental health disorders. This would help quantify the impact of barriers and identify areas where early intervention could prevent more severe health outcomes.

THE EFFECTIVENESS OF CULTURALLY TAILORED HEALTH PROGRAMS

Future studies should evaluate the impact of culturally tailored health education programs on health outcomes. Research should focus on whether these programs lead to improved healthcare engagement and reduced rates of preventable diseases in marginalized populations. Further work is needed to identify what specific cultural factors make these programs more effective.

IMPACT OF MENTAL HEALTH STIGMA ON HEALTHCARE UTILIZATION

Mental health remains a significant concern, especially for youth and seniors. Further research is needed to assess how stigma surrounding mental health care affects utilization within marginalized communities. This will help explore effective interventions to reduce these barriers and increase access to mental health services.

EFFICACY OF COLLABORATIVE MODELS BETWEEN COMMUNITY ORGANIZATIONS AND HEALTHCARE PROVIDERS

Future research should assess the outcomes of partnerships between community organizations and healthcare providers. Studies should focus on the benefits and challenges of these collaborations in improving healthcare access and quality for marginalized communities, as well as examining the sustainability of these partnerships.

EXPLORE THE ROLE OF SOCIAL DETERMINANTS IN HEALTH INEQUITIES

Research should explore how socio-economic factors such as income, housing, and employment status contribute to healthcare inequities. Understanding the ways in which these factors intersect with race, ethnicity, and immigration status is critical for developing interventions that address broader determinants of health.

HEALTHCARE ACCESS FOR IMMIGRANTS AND MIGRANTS

There is currently very little information and policy available to advocate for the specific needs of immigrants, particularly those with precarious status or those who are newly immigrated. Discrimination, racism, and refusal of care are issues that face these populations. Future research should explore their healthcare needs, focusing on cultural barriers, language challenges, and access to services that cater to the distinct experiences of newcomers. This research could inform new policies that address the unique needs of these individuals, including those without permanent status.

SYSTEMIC RACISM IN HEALTHCARE

While systemic racism was identified as a factor influencing health outcomes, further research should examine its deeper roots within healthcare systems. This includes studying how marginalized communities experience discrimination, not only from healthcare providers but also within institutional structures. Understanding how this affects health outcomes can provide data for cultural-sensitivity and anti-racism training for healthcare professionals and inform policy changes that create discrimination-free healthcare environments.

LONG-TERM IMPACT OF LIMITED HEALTHCARE ACCESS ON MENTAL HEALTH

Research is needed to understand the cumulative effects of limited access to healthcare on mental health, particularly within marginalized communities. Studies should investigate how lack of access to mental health services, delayed care, and cultural insensitivity affect long-term psychological well-being, and explore potential solutions for better integration of mental health care into primary healthcare settings.

CULTURALLY COMPETENT CARE MODELS

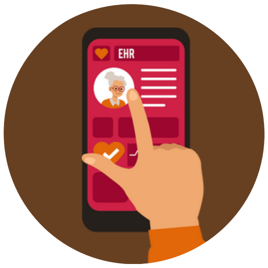
Research should explore effective models of culturally competent care and how healthcare systems can provide better care for diverse populations. This includes assessing what constitutes cultural competence training and how it can be adapted to various healthcare settings. Additionally, research should examine how healthcare professionals' cultural competence influences patient engagement and overall health outcomes.

LANGUAGE BARRIERS AND HEALTHCARE UTILIZATION

Research on language barriers in healthcare is essential to understanding how communication difficulties affect healthcare utilization. Studies should examine the effectiveness of bilingual services, the role of interpreters, and the impact of language proficiency on health outcomes. This research could lead to the development of better practices and policies to reduce language-related disparities in care.

HEALTH LITERACY AND PREVENTION PROGRAMS

Further research is needed on the role of health literacy in preventing chronic diseases and promoting health equity. This includes studying how health literacy varies across different racial and ethnic groups and understanding how improving health literacy can increase healthcare utilization and engagement in prevention programs. Additionally, the research should focus on how health literacy impacts decision-making and health behaviors in diverse populations.



THE IMPACT OF DIGITAL HEALTH TECHNOLOGIES

The use of digital health technologies, including telemedicine, health apps, and electronic health records, can significantly improve healthcare access. However, research is needed to explore how these technologies are adopted by marginalized communities, the barriers they face in using these technologies, and how digital health can be integrated into community-centered care models to promote equity in healthcare.

FUTURE RESEARCH DIRECTIONS FOR OTHER RACIALIZED COMMUNITIES

While this study primarily focused on a specific subset of marginalized communities, future research should extend to other racialized groups, such as Indigenous peoples and Southeast populations. This will provide a more comprehensive understanding of healthcare disparities across different groups, identify unique challenges, and inform development of targeted, culturally relevant interventions to improve access and outcomes for these groups.

By addressing these critical areas of research, we can build a deeper understanding of healthcare disparities, identify the underlying factors contributing to these inequities, and develop more targeted, effective interventions. This will ultimately improve healthcare access, outcomes, and the overall well-being of marginalized communities.

CONCLUSION

Racialized communities in Ontario continue to face persistent health inequities due to systemic barriers within the healthcare system, such as language barriers, financial constraints, and long wait times. These challenges are exacerbated by a lack of multilingual providers, culturally appropriate mental health services, and underrepresentation in healthcare leadership. Additionally, cultural, historical, and socio-economic factors create unique disparities for different groups, including BAC individuals, South Asians, and MENA populations, who experience heightened discrimination in medical settings, leading to mistrust and reluctance to seek care.

The disparities in chronic disease management, maternal health, and mental health access across racialized communities highlight the urgent need for race-conscious policies, expanded preventative care programs, and stronger community partnerships to bridge these healthcare gaps. The underutilization of traditional healing practices, lack of insurance for holistic healthcare options, and digital literacy barriers further indicate the need for more inclusive healthcare strategies.

Addressing these challenges requires a multi-pronged approach, combining policy reform, community-driven interventions, and continued research. Recommendations emphasize the importance of enhancing language accessibility, implementing race-based data collection, and expanding cultural competency training to reduce systemic barriers in care delivery. Additionally, improving financial support programs, increasing workforce diversity in healthcare professions, and strengthening trust between racialized communities and healthcare institutions are essential to achieving health equity.

Beyond policy reform, community-based solutions such as mobile health clinics, culturally tailored mental health programs, and patient-centered outreach initiatives are critical in ensuring equitable access to healthcare. Partnerships between healthcare institutions and grassroots organizations can play a transformative role in bridging gaps in service delivery and empowering racialized communities to engage more confidently with the healthcare system.

Future research should prioritize race-based disaggregated health data collection, studies on culturally competent care models, and the long-term health impacts of systemic barriers to develop evidence-based solutions. Moreover, integrating traditional healing practices, improving telehealth accessibility, and addressing the socio-economic determinants of health will be key in fostering a more inclusive and responsive healthcare system.

Ultimately, progress depends on sustained investment, targeted policies, and continued collaboration with affected communities. By embracing inclusive strategies and prioritizing racialized voices in healthcare planning, Ontario can move toward a more equitable system where all individuals receive respectful, effective, and culturally attuned care.

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RACIALIZED HEALTH
WORKING GROUP

Public Health
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