INVESTIGATING THE HEALTH AND WELLBEING OF AGING BLACK WOMEN IN CANADA

AGING AT THE INTERSECTION OF RACE AND GENDER:
INVESTIGATING THE HEALTH AND WELLBEING OF AGING BLACK WOMEN IN CANADA

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Abstract

Inequities in health systematically put groups of people who are socially disadvantaged due to being poor, female, a particular age and/or a member of a disenfranchised racial group at further disadvantage. Black people comprise 3% of Canada's population and are more likely to be exposed to risk but less likely to seek preventative care. Older Black women face further disadvantages because of multiple intersecting factors related to their race, gender, and age. This dissertation presents findings from a sequential mixed methods study conducted to understand the health, wellbeing, and aging experiences of older Black women aged 55 and older in Canada. The study design and data analysis were informed by two theoretical frameworks: intersectionality and the life course perspective. First, using data from the Canadian Community Health Survey (CCHS), several multilevel logistic regression models were used to establish and compare association between racial identity and inequalities in hypertension, diabetes, cancer, chronic obstructive pulmonary disease (COPD), asthma, self-rated health, and self-rated mental health between Black and White men and women aged 55 and older. Second, qualitative phenomenological interviews were conducted simultaneously to gain a deeper understanding of the health and wellbeing of older Black women and factors that have influenced their health and wellbeing across their life course. These were factors that could not be deeply explored through the CCHS. Twenty-seven semi-structured interviews were conducted with Black women aged 55 and older living in the Greater Toronto Area. Following the conclusion of the first two phases, a thematic content analysis was completed for eight policy documents to determine whether and how the need for adequate housing among older Black women was addressed. These needs were identified in the semi-structured interviews conducted in the previous qualitative phase of the study. Overall, this study demonstrated that there are opportunities for additional research to understand the diverse aging

experiences of women across their life course. It also demonstrated the opportunities for the use of intersectionality in mixed methods studies. Doing so will bridge an evidence gap as well as contribute to addressing health and social programming needs among understudied populations.

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As I reflect on this journey and where it has taken me, I am amazed to see where I am today in comparison to where I started four years ago. My supervisor, Dr. Lydia Kapiriri, has been instrumental in guiding me as I navigated my way through this process. Dr. Kapiriri has been extremely generous with her time by meeting with me frequently, providing constructive feedback, and always finding opportunities for me to grow as an academic researcher. She always challenged me and pushed me to do more so that I could reach my full potential and think critically about the decisions I made related to my research. I will forever be grateful for Dr. Kapiriri's support and encouragement that always came in moments where I needed them the most. I am also very grateful for her patience and professionalism during difficult moments.

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of the study's mixed methods approach. I am very grateful to have had the support and guidance of both Dr. Grenier and Dr. Griffin.

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The first study in this dissertation was made possible by Dr. Senay Asma, Research Associate, who taught me so much about coding in R and understanding how to execute the commands. I

cannot express how grateful I am for Dr. Asma's support in implementing the analysis for the quantitative component of this study and teaching me how to code in R. I want to also thank her for sharing resources that furthered my understanding of the software and how to manage the data that I was using from the CCHS. I would also like to thank Professor Housne Begum, who guided me through the quantitative data interpretation and was very generous with her time and pointing me towards resources that would help me in the development of this work.

The phenomenological study was possible only with the support of several organizations that aided in the recruitment of participants for this study. I would like to thank the Jamaican Canadian Association, the Scarborough Centre for Health Communities, Carefirst, Women's Health in Women's Hands, and the 100 Most Successful Black Women in Canada organization. In addition, several churches in the Greater Toronto Area were instrumental in helping me recruit women for the qualitative interviews that were completed as a part of this study. And thank you also to all the women who graciously participated and took the time to sit with me and tell me their stories. They have all made lasting impressions and have greatly benefited my study!

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Declaration of Academic Achievement

I, Nicoda Foster, am responsible for this thesis in its entirety. Throughout the development of this study, I collaborated with Dr. Lydia Kapiriri to conceptualize the study's design, and Dr. Michel Grignon on the quantitative analysis for the first paper presented as a part of this dissertation. Dr. Lydia Kapiriri, Dr. Michel Grignon, and Dr. Kwame McKenzie, in the capacity as my supervisory committee, also supported the writing process, offering guidance and feedback on multiple drafts of this thesis.

INTRODUCTION

There are opportunities for more integrated analyses on the impact of the intersection of race and gender with interlocking systems of marginalization throughout an individual's life in Canada. Inequalities in health systematically put groups of people who are already socially disadvantaged due to being poor, female, of a particular age, and/or a member of a disenfranchised racial group at further disadvantage. Racial inequalities in health have been one of the most pervasive public health crises that have only recently been categorized as such in Canada (Ferrer, Grenier, Brotman, & Koehn, 2017). Public health theories suggest that, fundamentally, racial inequalities in health in old age are in large part attributable to the accumulation of exposures to specific risk factors such as racism over an extended period (Crystal & Shea, 2003a; Crystal, Shea, & Reyes, 2017; Dannefer, 2003).

Canada has demonstrated its political commitment to bridging gaps in health inequality through cross-sector collaborations that have been largely led by public health organizations. For instance, the Pan-Canadian Public Health Network (PHN) was created to strengthen public health in Canada, including the measurement and reporting of health inequalities. The PHN council endorsed a set of indicators to measure health outcomes, health-related behaviours, and social determinants of health inequalities and recommended that the Public Health Agency of Canada (PHAC), the Canadian Institutes of Health Information (CIHI) and Statistics Canada report on these indicators. CIHI published a report in 2016 using these indicators as a part of its "Trends in Income-Related Health Inequalities in Canada" (Trends report) project. The report highlighted differences in health across three indicators, including smoking, hospitalization of adults for chronic obstructive pulmonary disease (COPD), and fair/poor self-rated mental health (Huston, 2016). Describing or determining whether there are differences in health outcomes between races

in Canada as well as the location and cause of these inequalities is difficult. Comparatively, the factors that lead to differences in health has been well documented and studied in the United States (Ailshire & House, 2011; Brown, Richardson, Hargrove, & Thomas, 2016; Geronimus, Bound, Keene, & Hicken, 2007; Richardson & Brown, 2016; Phelan & Link, 2015).

I present this dissertation as an addition to the body of evidence around the health status and wellbeing of a chronically understudied racialized group, older Black women in Canada. This introduction will outline the rationale for this study by clearly highlighting the history of Black people in Canada, the importance of race, gender, and aging in the study of health and wellbeing, as well as the gaps in the existing evidence related to the health and wellbeing of older Black women in Canada. Further, the role of policy in addressing inequalities will be described. This study's research questions will be presented in conjunction with the methods that were used in the investigation. An overview of each chapter of this dissertation will also be described in this introduction.

The Black Diaspora in Canada

Canadians of African descent or 'Black Canadians' who self-identify as Black immigrants or children of Black immigrants from parts of Africa or the West Indies/Caribbean have lived in Canada since the transatlantic settlement, with the earliest arrival being enslaved people brought from New England or the West Indies/Caribbean. In the early 20th century, the Canadian government had an unofficial policy of restricting immigration by Black people. During the 1960s, immigration policy reforms eliminated preferences for immigrants of European origin and implemented a points-based system for immigrants to ensure maximum employability in an economy where skilled labour was becoming a priority (Milan & Tran, Spring 2004). Immigrants gained points based on criteria such as occupational skills, educational level, knowledge of English

or French, and age. Consequently, the source countries of immigrants became more diversified, including increasing numbers of Black people from the Caribbean and Africa. By 1991, there were 504,300 Black people living in Canada, roughly 1.9% of the total population (Milan & Tran, Spring 2004). This proportion grew, and in 2011 Black people comprised approximately 3% of the nation's population, with Black women accounting for 3% of all Canadian women and 15.3% (n=492,660) of all visible minority women in Canada (Hudon, 2016).

Empirical studies investigating differences in health status among minority groups in Canada have been conducted; however, they typically include only the largest minority groups such as East or South Asians or are geared towards Indigenous Canadians with very few studies focused on Black people. To date, most of the literature on health inequalities among Black Canadian people have not explored the systemic, individual, and community factors, over the population's life course that have contributed to their current health status. Of these studies, very few look specifically at the health of Black women, and even fewer focus on the health of aging Black women. Existing evidence related to the health status of Black women is largely conducted among the African American female population and illustrates the poor health status among the group as compared with other minority female groups (LeBrun & LaVeist, 2013; Ramraj, et al., 2016; Siddiqi & Nguyen, 2010). As Canadians age, Black people will have an increased need for health and social services but are more likely to be socially disadvantaged and are less likely to seek preventative care (Etowa, Bernard, Oyinsan, & Clow, 2007b; Etowa, Wiens, Bernard, & Clow, 2007). Aging Black women face further disadvantages because of multiple intersecting factors such as race, gender, and age.

The gap in research that exists related to the health and wellbeing of older Black women demonstrates that there is a great deal that is still unknown and needs to be investigated. Taking a

comprehensive approach to the study of different factors, over the life course, that lead to inequalities in health can provide rich information to support programming across all ages. This study will address this gap in knowledge about older Black Canadian women's health and factors that may impact their health.

Race as a Determinant of Health

Early definitions of race reflected a more biological understanding of race with little to no acknowledgment of social environments (Williams, 1997). The evolution in the definitions of race over time in the social sciences reflects a growing consensus that racial classification schemes do not reflect genetic homogeneity but rather sociopolitical constructs with strong cultural and ethnic components that have been used to classify differences between people (Williams, 1997). Veenstra (2009) highlights the social importance of race in the measurement of health as it is meant to capture the process of racialization, which is expressed in the form of racism embedded in institutional and state policies as well as displayed by individuals in day-to-day interactions (LaVeist T. A., 1994; Williams, Lawrence, & Davis, 2019). Race has been used as a proxy for other variables that are either known or believed to correlate with race (e.g., socioeconomic status, discrimination, cultural factors, unspecified biological differences among race groups, etc.) (LaVeist T. A., 1994).

The social science literature notes that the persistence of racial inequalities in health are understood in the context of relatively stable racialized social structures that determine differential access to risks, opportunities, and resources that drive health (Williams, Lawrence, & Davis, 2019). David Williams (1997) made the argument that, alongside socioeconomic status and other upstream social factors, racism should be recognized as a fundamental cause of inequities in health. Similarly, in 2015 Phelan and Link published results that expanded their 1995 study that provided

a considerable evidence base where they conceptualize social conditions as "fundamental causes" of disease (Link & Phelan, 1995). The expanded analysis demonstrated multiple racial inequalities in mortality and other health outcomes between Black and White people, supporting the argument that race is a fundamental cause of health inequalities (Phelan & Link, 2015). Race as a fundamental cause of health inequalities was attributed to several factors such as lack of prestige (i.e. status, present in occupational structures), lack of power, lack of beneficial social connections, stress (physiological and health deterioration due to cumulative stress from discrimination – also known as "weathering"), poor quality of care, and neighbourhood effects (Phelan & Link, 2015).

The concept of anti-Black racism has gained more traction in studies of health and health related services in Canada. Anti-Black racism is a specific form of racism, rooted in the history and experience of enslavement, that is targeted against Black people (Dryden & Nnorom, 2021). Existing evidence on health inequality relies on cross-sectional studies that are almost always quantitative, often comparing differences in disparities between Canada and the US largely due to the similarities in the demographic make-up and geographic proximity of the two countries. Also, both Canada and the US are liberal democratic states that use neo-liberal economic policies to regulate markets. In a descriptive analysis of the 2002-2003 joint Canada-USA Survey of Health (JCUSH), Lasser et al. (2006) found that only in the US are non-Whites more likely than White Americans to have self-perceived unmet medical needs, have difficulties with access to medication because of not being able to afford them, and are less likely than White Americans to rate their healthcare as excellent. Another study conducted by Ramraj et al. (2016) was also a comparative study looking at patterns of health inequality between Canada and the US. This study used data collected through the National Health Interview Survey (NHIS) between 2000 and 2010 in the United States and compared its results to data collected through the Canadian Community Health

Survey (CCHS) for the same period (2000-2010) in Canada. The largest health disparities were found between the Canadian Indigenous and White populations with a smaller health gap found between Black Canadians and White Canadians. The finding that Black-White inequalities are more evident in the US than in Canada was explained by the authors as being attributed to the higher proportion of Black immigrants in Canada (that is, the "healthy immigrant" effect that suggests that recent immigrants are healthier than long-standing residents). It can likely be concluded that a large proportion of the respondents to the CCHS who self-identified as "Black" may have been recent immigrants to Canada as the healthy immigrant effect is eroded over time after an extended period of residency in Canada. The authors noted the differences between the health status of African/Black Americans and Black Canadians as being a result of the historical contextual differences between the United States and Canada. Specifically, Black Americans are far more likely than Black Canadians to be descendants of ancestors who had been exposed to the American system of plantation-based slavery, widespread government-sanctioned segregation, and ongoing discrimination and racism reinforced by policies (Ramraj, et al., 2016). While there were some similarities and parallels between the experiences of African Americans and Black Canadians, there were large differences in terms of slavery and the implementation of redlining policies in Canada.

