Building INCLUSIVE Age-friendly Cities: Supporting Racial and Ethnocultural Needs of Residents in Urban Long-term Care Homes

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The World Health Organization’s Ag-Friendly Cities Guide (2007) identified core characteristics of age-friendly cities which focused on the following 8 domains of urban life:

- Outdoor Spaces and Buildings
- Transportation
- Housing
- Social Participation
- Respect and Social Inclusion
- Civic Participation and Employment
- Communication and Information
- Community Support and Health Services

- Despite this, there is a paucity of research that has examined age-friendliness in diverse communities, overlooking the diversity of experiences, preferences, and needs within culturally diverse aging populations.
  - For example, Canada is home to over 6.8 million immigrants who will soon constitute 30% of Canada's ageing population (Statistics Canada, 2017).
- For Immigrant and BIPOC older adults, the challenges of ageing intersect and exacerbate vulnerabilities related to ethnicity, culture, race, income, language, education and literacy, gender, sexuality and citizenship status.
Mental Health of Immigrant and BIPOC Populations

- Immigrant and BIPOC populations are more prone to known social determinants that contribute to mental health problems and illnesses while simultaneously facing barriers to accessing mental health programs and services, including:
  - Stigma
  - Language barriers – more than 4.9% of Toronto’s population, 4.1% of Ontario’s population, and 1.9% of Canada’s population do not have knowledge of neither English or French
  - Lack of culturally-sensitive services and programs
  - Lack of BIPOC Representation among Health Care decision-makers and practitioners
- Ethnocultural-minority seniors face both racial/cultural and age-based marginalization
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Methodology

- Conducted a scoping review of mental health programs for older adults for all the major cities in Canada, namely, Toronto, Ottawa, Waterloo, Vancouver, Edmonton, Montreal, Winnipeg, Halifax, and Calgary
- Conducted thematic analysis to identify gaps and opportunities within mental health programs for older adults offered
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Program Gap 1: Lack of Culturally-Sensitive, Targeted Programs

- Despite the unique mental health barriers that Immigrant and BIPOC older adults face, the vast majority of mental health programs are very broad in scope and scale and overlook the diversity of experiences, preferences, and needs within culturally diverse aging populations.

- Most funding opportunities tend to reward mental health programs and initiatives that are large scale and wide scoped.
  - While this allows for the largest number of seniors to be reached, this leaves the ethnocultural-minority older adult population underserviced as their needs are left unmet by general, “mainstream” mental health programs.
Programs Gap 2: Lack of Systematic Evaluation of Programs

- While there are vast mental health programs offered, there is a paucity of systematic evaluation that looks at the outcomes and participation rates of these programs.
- This lack of systematic evaluation hinders advancements to existing mental health research and initiatives, and our ability to adapt programs to meet the changing needs of the older adult population.
Programs Gap 3: Lack of Active Outreach and Inclusive Marketing

- Few programs engage in active outreach to reach older adults and depend on older adults seeking out the programs themselves or to be notified of them, which disproportionately impacts ethnocultural-minority older adults as they lack networks that would inform them of available programs.
- Promotional materials do not reflect the culturally diverse aging population which may discourage BIPOC older adults from participating.

People are more likely to consider, or even purchase, a product after seeing an ad they consider to be diverse or inclusive.

- 64% of those surveyed said they took some sort of action after seeing an ad that they consider to be diverse or inclusive.
- 69% of Black consumers say they are more likely to purchase from a brand whose advertising positively reflects their race/ethnicity.
- 71% of LGBTQ consumers said they are more likely to interact with an online ad that authentically represents their sexual orientation.

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Adopting a Social Exclusion Lens to Program and Service Development and Delivery

- Social Exclusion is defined as “[t]he lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political terms. It affects both the quality of life of individuals and the equity and cohesion of society as a whole” (Levitas et al., 2007).

- A social exclusion lens addresses the ways in which bias and discrimination are embedded in policies, programs, and processes.

Questions to Consider...

- Who are the individuals/groups often missing from your program?
- What are the barriers that limit their participation? Which of those barriers can we address and how?
- How can we capture these groups’ experiences? e.g. would surveys/questionnaires be sufficient to capture this groups’ experience?
- What steps are you taking to ensure inclusive outreach? Are promotional materials accessible and representative of your target group?
- What additional supports are needed during the programs to ensure accessibility of the program?
- Were there successful outcomes with the modifications made? What lessons can be drawn for future programs?
Collecting Disaggregated Data - “you can’t respond to a challenge until you can name it and identify what needs to change” (The Black Experiences in Health Care Symposium, 2020)

- The older adult population is often cast as a cultural monolith which conceals significant differences within culturally diverse older adult population
- Despite effective data collection tools and evidence of the value of data collection, most publicly available data does not provide the level of granularity needed for an intersectional analysis of issues affecting the Immigrant and BIPOC older adult population leaving those with multiple identities underserviced
- Collecting, documenting, analyzing and publicly reporting disaggregated data is key to conceptualizing, designing, and implementing effective interventions.
Promoting BIPOC Representation among Health Care Decision-Makers and Practitioners

- Lack of longitudinal socio-demographic and race-based data on representation of BIPOC populations among health care decision-makers and practitioners
  - e.g., Until 2007, the National Physician Survey only collected data on the age and sex of medical students and residents (even then, the survey was voluntary with a low response rate).

Systemic issues are clear:

- Of Canada’s 39 federal health ministers between 1919 to 2017, 1 identifies as First Nations, 1 identifies as Racialized
- Of Ontario’s 31 provincial health ministers between 1924 to 2017, NONE were from BIPOC populations
- ≈ 10 percent of Psychologists in Canada identify as BIPOC (2,390/23,485)
- Dr. Chika Oriuwa was the ONLY Black medical student out of a total of 259 students in the class of 2020 at the University of Toronto - Toronto is home to Canada’s largest Black population (36.9% of Canada’s Black population)
Thank You!

- Professor Marieme Lo
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- Check out the Age Actively Initiative website: ageactivelyinitiative.com