Siddiqi, Shahidi, Ramraj and Williams (2017) used data from the 2013 cycle of the CCHS with an abbreviated version of the validated Williams Everyday Discrimination Scale to measure experiences of discrimination. The study found that White Canadians were six to seven times less likely to be immigrants (Siddiqi, Shahidi, Ramraj, & Williams, 2017). Both Whites and Asians in Canada were nearly half as likely as Black Canadians to be in the lowest income quintiles and were also more likely than Black people to be in the highest income quintile. Black people also

had the highest proportion of reports of experiencing any form of discrimination, followed by Indigenous, Asians, and Whites (Siddiqi, Shahidi, Ramraj, & Williams, 2017). Further analysis for statistical associations between health outcomes and discrimination found that many chronic conditions and their related risk factors were associated with discrimination. For instance, experiencing frequent discrimination was associated with 68% higher odds of having chronic conditions (Siddiqi, Shahidi, Ramraj, & Williams, 2017). Experiencing frequent discrimination was also associated with smoking and infrequent physical activity (Siddiqi, Shahidi, Ramraj, & Williams, 2017). Another cross-sectional study conducted by Veenstra and Patterson (2016) investigated health inequalities among Black Canadian women as a sub-population of their overall analysis. Results demonstrated that Black women were more likely than White women to report diabetes and hypertension and less likely to report cancer (Veenstra & Patterson, 2016). There were significant differences reported in the likelihood of fair/poor health, fair/poor mental health, heart disease, and asthma (Veenstra & Patterson, 2016).

Overall findings from most studies comparing the health status of Black Canadians and White Canadians demonstrate that there are some differences, although they are varied and would suggest that they are highly dependent on context such as differences in social and political structures that affect access to services or opportunities that can improve life circumstances.

Sex, Gender, and Health

Although the terms sex and gender are often used interchangeably, they have distinct meanings. Sex refers to biology whereas gender is a classification based on the social construction of cultural distinctions between males and females (Hernandez & Blazer, 2006; World Health Organization, 2007). Both sex and gender influence risks, health-seeking behaviours, and health

outcomes for men and women, thus influencing their access to healthcare systems and the response of those systems (World Health Organization, 2007).

The relative contributions of gender relations and sex-linked biology to health differences between males and females depend on the specific health outcome under consideration. In some instances, sex-linked biology is the sole determinant of a health outcome, and in other instances gender relations account substantially for observed gender differentials for a given health outcome (McKinlay, 1996). In some instances, sex-linked biology can be obscured by the influence of gender relations in producing health differentials between women and men (McKinlay, 1996; Arber, et al., 2006). For instance, women's lower risk of coronary heart disease (CHD) prior to menopause is often ascribed to the cardio-protective effects of endogenous estrogens (a sex difference) (Arber, et al., 2006). Simultaneously, the male/female differential in heart disease also may reflect a diagnostic artifact – specifically, the under-detection of heart disease among women caused by an unconscious bias among physicians to ascribe the symptoms of a heart attack among premenopausal women to some other disorder (a gender difference) (McKinlay, 1996).

There are other important social factors that contribute to gender inequalities in health. For instance, wage gaps, low occupational status, and poverty are common observations in any analysis of women's socioeconomic status that impact their health (Statistics Canada, 2012; Bierman, et al., 2012). The gender wage gap in turn contributes to the feminization of poverty. The Project for an Ontario Women's Health Evidence-based Report (the POWER study) found that 85% of single-parent households were headed by women and were twice as likely to have lower incomes as those headed by men in similar circumstances (Bierman, et al., 2012). Women, especially female heads of households, are over-represented among poor households in practically every society (Bartley, 2004). These female heads of households are often also racialized. As a

result, the adverse health effects of poverty fall disproportionately on women and their children, and there is clear evidence that demonstrates an association between income and ill health. For instance, in a panel study of income dynamics, post-tax family income was associated with risk of dying among working-age adults even after controlling for education and occupational status, comparing the top income category to the bottom (Duncan, Daly, McDonough, & Williams, 2002). The association between income and mortality has also been described as a "gradient," meaning the excess risks of poor health are not confined to individuals below the poverty line (Bartley, 2004). Rather, an individual's chances of having good health improve with each incremental rise in income (Bartley, 2004).

When combined with other social factors such as race, differences in health between men and women become more nuanced and add an additional layer of complexity. Several cross-sectional studies highlight the multiplicative effect of race and sex among African American women, as well as several qualitative studies and reports that detailed the health experiences of Black Canadian women. Ailshire and House (2011) used an intersectional approach in analyzing the longitudinal and nationally representative American's Changing Lives study (1986-2011/2012) to study social disparities in body mass index (BMI) trajectories. Results showed the greatest increase in BMI was among individuals aged 25-39 and 45-54 during the study period as well as among low-educated and low-income Black women, while high-educated and high-income White men experienced the least BMI growth (Ailshire & House, 2011). Similarly, another study conducted by Richardson and Brown (2016) used an intersectional and life course approach to assess disparities in hypertension prevalence. Findings from the Richardson and Brown study was consistent with findings from Ailshire and House that demonstrated the health disadvantage of Black women compared to other race/ethnicity-gender groups (Richardson & Brown, 2016). These

results were also consistent with an earlier study conducted by Geronimus, Bound, Keene, and Hicken (2007) to describe age patterns of hypertension prevalence in young through middle-aged adults and to test the hypothesis that hypertension prevalence rises more rapidly with age among Black people than Whites in the US. Study outcomes demonstrated that Black/White odds of hypertension increased from 1.71 to 3.12 among individuals between the ages of 15 and 65 (Geronimus, Bound, Keene, & Hicken, 2007). Odds for women increased faster, from 2.11 to 4.04, with Black women having the highest hypertension rates by age 40. Adjustment for income did not change the results (Geronimus, Bound, Keene, & Hicken, 2007).

There are fewer Canadian studies that focus specifically on the health of Black women as compared to those that assess the health and wellbeing of African American women. Etowa, Wiens, Bernard, and Clow (2007) conducted a qualitative study where a total of 237 in-depth one-on-one interviews were conducted with Black Canadian women residing in rural and remote regions in Nova Scotia to investigate their health status, healthcare delivery, and use of health services. Themes emerged from the data that emphasized Black women's multiple roles, perceptions of health, experiences with the healthcare system, factors that affected their health, and strategies they used to manage their health. Black women discussed their experiences with racism and expressed that it caused significant stress which contributed to other issues and conditions such as low self-esteem (Etowa, Wiens, Bernard, & Clow, 2007). Participants explored the connection between racism and health in the context of their experiences with healthcare providers. Some Black women felt that they were treated differently than White women by health professionals. In outpatient clinics, they were made to wait longer than White patients and they felt that their doctors did not believe them, did not present information in an understandable way, did not spend an adequate amount of time with them and would not touch them (Etowa, Wiens,

Bernard, & Clow, 2007). Black women's concerns about their experiences with healthcare were also consistent with a community-based research study conducted by Women's Health in Women's Hands, a community health centre in Toronto (Women's Health in Women's Hands, 2011).

Consequently, to understand the impact of sex and gender on health, it is important to understand that neither are simple categorical variables that are ultimately definable by the presence or absence of the Y chromosome (Committee on Assessing Interactions Among Social, 2006). Rather, it is a multifaceted variable, biologically, psychologically, and socially, with each facet having different effects on health and risk for disease. This study focuses on gender as a classification based on the social construction of cultural distinctions between males and females and how it has shaped the health and wellbeing of older Black women across their life course.

Aging and Health

Health challenges become more complex with aging. The population in Canada, as in many other industrialized countries, is aging. In 2015, 3.2 million of Canada's 5.8 million older adults aged 65 and over were women, accounting for 54.7% of this age group and 17.5% of the overall female population (Hudon & Milan, 2016). According to Statistics Canada (2016), population aging in Canada will gain momentum during the next 15 years. This can be attributed mostly to the movement of the large cohort of baby boomers born between 1946 and 1965 – aged 50 to 69 in 2015 – who are progressing into their later years (Hudon & Milan, 2016). By 2031, projections show that there will be 5.1 million older adult women, representing 53% of the population age 65 years and older, and over 24% of the overall female population (Hudon & Milan, 2016).

Like gender, aging is both a biological and social construct. Psychological changes such as reduction in bone density and visual acuity are a normal part of the aging process. At the same

time, socioeconomic factors such as living arrangements, income, and access to healthcare greatly affect how individuals and populations experience aging. There are several conceptual orientations that have shaped the study of aging, both as a concept and process of life. At the beginning of the 20th century, social scientists began to move beyond the traditional descriptive compilations of physical and pathological manifestations of growing older to construct holistic theories of aging that attempted to integrate the different scientific techniques of biology and sociology (Bengtson & Settersten, 2016). As a result, several theories of aging have emerged that all attempt to explain aging as a phenomenon. Theories of aging have been grouped into three broad categories: biological, psychological, and social. Biological theories of aging are biomedical, focus on genetics, and are built around health and functional capacity with age (Bengtson & Settersten, 2016). An example of a biological theory of aging would include stress theories of aging that would describe the dysfunction of the hypothalamic-pituitary-adrenal (HPA) axis with aging and associated diseases that may arise (Bengtson & Settersten, 2016). Psychological theories of aging are focused on competence, cognition, and personality change with age (Bengtson & Settersten, 2016). Social theories of aging are rooted in anthropological and ethnographical models in studying aging. Social theories also include social constructivism and the life course perspective as examples (Bengtson & Settersten, 2016).

There are both biological and social differences in the aging process for men and women. Biologically, there is increasing evidence across behavioural, neuroanatomical, and neurophysiologic domains that sex differences play a prominent role in modifying the effects of aging on brain function (Gur & Gur, 2002). Overall, research findings generally indicate that age-related decline begins earlier in men than in women (Gur & Gur, 2002). However, rates of specific diseases such as dementia are higher among women and, although not a disease, menopause brings

many physiological changes for women that place them at risk of developing cardiovascular diseases or osteoporosis (Government of Canada, 2010; Committee on Assessing Interactions Among Social, 2006).

As women tend to have longer life expectancies, they are also more likely to assume caregiving roles for their partners and other members at the end of life. As a result, several studies have demonstrated higher rates of caregiver stress, lower physical health, and higher rates of depression among older women compared to older men (Pinquart & Sorensen, 2006). In addition to caregiver stress and burden, older women are more likely than older men to be exposed to poverty due to interruptions or non-participation in the paid labour force during periods of childbirth and when providing childcare, or due to low wages and benefits (Gur & Gur, 2002). In Canada, the median total income from all sources for women aged 65 years and over has followed an upward trend since the mid-1970s. Despite the upward trend, older women still had a lower median income when compared to older men, whose income also increased during the same time (Hudon & Milan, 2016). Consequently, women aged 65 and over are more likely to live in low-income households when compared to their male counterparts (Hudon & Milan, 2016). Although there was some evidence of the income gap decreasing between 1976 and 1995, the gender gap in income among older adults has widened to some extent, as the proportion of older women living in low-income households increased by 11.6% compared with the proportion of older men living in a low-income household (9.1%). By 2015, 16.3% of elderly women were low income, compared with 11.9% of their male counterparts (Hudon & Milan, 2016). As such, aging presents a myriad of challenges that are rooted in not only biology representing the physiological changes, but also changes in the social aspects of individual’s lives. Further, in many instances the aging process is heavily influenced by periods during childhood and adulthood where results typically manifest later in life.

Addressing Equity Gaps through Policy

As a welfare state, Canada seeks to embody traditional egalitarian principles by addressing involuntary inequalities or disadvantages across the population through redistributive policies. The political philosopher John Rawls (1971) and a number of other scholars (Anand, 2002; Chan, 2002; Daniels, 1986) have focused their work on distributive justice. Rawls' articulation of justice as fairness in his seminal work titled "A Theory of Justice" provides the foundation for egalitarian approaches to the distribution of resources for health in decision-making.

Operationalizing Rawl's approach to fairness would require a clear definition of "need." Existing literature defines need in the context of access to health services. In 1974, Donabedian defined need "in terms of phenomena that require medical services" (Acheson, 1978). Donabedian's definition provided the basis for a humanitarian view which implies that when there is human suffering one must do something about it. His definition focuses on the identification of the suffering rather than on how it can be relieved (Acheson, 1978). A second approach, defined as "realistic," states that consideration must be given to the utility of the procedures available to meet the need as well as to the qualities of the population itself (Acheson, 1978). Social policy is aligned to the humanitarian view of need. Social policy is the primary vehicle through which welfare states realize their egalitarian objectives as it seeks to improve the welfare of individuals and families by addressing their need and the conditions that cause inequalities (Shapiro, 2002). Throughout Canadian history, the social policy framework has been composed of efforts to address the sociopolitical rights of marginalized segments of the population (such as labourers, Indigenous people and other visible minority populations, etc.), along with addressing the negative conditions in which people live. Social policy addresses the rights of individuals and the human condition through the creation of national and provincial programs of social support (such as community

programs of support directed toward new immigrants or people with disabilities) and economic support (such as unemployment insurance or family allowance payments) (Shier & Graham, 2014). The sociohistorical context of Canada being originally inhabited by Indigenous people and the division between English and French speakers has greatly influenced the country's social policy development. Changes to the immigration policy and an increase in the number of migrants coming to Canada have further influenced changes in Canadian social policy to reflect not only changes in the country's demographic make-up but also the evolving complexity of the population's needs. Regardless, it is important to note that while being a welfare state, Canada's democracy is infused with liberalist ideals that value free and open markets, and so there may be limits on the extent to which the state can intervene through the implementation of social policy (Shier & Graham, 2014). Policies emphasize remedial measures of redistribution through income security programs and direct support programs that are designed to enable individuals to participate in the Canadian labour market (Shier & Graham, 2014; Shapiro, 2002).

Similarly, the Government of Canada and provincial governments have developed comprehensive policies designed to address the needs of seniors. For instance, the Old Age Security (OAS) program and the Canada Pension Plan (CPP) are two examples of government programs that were created to ensure the financial security of older adults (Sheets & Gallagher, 2012). Programs such as the Targeted Initiative for Older Workers help workers aged 55 and 64 develop their skills and find new work. The ThirdQuarter Initiative helps experienced workers who are over 50 find jobs that match their skills (Government of Canada, 2022). Both programs are designed to enable older adults to actively participate in the labour market. In additon, the federal government of Canada recognized Gender Based Policy Analysis Plus (GBPA+) as a key competency in support of the development of effective policies, programs and legislation since

1995. GBPA+ is an analytical process that provides a rigorous method for the assessment of systemic inequalities, as well as a means to assess how diverse groups of women, men, and gender diverse people may experience policies, programs and initiatives. It also considers many other identity factors such as race, ethnicity, religion, age, and mental or physical disability, and how the interaction between these factors influences the way people might experience government policies and initiatives. Using GBPA+ in evaluating the impact of policies and programs on different populations is an approach used by the federal government but is not mandatory nor has it been completely adopted by the other levels of government in Canada. Further, the approach emphasizes policy implementation however there are opportunities for more intent and direct focus on defining and formulating policies that reflect the complex social realities of most Canadians.

Study Rationale and Objectives

Canadian studies exploring health within the context of race, gender/sex, and age are limited in number. Existing studies emphasize the role of proximal factors, such as behaviours, and distal factors, such as socioeconomic disparities, in shaping health outcomes (Etowa J. W., Bernard, Oyinsan, & Clow, 2007b; LaVeist, Thorpe, Pierre, Mance, & Williams, 2014; LaVeist T. A., 1994; LeBrun & LaVeist, 2013; Lebrun & LaVeist, 2011; Ramraj, et al., 2016; Veenstra & Patterson, 2016; Patterson & Veenstra, 2016). Few studies investigate how these factors intersect to impact health later in life, specifically among older women in the Black Canadian community. The diversity of the aging experience cannot always be ascribed to genetics or life choices but are driven by factors beyond the individual’s control or a lack of options available to individuals (World Health Organization, 2015). Moreover, these distal factors vary according to personal characteristics including race and gender/sex (World Health Organization, 2015). These nuanced

differences may be hidden when reporting health outcomes using aggregated racial and ethnic variables.

Given the increased focus on evidence-based/informed decision-making, the absence of a significant or comprehensive body of evidence on the health status and aging experiences of Black women in Canada presents a challenge for program and policies to identify and address unique issues that affect Black women. Understanding the health and social needs of Black women 55 and older who are going through physical (e.g., menopause) and social (e.g., shifting social networks) changes and planning to or have retired contribute to the evidence base. Further, the synthesis of the evidence presented in the previous sections of this paper highlights that Black women are at higher risk of chronic health conditions such as diabetes and hypertension. Black women are also more likely to describe their health as being either fair or poor and struggle with the multiple barriers that they face across their life course. Consequently, identifying the critical time points during which these women are exposed to various risk factors is useful in informing programming and interventions to address these determinants with a life course perspective moving forward.

Given the gaps in research on aging Black women in Canada, this study aims to investigate the factors that contribute to or protect against poor health among Black women aged 55 years and older across their life course. Specific objectives of this study were:

(1) To describe, analyze, and compare the self-reported health status and needs of older Black women in Canada relative to those of their male counterparts and White men and White women in Canada.

(2) To understand the factors that affect the health and wellbeing of older Black women aged 55+ and how these factors intersect across their life course.

(3) To understand whether existing policies and strategies address the needs expressed by aging Black women.

To achieve the stated objectives, this study uses a sequential mixed method approach to address the following research questions:

1. What is the self-reported health status and unmet health needs of Black women aged 55+ as compared with White women and men (including Black men) who are 55+ in Canada?
2. What are the factors that have affected the health and wellbeing of older Black women aged 55+ and how have they intersected to affect their health and wellbeing over their life course?
3. To what degree do the relevant policies and strategies address the needs expressed by the aging Black women in this study?

Ethics clearance for this research was received through McMaster University Research Ethics Board (REB) (MREB #2370)

Theoretical Frameworks

Two theoretical approaches were used to guide this study: (1) intersectionality, and (2) the life course perspective. These frameworks were used as critical and analytical approaches to understanding the health and wellbeing of older Black women. A description of each approach and their relevance to this study are presented below.

Intersectionality

The term intersectionality was first introduced by Kimberlé Crenshaw in 1989 in her essay titled "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." In her essay, Crenshaw used intersectionality to explain how interactions of gender and race/ethnicity influence Black women's access to the American labour market and how women who are at the intersection of

gender and race/ethnicity experience marginalization (Crenshaw, 1989; Kaushik & Walsh, 2018). She identified several forms of intersectionality, specifically structural intersectionality, political intersectionality, and representational intersectionality. Structural intersectionality occurs when social structures that create and organize different social groups (e.g., gender and race) interact to produce effects that may not be intended. Political intersectionality occurs when the political movements working towards justice for different groups (e.g., feminism) interact to exclude or marginalize interests of some subset of the groups or reinforces another form of injustice. Finally, representational intersectionality occurs when images or tropes are taken to be representative of the group ignore or distort the complexity of the group. Crenshaw was able to demonstrate through several case examples how gender, race, and class interact to negatively impact marginalized women.

Over the last few years, intersectionality has grown as a field of study that is used across multiple disciplines, primarily in the health and social sciences. In scholarship, the consensus is that intersectionality references the critical insight that race, class, gender, sexuality, ethnicity, nationality, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities (Collins, 2015). The intersectional framework rests on several central tenets that define the nature of the paradigm: (1) human lives cannot be reduced to single characteristics; (2) human experiences cannot be accurately understood by prioritizing any one single factor or constellation of factors; (3) social categories, such as race/ethnicity, gender, class, sexuality, and ability, are socially constructed and dynamic; (4) social locations are inseparable and shaped by interacting and mutually constituting social processes and structures, which in turn are shaped by power and influenced by both time

and place; and (5) the promotion of social justice and equity are paramount (Hankivsky, et al., 2014).

Intersectionality is not an additive approach. In other words, it does not estimate the collective impact of gender, race, and class measured as several simple binaries as the sum of their independent effects (e.g., gender/class/race/ethnicity) (Hankivsky O. , 2012). Additive approaches have been critiqued for layering "several simultaneous oppressions" without questioning their relationships and mutually constructive processes (Ferrer, Grenier, Brotman, & Koehn, 2017; Hankivsky, 2012). In comparison, intersectionality focuses on examining how social locations and structural forces interact to shape and influence the individual experiences (Ferrer, Grenier, Brotman, & Koehn, 2017). Intersectionality is a multi-level analysis that incorporates attention to power and social processes at both micro and macro levels (Ferrer, Grenier, Brotman, & Koehn, 2017). Thus, treating race, gender, and age as separate dimensions in intersectional research would be inappropriate.

The approach has been used as a systematic approach to understanding human life and behaviour that is rooted in the experiences and struggles of marginalized people (Kaushik & Walsh, 2018). It proposes that axes of inequality brought about by discriminatory acts stemming from racism and sexism are mutually constituted (Patterson & Veenstra, 2016). Specifically, systemic relations of power along the lines of race, gender and age are all thought to be contingent upon one another rather than analytically distinct systems (Patterson & Veenstra, 2016). Consequently, for this study, health effects of racial identity and gender were not examined separately. Rather, the unique circumstances of the complex social identities manifested at the intersection of race and gender were analyzed to assess how they interact with one another in a

synergistic way to influence health and wellbeing across the life course (Patterson & Veenstra, 2016; Veenstra G. , 2013).

Life course perspective

The life course perspective is a multi-theoretical conceptual framework that has been used extensively to study various events individuals experience over the course of their lives. It suggests that events experienced earlier in life create changes in patterns of thoughts and actions later in life as the result of adaptation through the processes of socialization, stress and coping, and human development (Burton-Jeangros, Cullati, Sacker, & Blane, 2015). The life course perspective was used in this study to identify the "critical periods" of an individual's life where women may have been exposed to biological, psychosocial, and other social, material, and structural factors that might have impacted their health.

The life course approach has been used to study the physical and social hazards during gestation, childhood, adolescence, young adulthood, and midlife that affect chronic disease risk and health outcomes in later life. It aims to identify the underlying biological, behavioural, and psychosocial processes that operate across the life span. Growing evidence suggests that there are critical periods of growth and development, not just in utero and early infancy but also during childhood, adolescence, and adulthood, when environmental exposures do more damage to health and long-term health potential than they would at other times (Burton-Jeangros, Cullati, Sacker, & Blane, 2015; Geronimus, Bound, Keene, & Hicken, 2007; Richardson & Brown, 2016; Ailshire & House, 2011). A life course perspective is essential for understanding, and intervening effectively in, how health disparities are created, exacerbated, or mitigated, and reproduced across generations.

A fundamental element of the life course approach is considering systematically how biological, environmental, social, and other factors at each life stage can affect health at that life stage and subsequent stages (Braveman, 2014). The need to consider health effects of social factors is based on a large body of scientific knowledge. Psychosocial and biomedical knowledge has accumulated, particularly over the past two decades, indicating how diverse economic and social factors experienced early in life – such as the quality of child care in the first years of life, the quantity and quality of schooling, and the consequences of economic hardship and psychosocial trauma – are strongly linked with premature mortality and the development of cardiovascular disease and diabetes (Braveman, 2014; Geronimus, Bound, Keene, & Hicken, 2007; Link & Phelan, 1995; Phelan & Link, 2015). The life course perspective also encourages researchers to consider a person's experiences not only as an individual and a member of a household but in a social context. Several studies have demonstrated a consistent pattern of racial disparities in health that is consistent with the life course perspective. Studies demonstrate health disparities that have resulted from exposures to various structural determinants of health across different stages of life (Bierman, et al., 2012; Braveman, 2014; Link & Phelan, 1995; Phelan & Link, 2015). However, relatively few studies have focused on racial differences in adult health trajectories among aging Black women.

Methods

Sequential Mixed Methods Design. This study used a sequential mixed methods design to understand the health status and experiences of older Black women aged 55+ in Canada. Mixed methods research designs are used extensively among social and health sciences researchers. Mixed methods by definition is a procedure of collecting, analyzing, and integrating both quantitative and qualitative data at different stages of the research process within a single study

(Creswell J. W., 2014). When used in combination, quantitative and qualitative methods complement each other and allow for a more robust analysis, taking advantage of the strengths of each (Creswell J. W., 2014). Mixed methods is a comparatively new methodology that originated in the late 1980s and early 1990s based on work from individuals in diverse fields such as evaluation, education, management, sociology, and health sciences. Since its introduction, mixed methods has gone through several periods of development including philosophical debates surrounding research paradigms.

There are several schools of thought in the paradigm debate regarding research designs. On one end, there are the purists who believe that paradigms and methods should not be mixed (Cameron, 2009). Another school of thought, identified as the situationalists, contend that certain methods can be used in specific situations. In direct opposition to the purists are the pragmatists, who argue against a false dichotomy between the qualitative and quantitative research paradigms and advocate for the efficient use of both approaches (Cameron, 2009). Advocates and practitioners of mixed methods research identify with the pragmatic paradigm because it offers an immediate and useful middle position philosophically and methodologically; it offers a practical and outcome-oriented method of inquiry that is based on action and leads iteratively to further action and the elimination of doubt. It also offers a method for selecting methodological mixes that can help researchers better answer their research questions (Cameron, 2009).

Usually, sequential approaches involve firstly the implementation of quantitative methods followed by qualitative. This study conducted a secondary analysis of six cycles of the CCHS (quantitative) and semi-structured interviews (qualitative) concurrently followed by a document review of government policy and strategy documents (qualitative). Using a sequential mixed methods design to investigate the previously outlined research questions extends the breadth and

depth of this inquiry through its use of different research methods to investigate different components of the research. A more detailed overview of the quantitative and qualitative methods used in this study is provided in the sections below.

Quantitative Approach. The quantitative component of this study was designed to investigate the first research question of this study: What is the self-reported health status and unmet health needs of Black women aged 55+ as compared with White women and men (including Black men) who are 55+ in Canada?

An intersectional approach (Veenstra G. , 2013; Patterson & Veenstra, 2016) was used to conduct a multilevel analysis using six cycles (2013-2018) of the CCHS to understand whether the processes of social stratifications affect health. Intersectionality was used for the analytical strategy to generate multiple binary logistic regression models to explore the additive and multiplicative nature of race and gender hierarchies within different racial groupings (Richardson & Brown, 2016; Veenstra & Patterson, 2016). Using intersectionality leads to the hypothesis that health inequalities among aging Black women are conditioned by gender, age, and race in a synergistic way (Richardson & Brown, 2016; Hankivsky & Cormier, Intersectionality and public policy: Some lessons from existing models, 2011). It was determined that six years would generate a sufficiently large enough sample size to conduct significant analysis while also capturing data collected during periods where there were changes in the provincial and federal landscape of Canadian governments. The sampling frame consisted of Black and White men and women aged 55 years and older. Individuals living on Reserves or Crown land, institutionalized persons, and full-time members of the Canadian Forces were excluded.

The variables selected for analysis were identified based on empirical evidence that suggested differences in health outcomes between different races and genders. For this study,

dichotomous variables were created to reflect whether respondents had ever been diagnosed with one or more of the following chronic conditions: hypertension, diabetes, asthma, arthritis, and cancer. Modifiable risk factors such as obesity, smoking, physical inactivity, and alcohol use were included as co-variates. Variables of self-rated physical and mental health were also assessed. Binary regression models were then produced to determine the associations between racial identity and each outcome.

Qualitative Approach. Semi-structured interviews and a document review were used to address research questions two and three respectively. These questions are outlined below:

2. What are the factors that have affected the health and wellbeing of older Black women aged 55+ and how have they intersected to affect their health and wellbeing over their life course?
3. To what degree do the relevant policies and strategies address the needs expressed by the aging Black women in this study?

The methods for question two used descriptive phenomenology. Phenomenological research describes the lived experiences of a concept or phenomenon (Creswell J. W., 2007). The basic purpose of phenomenology is "to reduce individual experiences with a phenomenon to a description of universal experiences" (Creswell, Plano Clark, Gutmann, & Hanson, 2003). Whereas other qualitative methods such as narrative inquiry report on the life of a single individual or grounded theory that aims to develop an explanatory theory of basic social processes, phenomenology has allowed for a deeper understanding of the common lived experiences of several individuals through descriptions of the essence of their experiences (Creswell J. W., 2007). Phenomenologists focus on describing what all participants have in common and thereby reduce the individual experiences to a description of the nature of the experience. Knowing common

experiences is valuable for groups such as health professionals and policymakers. To this end, phenomenologists identify a phenomenon or an "object" of human experience to study. For this study, the object of interest was the health and wellbeing of aging Black women. Health and wellbeing were used as holistic terms to describe the physical, mental, and social health and wellbeing of the aging Black women.

Semi-structured interviews were conducted with Black women aged 55 and older who live in the Greater Toronto Area. The life course perspective and intersectionality were used to both conceptualize and operationalize the research questions and data analysis. Participants were asked questions relevant to the critical periods of their life as described by the life course perspective. The study used a mix of purposive and snowball sampling approaches for recruitment. Data were analyzed using the steps outlined by Moustakas (1994). During the process of analysis, Moustakas recommended that phenomenologists ask the following questions: What are the individual's experiences, and in what context did they experience them? (Phillips-Pula, Strunk, & Pickler, 2011). His approach focuses on the wholeness of the experience.

The methods for question three was informed by the Stages Model of policy development to conduct a document review of government policies and strategies. The Stages Model outlines the process of producing public policies divided into several stages: agenda setting, policy formulation, adoption or decision-making, implementation, and evaluation (Benoit, 2013). The Stages Model has been useful in helping to situate the context and the channels of influence and can also help to determine what type of information is required by decision-makers (Benoit, 2013). Document reviews have been identified as a useful tool to track change and development over time (Bowen, 2009). The Stages Model provided a useful analytical framework for examining housing policies in Ontario. It made it possible to distill the complex process of public policy development

in a relatively simple way. Policies and strategies were identified based on the needs articulated by women in the semi-structured interviews conducted to address question and objective two. Documents were analyzed for mention of social identities to determine whether they were geared towards or recognize the social challenges specific to older Black women in accessing adequate housing.

Overview of Dissertation

Three independent research articles are presented in this dissertation. Each article addresses one of the research questions outlined in this introduction. The first paper presents findings for research question one, which was designed as the quantitative component of this study. This paper presents the results from using an intersectional approach to analyze six cycles of the CCHS to evaluate the self-reported health outcome of older Black and White men and women aged 55 and older. This paper contributes to the scientific inquiry on the health and wellbeing of Black women in Canada. It also adds to the empirical evidence surrounding the use of intersectionality in investigating the impact of racialization on health and wellbeing.

The second paper presents findings from the phenomenological study that addressed the second research question. It discusses factors that affect the health and social wellbeing of older Black women living in the Greater Toronto Area across their life course. Interviews were conducted with 27 women who self-identify as Black, aged 55 or older and living in the Greater Toronto Area. Interview data were analyzed using phenomenology. This paper contributes to the empirical evidence base regarding the health and wellbeing of older Black women from their own perspective. It provides an in-depth look at the experiences of Black women in Canada and qualitatively provides more contextual information about their social positions using the life course perspective.

The third and final paper of this dissertation addresses the need for appropriate housing identified by the women who were interviewed for question two. The document review of government and policy strategies was designed to identify the degree to which they address adequate housing for older Black women. Adequate housing was defined as encompassing more than a habitable physical space, but also includes adequacy in terms of safety, location, transportation, social integration, and age friendly (Cawley, 2019).

The final section presents (i) a summary of the key findings from the three studies and how the three studies relate to each other; (ii) future research; (iii) limitations of this study; and finally (iv) a reflexive discussion on my role as a mixed methods researcher conducting research on older Black women.

References

Acheson, R. M. (1978). The definition and identification of need for care. *Journal of Epidemiology and Community Health, 32*, 10-15.

Ailshire, J. A., & House, J. S. (2011). The unequal burden of weight gain: An intersectional approach to understanding social disparities in BMI Trajectories from 1986 to 2001/2002. *Social Forces, 90*(2), 397-423.

Anand, S. (2002). The concern for equity in health. *Journal epidemiology community health, 56*, 485-487.

Arber, S., McKinlay, J., Adams, A., Marceau, L., Link, C., & O'Donnell, A. (2006). Patient characteristics and inequalities in doctor's diagnostic and management strategies relating to CHD: A video-simulation experiment. *Social Science and Medicine, 62*(1), 103-115.

Bartley, M. (2004). *Health inequality: An introduction to theories, concepts and methods.* Cambridge, UK: Polity Press.

Bengtson, V., & Settersten, R. (2016). *Handbook of theories in aging.* New York: Springer Publishing Company.

Benoit, F. (2013). *Public Policy and Their Usefulness in Public Health: The Stages Model.* Montreal: National Collaborating Centre for Healthy Public Policy.

Bierman, A. S., Johns, A., Hyndman, B., Mitchell, C., Degani, N., Shack, A. R., . . . Parlette, V. (2012, Jan 01). *Project for an Ontario Women's Health Evidence-Based Report: Volume 2.* Retrieved Dec 19, 2018, from Project for an Ontario Women's Health Evidence-Based Report: http://www.powerstudy.ca/power-report/volume2/social-determinants-of-health-populations-at-risk/

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40.

Braveman, P. (2014). What is Health Equity: And How Does a Life-Course Approach Take Us Further Toward It? *Journal of Maternal Child Health, 18*, 366-372.

Brown, T. H., Richardson, L. J., Hargrove, T. W., & Thomas, C. S. (2016). Using Multiple-hierarchy Stratification and Life Course Approaches to Understand Health Inequalities: The Intersecting Consequences of Race, Gender, SES, and Age. *J Health Soc Behav., 57*(2), 200-222. doi:10.1177/0022146516645165.

Burton-Jeangros, C., Cullati, S., Sacker, A., & Blane, D. (2015). *A life course perspective on health trajectories and transitions.* New York: Springer International Publishing.

Cameron, R. (2009). A sequential mixed model research design: Design, analytical and display issues. *International Journal of Multiple Research Approaches, 3*(2), 140-152.

Cawley, G. D. (2019). Law and inclusive urban development: Lessons from Chile's enabling markets housing policy regime. *The American Journal of Comparative Law, 67*, 587-636.

Chan, W. C. (2002). The meaning and goals of equity in health. *Journal of Epidemiological Community Health, 56*, 488-491.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology, 41*, 1-20. doi:10.1146/annurev-soc-073014-112142

Committee on Assessing Interactions Among Social, B. a. (2006). *Genes, Behavior, and the Social Environment* . Institute of Medicine. Washington: The National Academies Press.

Creswell, J. W. (2007). *Qualitative Inquiry and Research Design: Choosing Among five Approaches* (2nd ed.). Thousand Oaks, California: Sage Publications, Inc.

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches.* Thousand Oaks, California: SAGE Publications, Inc.

Creswell, J. W., Plano Clark, V. L., Gutmann, M., & Hanson, W. (2003). Advanced mixed-methods researh designs. In A. Tashakkori, & C. Teddlie, *Hanbook on mixed-methods in the behavioral and social sciences* (pp. 209-240). Thousand Oaks, CA: Sage.

Crystal, S., & Shea, D. (2003a). Cumulative advantage, public policy, and late-life inequality. In S. Crystal, & D. Shea, *Economic outcomes in later life: Pulic policy, health, and cumultive advantage* (pp. 1-13). New York: Springer.

Crystal, S., Shea, D. G., & Reyes, A. M. (2017, March 20). Cumulative Advantage, Cumulative Disadvantage, and Evolving Patterns of Late-Life Inequality . *The Gerontologist, 57*(5), 910-920.

Daniels, N. (1986). Why saying no to patients in the United States is so hard. Cost containment, justice, and provider autonomy. *New England Journal of Medicine, 314*, 1380-1383.

Dannefer, D. (2003). Cumulative Advantage/Disadvantage and the Life Course: Cross-Fertilizing Age and Social Science Theory . *Journal of Gerontology: Social Sciences, 58B*(6), S327-S337.

Dryden, O., & Nnorom, O. (2021). Time to dismantle systemic anti-Black racism in medicine in Canada. *CMAJ, 193*(2), E55-E57.

Duncan, G. J., Daly, M. C., McDonough, P., & Williams, D. R. (2002). Optical indicators of socioeconomic status for health research. *American Journal of Public Health, 92*(7), 1151-1157.

Etowa, J. W., Bernard, B., Oyinsan, B., & Clow, B. (2007b). Participatory action research (PAR): An approach for improving Black women's health in rural and remote communities. *Journal of Transcultural Nursing, 18*(4), 349-357.

Etowa, J., Wiens, J., Bernard, W. T., & Clow, B. (2007). Determinants of Black Women's Health in Rural and Remote Communities . *CJNR, 39*(3), 56-76.

Ferrer, I., Grenier, A., Brotman, S., & Koehn, S. (2017). Understanding the experiences of racialized older people through an intersectional life course perspective. *Journal of Aging Studies, 41*, 10-17.

Geronimus, A. T., Bound, J., Keene, D., & Hicken, M. (2007). Black-White difference in age trajectories of hypertension prevalence among adult women and men, 1999-2002. *Ethnicity & Disease, 17*(1), 40-48.

Government of Canada. (2010). *Women's Health Strategy.* Health Canada. Ottawa: Government of Canada.

Government of Canada. (2022, January 23). *Funding: Employment Assistance for Older Workers*. Retrieved from Employmnt and Social Development Canada: https://www.canada.ca/en/employment-social-development/programs/training-agreements/older-workers.html

Gur, R. E., & Gur, R. C. (2002, June). Gender differences in aging: cognition, emotions, and neuroimaging studies. *Dialogues in Clinical Neuroscience, 4*(2), 197-210.

Hankivsky, O. (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science and Medicine, 74*, 1712-1720.

Hankivsky, O., & Cormier, R. (2011). Intersectionality and public policy: Some lessons from existing models. *Policy Research Quarterly, 64*(1), 217-229.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., . . . Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International Journal for Equity in Health, 13*, 119.

Hernandez, L. M., & Blazer, D. G. (2006). *Genes, Behavior, and the Social Environment.* Washington, DC: The National Academies Press.

Hudon, T. (2016). *Women in Canada: A Gender-based Statistical Report.* Ottawa: Statistics Canada.

Hudon, T., & Milan, A. (2016). *Women in Canda: A Gender-Based Statistical Report.* Ministry of Industry, Statistics Canada. Ottawa: Government of Canda.

Huston, J. B. (2016). Advancing health equity in improving health: The time is now. *Canadian Communicable Disease Report, 42-Suppl 1*, S1-6. doi:https://doi.org/10.14745/ccdr.v42is1a01

Kaushik, V., & Walsh, C. A. (2018). A critical analysis of the use of intersectionality theory to understand the settlement and integration needs of skilled immigrants to Canada. *Canadian Ethnic Studies, 50*(3), 27-47.

Lasser, K. E., Himmelstein, D. U., & Woolhandler, S. (2006). Access to care, health status and health disparities in the United States and Canada: Results of a cross-national population-based survey. *American Journal of Public Health, 96*(7), 1300-1307.

LaVeist, T. A. (1994, Apr). Beyond Dummy Variables and Sample Selection: What Health Services Researchers Ought To Know about Race as a Variable. *Health Services Research, 29*(1), 1-16.

LaVeist, T., Thorpe, J. R., Pierre, G., Mance, G., & Williams, D. (2014). The relationships among vigilant coping style, race, and depression. *Journal of Social Issues, 70*(2), 241-255.

LeBrun, L. A., & LaVeist, T. A. (2013). Health status among Black Canadians: Results from a National Survey. *Canadian Ethnic Studies, 45*(1-2), 143-155.

Lebrun, L., & LaVeist, T. (2011). Black/White racial disparities in health: A cross-country comparison of Canada and the United States. *Archives of Internal Medicine, 171*(17), 1591-1593.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*(Extra Issue), 80-94.

McKinlay, J. (1996). Some contributions from social system to gender inequalities in heart disease. *Journal of Health and Social Behavior, 37*(1), 1-26.

Milan, A., & Tran, K. (Spring 2004). Blacks in Canada: A long history. *Canadian Social Trends*, pp. 1-6.

Moustakas, C. (1994). Transcendental phenomenology: Conceptual framework. In C. Moustakas, *Phenomenological Research Methods* (pp. 25-44). Thousand Oaks, CA: SAGE Publications, Inc.

Patterson, A. C., & Veenstra, G. (2016). Black-white health inequalities in Canada at the intersection of gender and immigration. *Canadian Journal of Public Health, 107*(3), e278-e284.

Phelan, J. C., & Link, B. G. (2015). Is racism a fundamental cause of inequalities in health? *Annual Review of Sociology, 41*, 311-330.

Phillips-Pula, L., Strunk, J., & Pickler, R. H. (2011). Understanding Phenomenological Approaches to Data Analysis. *Journal od Pediatric Health Care, 25*(1), 67-71.

Pinquart, M., & Sorensen, S. (2006). Gender Differences in Caregiver Stressors, Social Resources, and Health: An Updated Meta-Analysis . *Journal of Gerontology: Psychological Sciences, 61B*(1), P33-P45.

Ramraj, C., Shahidi, F. V., Darity Jr., W., Kawachi, I., Daniyal, Z., & Siddiqi, A. (2016). Equally inequitable? A cross-national comparative study of racial health inequalities in the United States and Canada. *Social Science and Medicine, 161*, 19-26.

Rawls, J. (1971). *A theory of justice.* Cambridge, United States: Belknap.

Richardson, L. J., & Brown, T. H. (2016). (En)gendering racial disparities in health trajectories: A life course and intersectional analysis. *SSM-Population Health, 2*, 425-435.

Shapiro, D. (2002, August 16). Egalitarianism and welfate-state redistribution. *Social Philosophy and Policy, 19*(1), 1-35.

Sheets, D. J., & Gallagher, E. M. (2012). Aging in Canada: State of the arty and science. *The Gerontologist, 53*(1), 1-8.

Shier, M. L., & Graham, J. R. (2014). Social Policy in Canada. *Encyclopedia of Social Work*, 1-18. doi:https://doi.org/10.1093/acrefore/9780199975839.013.947

Siddiqi, A., & Nguyen, Q. C. (2010). A cross-national comparative perspective on racial inequities in health: the USA versus Canada. *J. Epidemiol. Commun Health, 64*(1), 29-35.

Siddiqi, A., Shahidi, F. V., Ramraj, C., & Williams, D. R. (2017). Associations between race, discrimination and risk for chronic disease in a population-based sample from Canada. *Social Science and Medicine, 194*, 135-141.

Statistics Canada. (2012, Jan 01). *Average female and male earnings and female-to-male earnings ratio*. Retrieved Dec 19, 2018, from Statistics Canada: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110014301

Veenstra, G. (2013). Race, gender, class, and sexuality (RGCS) and hypertension. *Social Science and Medicine, 89*, 16-24.

Veenstra, G., & Patterson, A. C. (2016). Black–White Health Inequalities in Canada. *J Immigrant Minority Health, 18*, 51-57.

Veentra, G. (2009, Aug). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science and Medicine, 69*(4), 538-542.

Williams, D. R. (1997). Race and Health: Basic Questions, Emerging Directions. *Ann Epidemiol, 7*, 322-333.

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and Health: Evidence and Needed Research. *Annual Review of Public Health, 40*, 105-125.

Women's Health in Women's Hands. (2011). *Every women matters: A report on accessing primary health cre for Black women and women of colour in Ontario.* Toronto: Women's Health in Women's Hands.

World Health Organization. (2007). *Women, Ageing and Health: A Framework for Action.* Geneva: World Health Organization.

World Health Organization. (2015). *World Report on Ageing.* Geneva: World Health Organization. Retrieved from World Health Organization: https://www.who.int/ageing/healthy-ageing/en/

ARTICLE 1: AGING AND HEALTH AT THE INTERSECTION OF GENDER AND RACE IN CANADA: A COMPARATIVE ANALYSIS OF DIFFERENCES IN HEALTH STATUS BY RACE AND GENDER

Abstract:

Differences in health based on race are still an emerging area of study in Canada. Studies have contributed significantly to the general understanding of the health status of racialized people, but few studies have focused on health outcomes among racialized older Canadians, particularly among older Black women. This study compares the self-reported health status of Black and White men and women over the age of 55. Six cycles (2013-2018) of the Canadian Community Health Survey (CCHS) were pooled. Multivariate logistic regression models were used to establish associations between self-perceived racial identity and the prevalence of five major chronic conditions (hypertension, diabetes, cancer, chronic obstructive pulmonary disease (COPD), cardiac disease, asthma), self-rated health, and self-rated mental health. Data analysis was informed by intersectional theory and aimed to determine whether health inequalities by race and gender were additive or multiplicative. Among the 55-year-old and older, Black women were more likely to report diabetes and hypertension as well as poor or fair health than White men. However, interaction terms, measuring the joint effect of being Black and a woman, were not significant. Also, first order coefficients of race and gender were not affected by the introduction of the interaction terms, suggesting that the relationships between health and race and sex may be additive. This result, if confirmed, would be inconsistent with the existing literature on intersectionality, but further investigation is warranted to further research this important area.

Introduction

Empirical studies have demonstrated that race and gender are strong and pervasive determinants of health (Ailshire & House, 2011; Geronimus, Bound, Keene, & Hicken, 2007; Patterson & Veenstra, 2016; Richardson & Brown, 2016; Siddiqi, Shahidi, Ramraj, & Williams, 2017). This study uses an intersectional approach to describe, analyze, and compare the self-reported health status of older Black women in Canada to those of their older Black male counterparts and older White men and women. This study focuses on self-assigned race rather than ethnicity as it is designed to understand the effects of racialization on health later in life, and whether there are differences between older men and women.

The concept of racialization aims to capture the process by which society uses perceived differences between people to categorize them and change their life expectancies. Racialization has been applied in various ways, and its scope extends to many issues, concerns, and topics across different disciplines. Veenstra (2009) highlights the social importance of race in the measurement of health as it is meant to capture the process of racialization. In Canada, most racialized persons are immigrants. This complicates the analysis of racialization and health because immigrants on arrival to Canada have better health than their Canadian-born counterparts of the same gender and age (Lu & Ng, 2019).

Canada and the United States are often compared socially, politically, and economically to each other. A comparative study conducted by Ramraj et al. (2016) investigated the pattern of health inequality between Canada and the US. The largest health disparities on the Canadian side were found to be between the Canadian Indigenous and the White populations, with a smaller health gap found between Black populations and the White population. In contrast, the largest differences in the US were between the White American population and the Black American

population (Ramraj, et al., 2016). Canadian Indigenous health disadvantages persisted regardless of demographic, socioeconomic, and behavioural factors (Ramraj, et al., 2016). Siddiqi and Nguyen (2010) found that racial inequalities in health were less apparent in Canada compared with the US. In the US, racial inequalities in chronic diseases and fair or poor self-rated health were largely driven by inequalities found among the native born. In Canada, however, there were few significant racial inequalities and those occurred exclusively among the racialized foreign-born groups (Siddiqi & Nguyen, 2010).

Even though less pronounced than in the US, differences in health status across race still exist in Canada. For instance, Veenstra and Patterson (2016) investigated health inequalities between Black and White Canadians and found that Black men and women were more likely than their White counterparts to report hypertension and diabetes. The study also reported that Black women were less likely than White women to report that they had a diagnosis of cancer and to report fair/poor mental health, and Black men were less likely than White men to report heart disease (Veenstra & Patterson, 2016). These differences were associated with the experience of race-based discrimination. Siddiqi, Shahidi, Ramraj, and Williams (2017) using data from the Canadian Community Health Survey (CCHS) and an abbreviated version of the validated Williams Everyday Discrimination Scale to measure experiences of perceived discrimination found that Black people in Canada had the highest proportion of self-reported experiences of discrimination, followed by Indigenous, Asian, and White respondents (Siddiqi, Shahidi, Ramraj, & Williams, 2017). They reported that hypertension, obesity, self-rated health as well as frequency of smoking, drinking, and physical inactivity were associated with perceived discrimination. Experiencing frequent discrimination was also associated with smoking, infrequent physical activity, but a lower risk of hypertension (Siddiqi, Shahidi, Ramraj, & Williams, 2017).

Aging, sex, and multiple-hierarchy stratifications

Literature on aging and health inequality investigates whether the impact of social inequality on health decreases, remains stable, or increases with age (Brown, Richardson, Hargrove, & Thomas, 2016). Evidence varies depending on how health and socioeconomic status are measured. A life course perspective on the social stratification of health posits that exposures to risk factors over the life course vary between social status groups and that resulting differences in exposure trajectories underlie social inequalities in health trajectories (Chiu, Maclagan, Tu, & Shah, 2015). The cumulative advantage/disadvantage theory refers to the systemic growth of inequality over time due to the social structuring of risks, resources, opportunities, and resultant differences (Crystal & Shea, 2003a; Richardson & Brown, 2016; Brown, Richardson, Hargrove, & Thomas, 2016). It predicts that health inequalities associated with race and gender would increase between middle and late life and would be complicated by prolonged exposure to detrimental determinants of health.

Canadian studies investigating racial inequality in health have not specifically attempted to investigate life course theories. Further, these studies do not present analysis stratified by age. In the US, there are several longitudinal studies that assess racial inequality in health over the life course (Geronimus, Bound, Keene, & Hicken, 2007; Richardson & Brown, 2016; Brown, Richardson, Hargrove, & Thomas, 2016). Ailshire and House (2011) used the longitudinal and nationally representative American's Changing Lives study to examine the social inequality in body mass index (BMI) trajectories. Results showed the greatest increase in BMI was among individuals aged 25-39 to 45-54 during the study period as well as among low-educated and low-income Black women while high-educated and high-income White men experienced the least BMI growth (Ailshire & House, 2011). Another study conducted by Richard and Brown (2016) also

used a life course approach to assess inequality in hypertension prevalence. Findings from the Richard and Brown study were consistent with findings from Ailshire and House that demonstrated the health disadvantage of Black women compared to other race/ethnicity-gender groups (Richardson & Brown, 2016). These results were also consistent with an earlier study conducted by Geronimus, Bound, Keene and Hicken (2007) to describe age patterns of hypertension prevalence in young through middle-aged adults and to test the hypothesis that hypertension prevalence rises faster with age among Black people than White people in the US. Study outcomes demonstrated that Black/White odds of hypertension becomes three times higher between ages 15 and 65 (Geronimus, Bound, Keene, & Hicken, 2007). Odds for women increased faster and were twice as high, with Black women having the highest hypertension rates by age 40. Adjustment for income did not change the results (Geronimus, Bound, Keene, & Hicken, 2007). Though the present study is not longitudinal, the data assesses outcomes among men and women aged 55 years and older, which is 10 years before the legal retirement age and an increase in the incidence and prevalence of chronic illnesses such as diabetes and hypertension among older adults (Public Health Agency of Canada, 2011; Public Health Agency of Canada, 2021).

Intersectionality and the study of race and gender

The study reported in this paper investigates multiplicative (interaction) effects between gender and race on health, most particularly whether being a Black woman is more harmful than being Black (versus being White) and being a woman (versus being a man). Intersectionality offers a framework through which these dimensions can be analyzed to identify interconnected or interlocking factors that are mutually reinforcing and affect health (Crenshaw, 1989; Brown, Richardson, Hargrove, & Thomas, 2016; Richardson & Brown, 2016). The theory depicts the interconnectedness of these dimensions as “interlocking systems of oppression” that interact to

create unique social contexts that condition the lived experiences and life chances of the individuals situated within those contexts (Brown, Richardson, Hargrove, & Thomas, 2016). There are several key tenets that capture the unique nature of intersectionality. Firstly, human characteristics cannot be reduced to single characteristics and their experiences cannot be accurately understood by prioritizing any one single factor or constellation of factors (Havinsky, et al., 2014; Gueta, 2017). Rather, social categories or locations, such as race/ethnicity, gender, class, sexuality, and ability, are all socially constructed and dynamic. They are also inseparable and shaped by interacting and mutually constituting social processes and structures, which, in turn, are shaped by power and influenced by both time and place.

For Black women, intersectionality highlights their simultaneous positioning at the disadvantaged ends of both race/ethnicity and gender hierarchies (Collins P. , 2000; Richardson & Brown, 2016). Intersectionality predicts that Black women are more likely to experience disadvantage than other race/ethnicity-gender groups (Richardson & Brown, 2016; Hyman, et al., 2019). This relative disadvantage is a result of Black women's experiences of "a double or triple load of discrimination" and/or "gendered racism" (Richardson & Brown, 2016; Hyman, et al., 2019). In America, the effects of the gendered racism experienced by Black women are further multiplied by additional burdens stemming from the plight of their African American male counterparts who suffer disproportionate rates of incarceration or interaction with the criminal justice system, unemployment, and premature mortality (Richardson & Brown, 2016).

Several Canadian studies have applied the theory to conceptualize and conduct multi-level analyses of categories. Veenstra (2013) conducted a study informed by intersectionality to investigate the degree to which race, gender, class, and sexuality manifest distinct and interconnected associations with self-reported hypertension in the CCHS. Binary logistic

regression models were used to model the main effects of, and interactions between race, gender, education, household income, and sexual orientation on hypertension, controlling for age, using data from the CCHS. From the additive perspective, Black respondents, respondents with less than a high school diploma, and poorer respondents were significantly more likely than White respondents, university-educated Canadians, and wealthier Canadians, respectively to report hypertension. However, the interactive model indicated that the additive models were poor predictors of hypertension for wealthy Black women, wealthy South Asian women, women with less than a high school diploma, and wealthy bisexual respondents. The additive models were also poor predictors for poor Black men, poor South Asian women, poor South Asian men and women with a university degree, who were less likely than expected to report hypertension. Lastly, Patterson and Veenstra (2016) tested the potential of intersectionality theory for explicating racial inequalities in Canada by investigating whether Black-White health inequalities are conditioned by gender and immigrant status in a synergistic way. The study used binary logistic regression to model Black-White inequalities in hypertension, diabetes, self-rated health, self-rated mental health, and asthma separately for native-born women, native-born men, immigrant women and immigrant men. After controlling for potentially confounding factors, the study found that immigrant Black women had significantly higher odds of hypertension, diabetes, and fair/poor self-rated health than immigrant White women, among other findings.

There are still opportunities to explore different ways in which intersectional principles are used in research. Patricia Hill-Collins (2015) highlighted several opportunities to produce new knowledge using intersectionality as an analytical strategy. This includes the expansion of research that focuses on race, class, and gender to incorporate ethnicity, age, and ability as similar categories of analysis (Collins P. H., 2015). Though some of these categories have been covered in different

ways, very few have dedicated their focus to age and aging-related topics using intersectionality beyond very specific disease outcomes such as hypertension.

As such, the aim of this paper is to present results from a study that applies intersectionality to self-reported health outcomes in Black and White adults 55 years and older through multivariate logistic regression modeling of indicators of race, gender, and socioeconomic status and multi-way statistical interactions between them using the CCHS. By implementing a multi-staged analytical strategy informed by intersectionality, the objective of this study is to highlight previously overlooked health inequalities by race, gender and SES among older adults that have manifested because of the accumulation of long-term exposures to disease risk factors.

Methods and Materials

Theoretical approach

There are three approaches that can be used to implement intersectionality in research: anti-categorical, inter-categorical and intra-categorical (McCall, 2005; Kaushik & Walsh, 2018; Else-Quest & Hyde, 2016). The anti-categorical approach deconstructs analytical categories and rejects them as social categories (Kaushik & Walsh, 2018). The inter-categorical approach adopts existing analytical categories to document relationships of inequality among social groups and changing configurations of inequality along multiple and conflicting dimensions. The intra-categorical approach acknowledges the stable and durable relationships that social categories represent at any given point in time (McCall, 2005). Overall, each approach shares the premise that relationships among social groups are containers of definable and measurable inequalities.

In quantitative research these categories can be framed as person variables that inform within-group or between-groups design (Else-Quest & Hyde, 2016). A within-group design allows for an intersectional approach to phenomenon by specifying a particular intersectional location, in lieu

of examining differences across multiple locations (Else-Quest & Hyde, 2016). Comparatively, a between-group analysis enables researchers to examine the impact of factors such as discrimination based on gender and race on health outcomes by looking at multiple intersectional locations. Both approaches can also be combined (Else-Quest & Hyde, 2016).

Considering the intersecting nature of relations of power at multiple levels of society, intersectionality researchers argue that individual-level subordinate-group identities (e.g., non-White, female, lower class, etc.) interact with one another in a synergistic way, leading to unique experiences as a “multiply organized other” (Purdie-Vaughns & Eibach, 2008). Intersectional research considers the experience and meaning of simultaneously belonging to multiple intertwined social categories (Else-Quest & Hyde, 2016). The use of intersectionality as a research method is still a relatively new approach. Generally, in a quantitative intersectional approach, an analysis of gender and race would include an examination and comparison of additive, multiplicative and intersectional effects (Else-Quest & Hyde, 2016). Specifically, these categories would be analyzed separately such that race may be construed as having effects that can be partitioned from the effects of gender. Conversely, the effects of multiple group memberships would include multiplicative effects, such that the effects of sexism might exacerbate the effects of racism (Else-Quest & Hyde, 2016). This present study first analyzes the categories separately and then together to include multiplicative effects to determine the association among race and gender and health outcomes.

Sample

This study uses pooled data from the annual component of the CCHS conducted by Statistics Canada in 2013, 2014, 2015, 2016, 2017, and 2018. Pooling was necessary to have enough statistical power, due to the small percentage of self-identifying Black men and women in the older

Canadian population. Data were obtained from survey respondents residing in Canada who participated in each cycle of the survey. Individuals living on reserves and on Crown Lands, institutional residents, and full-time members of the Canadian Armed forces were excluded. Men and women 55 years and older and who self-identified as Black or White were selected. Racial identity was based on the CCHS question which asked: "You may belong to one or more racial or cultural groups on the following list," and respondents who chose "White" or "Black" were selected. This is therefore a comparison between Black men and women and White men and women. Exclusion of cases without valid information for racial/cultural identity or gender produced a sample of 530 Black women, 81,296 White women, 494 Black men and 63,633 White men.

Survey measures

Several outcomes related to chronic diseases and associated risks were identified from the CCHS and analyzed. Health outcomes of interest were identified through the literature review, which demonstrated that Black women in Canada were more likely to be diagnosed with chronic health conditions such as hypertension and diabetes and were also more likely to report their health status as fair/poor (Veentra, 2009; Etowa, Wiens, Bernard, & Clow, 2007). These negative outcomes are known to worsen over time if not managed appropriately through modifications in health behaviours such as smoking cessation, diet, and physical activity. Consequently, for this study, a series of dichotomous variables were created to reflect whether respondents were ever diagnosed with one or more of the following chronic conditions: hypertension, diabetes, asthma, arthritis, cancer, and heart disease. Hypertension and diabetes were selected based on the evidence of the link between race and health presented. Given the paucity of research related to chronic diseases and older Black Canadians, asthma, arthritis, cancer, and heart disease were selected to

measure whether the results from previous studies would hold true from an aging perspective. Body weight (as measured by BMI) was assessed. Other modifiable risk factors, including smoking and alcohol use, were also included as outcome variables.

Self-rated health was also chosen as it is a good measure of overall health and wellbeing and has been noted as a predictor of mortality (Veentra, 2009). Self-rated health was assessed based on the following question: "In general, would you say your health is: excellent, very good, good, fair, or poor?". It was dichotomized in this study by opposing those who responded "excellent," "very good," or "good" to those who responded "fair" or "poor." Self-rated mental health was assessed using the question: "In general, would you say your mental health is: excellent, very good, good, fair, or poor?" and was dichotomized similarly to self-rated health. Unmet healthcare needs were also assessed using the question: "During the past 12 months, was there ever a time when you felt that you needed healthcare, other than homecare services, but you did not receive it?"

Covariates included immigrant status, household income, and education level.

Analysis

This analysis was completed for a sample of a selected population. As such, data modeling was implemented using unweighted data and a between-group approach comparing outcomes between Black and White, and men and women. White men were selected as the reference category in each analysis, then the analysis was executed in two phases to determine the association between race and gender. In phase one, multivariate logistic regression models were applied for each outcome variable and race and gender, controlling for age and survey year. The second phase implemented the same analysis completed in the first phase, however further controlled for immigration status, education, household income, and risk factors, specifically smoking and weight. These models

were meant to determine the degree to which socioeconomic status, health-related behaviours and BMI explain any previously established associations and disease risk.

To account for differences in the size of the Black and White populations, the master weight was applied, and bootstrap replicate weight variable provided by Statistics Canada was used. The statistical analyses were conducted using R. The study was approved by the Research Ethics Board at McMaster University.

Results

Socio-demographic characteristics of study population

Tables 1 and 2 present a description of the study's sample by race. The population was 99% White and 1% Black (Table 1.1) after pooling six years (2013-2018) of CCHS data. There were similar proportions of men and women across both racial categories and age groups. Black respondents were mostly immigrants (91%), whereas only 16% of White respondents were immigrants. Black respondents were more likely to have a post-secondary certificate or university degree (70%) than White respondents (60%). Most people in both racial groups in the sample earned between $15,000 and $50,000 per year, with a small proportion earning $100,000 or more, more so among White respondents (9%) than Black (6%).

Table 1.2 presents the selected self-reported outcomes by sex. Generally, both men (3%) and women (4%) had very few reports of unmet health needs. Women (46%) had higher reports of arthritis compared with men (32%). Similarly, women (54%) were also more likely to perceive life as stressful when compared to men (48%). Men were more likely to report being regular or occasional drinkers (80%) and smoking daily or occasionally (16%). It is also important to mention the mortality crossover bias where more men are dead at each age as compared to women, implying a selection effect; that is, to be alive as a man, you need to be healthy and robust (Corti, et al., 1999; Johnson, 2000; Lynch, Brown, & Harmsen, 2003).

Table 1.1. Socio-demographic characteristics of the sample population, aged 55 years and older by race

Socio-demographic categories	White (99%)	Black (1%)
Age Groups		
55-64	46%	49%
65-74	33%	36%
75-84	16%	14%
85 and older	5%	1%
Sex		
Male	48%	47%
Female	52%	53%
Immigrant to Canada		
Yes	16%	91%
Education		
Less than secondary school	18%	13%
Secondary school, no post-secondary	21%	17%
Post-secondary certificate/diploma or university	60%	70%
Income		
No income or income loss	3%	0%
Less than $5,000	2%	0%
$5,000 to $9,999	4%	6%
$10,000 to $14,999	8%	8%
$15,000 to $19,999	10%	12%
$20,000 to $29,999	18%	23%
$30,000 to $39,999	13%	16%
$40,000 to $49,999	11%	13%
$50,000 to $59,999	8%	10%
$60,000 to $69,999	6%	7%
$70,000 to $79,999	4%	3%
$80,000 to $89,999	3%	1%
$90,000 to $99,999	2%	1%
$100,000 or more	9%	6%

Table 1.2. Descriptive characteristics of the self-reported outcomes among sample population, aged 55 years and older by sex

Self-Reported Outcome	Men (%)	Women (%)
Unmet health needs		
Yes	3%	4%
Hypertension		
Yes	37%	38%
Self-rated health		
Fair, poor	17%	17%

Self-Reported Outcome	Men (%)	Women (%)
Has arthritis		
Yes	32%	46%
Has diabetes		
Yes	16%	12%
Has COPD		
Yes	6%	7%
Has cancer		
Yes	5%	3%
Has heart disease		
Yes	14%	9%
Satisfaction with life		
Satisfied, dissatisfied, very dissatisfied	90%	93%
Perceived life stress		
A bit stressful, quite a bit stressful, extremely stressful	48%	54%
Perceived mental health		
Fair, poor	5%	6%
Self-reported weight		
Weight issues	44%	47%
Type of drinker		
Regular or occasional drinker	80%	75%
Type of smoker		
Daily, occasional	16%	13%

Regression modeling: Additive versus. multiplicative effect

Table 1.3 presents a series of estimates of disease prevalence for Black and White individuals aged 55 years and older derived from multivariate logistic regression models. Model 1 is a conventional additive model that assumes the consequences of race and gender are independent of each other. It therefore includes only the main effects of race and gender, controlling for age and survey year as well as other confounding factors (socioeconomic status, etc.). This additive model suggests that disease risk can be shaped by both race and gender. Specifically, compared to White men, Black respondents were more likely to report having high blood pressure (OR = 1.84; CI = 1.62-2.08) and had higher odds of reporting diabetes (OR = 2.04; CI = 1.76-2.35). Black people were also more likely to perceive their health as fair or poor (OR = 1.37; CI = 1.18-1.59). The

results also suggest that gender does somewhat influence disease risk; while women were less likely to report having unmet health needs (OR = 0.84; CI = 0.79-0.89) and to perceive their health as fair or poor (OR=1.13; CI = 1.1-1.16), they were also more likely to report having cancer (OR = 1.43; CI = 1.36-1.51) and heart disease (OR = 1.66; CI = 1.61-1.71). Similarly, Black women were almost three times more likely to report having diabetes (OR = 2.77; CI = 2.26-3.4), even though they were less likely to report having weight issues (OR = 0.47; CI = 0.38-0.57) which is a risk factor for type II diabetes.

To test whether the effects of race and gender were instead contingent on each other in a multiplicative way (that is, the intersectionality hypothesis), Model 2 (Table 1.4) added a race x gender interaction term. Contrary to the hypothesis, the interaction coefficient was not statistically significant with the exception of arthritis (OR = 1.34; CI = 1.02-1.76), heart disease (OR = 1.62; CI = 1.02-2.57), and behaviour factors such as smoking (OR = 0.49; CI = 0.31-0.77) and drinking (OR = 0.55; CI = 0.42-0.72). However, the combination of a higher odds of high blood pressure for Black people compared to White people (OR = 1.84; CI = 1.62-2.08), lower odds of high blood pressure for females compared to males (though not significant), and a higher odds for Black + female (OR = 1.64; CI = 1.36-1.97) suggests that the impact may be gendered, though it is additive.

Table 1.3. Odds ratios from additive multivariate logistic regression models estimating risk of self-reported health, by race and gender (with 95% confidence intervals), controlling for age and survey year

Model 1						
	Black		**Female**		**Black Woman**	
	OR	**CI**	**OR**	**CI**	**OR**	**CI**
Unmet health needs	1.11	(0.81-1.51) ns	0.84	(0.79-0.89)	0.86	(0.52-1.43) ns
Perceived health	1.37	(1.18-1.59)	1.13	(1.1-1.16)	1.4	(1.12-1.74)
Satisfaction life	0.89	(0.64-1.24) ns	0.98	(0.92-1.04) ns	0.7	(0.45-1.07) ns
Perceived mental health	1.22	(0.96-1.56) ns	1.01	(0.97-1.06) ns	1.22	(0.85-1.74) ns
Perceived life stress	1.01	(0.89-1.15) ns	0.78	(0.76-0.8)	0.81	(0.67-0.98)
Has asthma	1.02	(0.81-1.29) ns	0.65	(0.62-0.67)	0.73	(0.51-1.04) ns
Has arthritis	0.81	(0.71-0.93)	0.58	(0.57-0.59)	0.4	(0.32-0.49)
Has high blood pressure	1.84	(1.62-2.08)	0.99	(0.96-1.01) ns	1.64	(1.36-1.97)
Has COPD	0.48	(0.35-0.67)	0.95	(0.91-0.98)	0.47	(0.29-0.76)
Has diabetes	2.04	(1.76-2.35)	1.45	(1.41-1.49)	2.77	(2.26-3.4)
Has cancer	0.98	(0.71-1.34)	1.43	(1.36-1.51)	1.7	(1.14-2.54)
Has heart disease	0.62	(0.49-0.79)	1.66	(1.61-1.71)	0.82	(0.58-1.15) ns
Self-reported weight issues	0.63	(0.55-0.72)	0.84	(0.82-0.86)	0.47	(0.38-0.57)
Smoking	0.56	(0.45-0.7)	1.21	(1.17-1.25)	0.91	(0.69-1.2) ns
Alcohol consumption	0.46	(0.4-0.52)	1.46	(1.42-1.49)	0.93	(0.76-1.15) ns

Note: This model aimed to establish associations between racial identity and outcomes while controlling for age and survey year as confounders. White men were used as the reference level.
ns = non-significant at the 0.05 level

Table 1.4. Odds ratios from multiplicative multivariate logistic regression models estimating risk of self-reported health, by race and gender (with 95% confidence intervals), controlling for survey year and age

Model 2		
Multiplicative Effect		
	OR	**CI**
Unmet health needs	1.12	(0.59-2.13) ns
Perceived health	1.21	(0.9-1.62) ns
Satisfaction life	1.65	(0.84-3.23) ns
Perceived mental health	1.04	(0.64-1.69) ns
Perceived life stress	0.94	(0.73-1.22) ns
Has asthma	0.86	(0.54-1.38) ns
Has arthritis	1.34	(1.02-1.76)
Has high blood pressure	1.21	(0.94-1.56) ns
Has COPD	0.96	(0.5-1.86) ns
Has diabetes	1.14	(0.86-1.52) ns
Has cancer	0.61	(0.32-1.2) ns
Has heart disease	1.62	(1.02-2.57)
Self-reported weight issues	1.25	(0.96-1.64) ns
Smoking	0.49	(0.31-0.77)
Alcohol consumption	0.55	(0.42-0.72)

Note: This model aimed to provide further insight into the degree to which any associations established in the previous model changed with the addition of interaction terms. White men were used as the reference level.
ns = non-significant at the 0.05 level

Regression modeling: Mediators of risk

To determine what factors, underlie the inequality observed in Model 1 for disease outcomes, Model 3 (Table 1.5.) adds controls for immigration and socioeconomic status as well as health behaviours such as smoking and drinking alcohol. It is observed that the magnitudes of the odds ratios for race, gender, and race x gender seen in Model 1 are slightly attenuated and largely remain statistically significant. Thus, controlling for group differences in these factors is insufficient in explaining, for instance, the elevated odds of hypertension observed in Black women. Similarly, results observed in Model 2, where gender and race were added to the model as interaction terms, were consistent in Model 4 after controls were added.

Table 1.5. Odds ratios from additive multivariate logistic regression models estimating risk of self-reported health, by race and gender (with 95% confidence intervals), controlling for survey year, immigration status, education, income, smoking, alcohol consumption and weight

Model 3						
	Black		**Female**		**Black Women**	
	OR	**CI**	**OR**	**CI**	**OR**	**CI**
Unmet health needs	1.12	(0.79-1.58) ns	0.92	(0.86-0.98)	0.87	(0.49-1.54) ns
Perceived health	1.44	(1.21-1.72)	1.41	(1.37-1.46)	1.7	(1.31-2.2)
Satisfaction life	0.88	(0.62-1.26) ns	0.8	(0.75-0.85)	0.63	(0.4-1.01) ns
Perceived mental health	1.14	(0.86-1.5) ns	1.23	(1.18-1.29)	1.22	(0.82-1.83) ns
Perceived life stress	1.02	(0.88-1.17) ns	0.75	(0.73-0.77)	0.73	(0.6-0.9)
Has asthma	1.32	(1.02-1.71)	0.69	(0.66-0.73)	1	(0.68-1.47) ns
Has arthritis	0.84	(0.73-0.98)	0.63	(0.61-0.64)	0.43	(0.34-0.54)
Has high blood pressure	2.01	(1.74-2.32)	1.09	(1.06-1.11)	1.98	(1.61-2.43)
Has COPD	0.65	(0.44-0.94)	1.03	(0.98-1.08) ns	0.52	(0.28-0.95)
Has diabetes	2.41	(2.04-2.84)	1.7	(1.64-1.75)	3.85	(3.06-4.85)
Has cancer	0.97	(0.68-1.4) ns	1.44	(1.36-1.53)	1.72	(1.1-2.7)
Has heart disease	0.66	(0.5-0.87)	1.82	(1.76-1.89)	1.01	(0.68-1.48) ns

Note: This model aimed to provide further insight into the degree to which socioeconomic status and modifiable risk factors changed any associations established in the previous model. White men were used as the reference level.
ns = non-significant at the 0.05 level

Table 1.6. Odds ratios from multiplicative multivariate logistic regression models estimating risk of self-reported health, by race and gender (with 95% confidence intervals), controlling for survey year, immigration status, education, income and alcohol consumption and weight.

Model 4		
Multiplicative Effect		
	OR	**CI**
Unmet health needs	1.3	(0.64-2.64) ns
Perceived health	1.41	(1-2)
Satisfaction life	1.27	(0.62-2.58) ns
Perceived mental health	1.31	(0.76-2.25) ns
Perceived life stress	1.07	(0.81-1.42)
Has asthma	0.85	(0.51-1.41) ns
Has arthritis	1.45	(1.07-1.97)
Has high blood pressure	1.18	(0.89-1.57) ns
Has COPD	1.57	(0.72-3.39) ns
Has diabetes	1.11	(0.81-1.53) ns
Has cancer	0.61	(0.29-1.28) ns
Has heart disease	1.52	(0.89-2.61) ns

Note: This model aimed to provide further insight into the degree to which socioeconomic status and modifiable risk factors changed any associations established in the previous model. White men were used as the reference level.
ns = non-significant at the 0.05 level

Discussion

This is one of the first studies in Canada to examine the health consequences of intersections of racialization and gender among older adults in Canada. Overall, there was no significant change between the results from the additive models when compared to the models with interaction terms, suggesting that the relationship may in fact be additive. There was however some evidence that inequality was conditioned by gender, as older women were twice as likely to be at risk of diabetes, high blood pressure, and heart disease than surviving men of the same age (caveat: mortality crossover bias). The models also indicate that differences in modifiable risk factors, which included smoking and alcohol consumption, are not sufficient to explain the differences in outcomes observed between men and women.

This study represents an important extension of previous work concerning the impact of the intersections of race and gender on health for several reasons (Veenstra G. , 2013; Veenstra & Patterson, 2016). Firstly, the results of this study vary from those that were previously presented, and as such they do not immediately support the hypothesis of the theory of cumulative advantage/disadvantage. In this sample, the results shown in Models 1, 2, and 3 would suggest that women are at higher risk of heart disease as compared to men in the sample. While the prevalence of heart disease is higher among men than women, it is still the number one cause of death in Canada among women over the age of 55. Women are more likely to die from heart disease than from other diseases because of menopause, hypertension, and diabetes (Government of Canada, 2022). There are studies that suggest the lower rates of heart disease reported among women can be attributed to either a "diagnostic artifact" or "gendered ageism," where ageism starts earlier for women than men in certain areas, including healthcare. The male/female differential in heart disease may be attributed to a diagnostic artifact, specifically, the under detection of heart disease

among women caused by an unconscious bias among physicians to ascribe the symptoms of a real heart attack among premenopausal women to some other disorder (McKinlay, 1996). Simultaneously, Arber et al. (2006) completed a factorial experiment to examine how four patient characteristics impact on primary care doctors' decisions regarding coronary heart disease. The results demonstrated that patients' gender significantly influenced doctors' diagnostic and management activities. Women were asked fewer diagnostic questions, received fewer examinations, and had fewer diagnostic tests for heart disease (Arber, et al., 2006). Gendered ageism was suggested as an explanation for this difference, as women between the age of 55 to 65 were asked the fewest questions and prescribed the least medication appropriate for heart disease (Arber, et al., 2006).

In this study, Black women were at increased risk of diabetes and hypertension after controlling for confounding factors (Model 3), which is consistent with the literature in both Canada and the US (Veenstra G. , 2013; Geronimus, Bound, Keene, & Hicken, 2007; Patterson & Veenstra, 2016; Richardson & Brown, 2016). The rates of diabetes particularly among Black Canadians is also consistent with research from the US, which links chronic stress and internalized racism to insulin resistance and other precursors of type II diabetes (Patterson & Veenstra, 2016). Further, given that most Black people in the sample were immigrants, the differences in the outcomes may also reflect the fact that the most common countries of origin of Black immigrants and White immigrants, for instance, have different rates of diabetes that affect the prevalence of these chronic illnesses in their emigrants (Patterson & Veenstra, 2016).

Also, unlike Veenstra's (2013) study, smaller differences were noticed between men and women from an additive perspective, and multiplicative effects were not observed among Black women where expected. Similarly, the results of this study were not aligned with results from

American studies such as those published by Richardson, Brown and Tyson (2016) and Geronimus et al. (2007). These differences between Canada and the US can be attributed to the context as suggested by Ramraj et al (2016). In Canada the differences can likely be explained by several factors. Firstly, a large proportion of the Black population in Canada are immigrants and thereby subject to the healthy immigrant effect. Moreover, the social and political history of Black people in Canada is vastly different from that of African Americans. Further, Canada's healthcare system and policy of universal health insurance mitigate many inequities, as hospital and physician services in Canada are delivered by publicly funded institutions (Siddiqi & Nguyen, 2010). This may likely explain the low reports of unmet health needs. Another study by Siddiqi and Hertzman suggested that greater income equality, social spending, and social cohesion may be explanations for the superior population health and smaller gaps in health inequality that are observed in Canada compared to the US (Siddiqi & Hertzman, 2007).

The results suggest that the extent of racial inequities in health is heavily dependent on societal context as the results are inconsistent with similar studies using intersectionality conducted in the US (Richardson & Brown, 2016). Similarly, studies that look at chronic diseases such as hypertension have shown an increased risk among racialized people in the US (Geronimus, Bound, Keene, & Hicken, 2007; Richardson & Brown, 2016). Further, the prevalence and incidence of chronic diseases such as arthritis among women is consistent with results published from the Canadian Chronic Disease Surveillance System, where arthritis diagnosis is higher among women aged 55 and older (1.7% and 1.0% per 1,000 persons per year respectively) compared to older men (Public Health Agency of Canada, 2020).

Although this study has the advantage of being the first of race inequalities in health among racialized older adults in Canada, it does have several limitations. Specifically, multiple cycles of

the CCHS were merged to produce large enough sample sizes for the Black category. Even after combining these available cycles of the CCHS, the sample of Black older adults was still comparatively smaller than the sample of White older adults, making further analysis of the study population at the intersection of different axes of inequality difficult. Combining multiple years makes interpretation of prevalence rates ambiguous, and even more so as the analysis is unweighted, and the samples do not represent the current population. In addition, the CCHS has several key issues with measurement of race. The measure of race confounds race and ethnicity by including the term "cultural background" in the survey question and by providing a range of racial and ethnic identities as potential responses to this question (Veenstra G. , 2013). Secondly, the absence of other variables related to discrimination in the CCHS limited the study's ability to conduct a proper analysis that links discrimination and internalized discrimination to health outcomes. Finally, this study examined self-reported responses to various health-related questions, rather than patient records with medical diagnoses. There may be concerns about recall bias if respondents in the sample remembered or perceived their health behaviours and health status incorrectly.

This study suggests important future considerations. Countries such as Canada, that have not been as progressive as countries such as the US in systematically collecting data on race and assuring adequate sample sizes of various racial groups should actively seek to improve survey data in this regard or over sampling in minority communities. Experiences of aging could be more accurately measured by developing measures of historical social wellbeing that could account for the source of chronic illnesses. In conclusion, despite its limitations, this study suggests there is still much to learn with regards to health inequalities in Canada and the need to explain the cumulative effect of health inequalities among racialized older adults.

References

Ailshire, J. A., & House, J. S. (2011). The unequal burden of weight gain: An intersectional approach to understanding social disparities in BMI trajectories from 1986 to 2001/2002. *Social Forces, 90*(2), 397-423.

Arber, S., McKinlay, J., Adams, A., Marceau, L., Link, C., & O'Donnell, A. (2006). Patient characteristics and inequalities in doctors' diagnostic and management strategies relating to CHD: A video-simulation experiment. *Social Science and Medicine, 62*(1), 103-115.

Brown, T. H., Richardson, L. J., Hargrove, T. W., & Thomas, C. S. (2016). Using multiple-hierarchy stratification and life course approaches to understand health inequalities: The intersecting consequences of race, gender, SES and age. *J Health Soc Behav, 57*(2), 200-222. doi:10.1177/0022146516645165

Chiu, M., Maclagan, L. C., Tu, J. V., & Shah, B. R. (2015). Temporal trends in cardiovascular disease risk factors among white, South Asian, Chinese and black groups in Ontario, Canada, 2001 to 2012: a population-based study. *BMJ, 5*(e007232). doi:10.1136/bmjopen-2014-00732

Collins, P. (2000). Gender, black feminism, and black political economy. *The Annal of the American Academy of Political and Social Science, 568*(1), 41-53.

Collins, P. H. (2015). Intersectionality's definitional dilemma. *Annual Review of Sociology, 41*(1), 1-20.

Corti, M.-C., Guralnik, J. M., Ferrucci, L., Izmirlian, G., Leveille, S., Pahor, M., . . . Havlik, R. J. (1999). Evidence for a Black-White crossover in all-cause and coronary heart disease mortality in an older population: the North Carolina EPESE. *American Journal of Public Health, 89*(3), 308-314.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feministy critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1), 139-167.

Crystal, S., & Shea, D. (2003a). Cumulative advantage, public policy, and late-life inequality. In S. Crystal, & D. Shea, *Economic outcomes in later life: Public policy, health, and cumultive advantage* (pp. 1-13). New York: Springer.

Else-Quest, N., & Hyde, J. S. (2016). Intersectionality in Quantitative Psychological Research: 1. Theoretical and Epistemological Issues. *Psychology of Women Quaterly, 40*(2), 155-170.

Etowa, J., Wiens, J., Bernard, W. T., & Clow, B. (2007). Determinants of Black Women's Health in Rural and Remote Communities . *CJNR, 39*(3), 56-76.

Geronimus, A. T., Bound, J., Keene, D., & Hicken, M. (2007). Black-White difference in age trajectories of hypertension prevalence among adult women and men, 1999-2002. *Ethnicity & Disease, 17*(1), 40-48.

Government of Canada. (2022, February 2). *Cardiovascular Disease: Are Women at Risk of Heart Disease*. Retrieved from Public Health Agency of Canada: https://www.canada.ca/en/public-health/services/chronic-diseases/cardiovascular-disease/women-risk-heart-disease.html [Accessed March 14, 2022]

Gueta, K. (2017). A qualitative study of barriers and facilitators in treating drug use among Israeli mothers: An intersectional perspective. *Social Science and Medicine, 187*, 155-163.

Havinsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., . . . Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International Journal for Equity in Health, 13*, 119.

Hyman, I., O'Campo, P., Ansara, D. L., Siddiqi, A., Forte, T., Smylie, J., . . . McKenzie, K. (2019). *Prevalence and predictors of everyday discrimination in Canada: Findings from the Canadian Community Health Survey.* Toronto: Wellesley Institute. Retrieved from https://www.wellesleyinstitute.com/wp-content/uploads/2019/10/Prevalence-and-Predictors.pdf [Accessed March 14, 2022]

Johnson, N. (2000). The racial crossover in comorbidity, disability, and mortality. *Demography, 37*(3), 267-283.

Kaushik, V., & Walsh, C. A. (2018). A critical analysis of the use of intersectionality theory to understand the settlement and integration needs of skilled immigrants to Canada. *Canadian Ethnic Studies, 50*(3), 27-47.

LaVeist, T. A. (1994, Apr). Beyond Dummy Variables and Sample Selection: What Health Services Researchers Ought To Know about Race as a Variable . *Health Services Research, 29*(1), 1-16.

Lu, C., & Ng, E. (2019). *Healthy immigrant effect by immigrant category in Canada.* Ottawa: Statistics Canada. Retrieved from https://www150.statcan.gc.ca/n1/pub/82-003-x/2019004/article/00001-eng.htm [Accessed March 14, 2022]

Lynch, S., Brown, J., & Harmsen, K. (2003). Black-white differences in mortality compression and deceleration and the mortality crossover reconsidered. *Research on Aging, 25*(5), 456-483.

McCall, L. (2005). The Complexity of Intersectionality. *Signs: Journal of Women in Culture and Society, 30*(3), 1771-1880.

McKinlay, J. (1996). Some contributions from social system to gender inequalities in heart disease. *Journal of Health and Social Behavior, 37*(1), 1-26.

Patterson, A. C., & Veenstra, G. (2016). Black-white health inequalities in Canada at the intersection of gender and immigration. *Canadian Journal of Public Health, 107*(3), e278-e284.

Public Health Agency of Canada. (2011). *Diabetes in Canada: Facts and Figures from Public Health Perspective.* Ottawa. Retrieved from https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/pdf/facts-figures-faits-chiffres-eng.pdf [Accessed March 14, 2022]

Public Health Agency of Canada. (2020, December 24). *Rheumatoid arthritis in Canada*. Retrieved from Government of Canada: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/rheumatoid-arthritis.html [Accessed March 14, 2022]

Public Health Agency of Canada. (2021, 10 13). *Surveillance of heart diseases and conditions*. Retrieved from Government of Canada: https://www.canada.ca/en/public-health/services/diseases/heart-health/heart-diseases-conditions/surveillance-heart-diseases-conditions.html [Accessed March 14, 2022]

Purdie-Vaughns, V., & Eibach, R. (2008). Intersectional invisibility: the distinctive advantages and disadvantages of multiple subordinate-group identities. *Sex, 59*, 377-391.

Ramraj, C., Shahidi, F. V., Darity Jr., W., Kawachi, I., Daniyal, Z., & Siddiqi, A. (2016). Equally inequitable? A cross-national comparative study of racial health inequalities in the United States and Canada. *Social Science and Medicine, 161*, 19-26.

Richardson, L. J., & Brown, T. H. (2016). (En)gendering racial disparities in health trajectories: A life course and intersectional analysis. *SSM-Population Health, 2*, 425-435.

Siddiqi, A., & Hertzman, C. (2007). Towards an epidemiological understanding of the effects of long-term institutional changes in population health: A case study of Canada vs the US. *Social Science and Medicine, 64*, 589-603.

Siddiqi, A., & Nguyen, Q. C. (2010). A cross-national comparative perspective on racial inequities in health: the USA versus Canada. *J. Epidemiol. Commun Health, 64*(1), 29-35.

Siddiqi, A., Shahidi, F. V., Ramraj, C., & Williams, D. R. (2017). Associations between race, discrimination and risk for chronic disease in a population-based sample from Canada. *Social Science and Medicine, 194*, 135-141.

Veenstra, G. (2009, Aug). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science and Medicine, 69*(4), 538-542.

Veenstra, G. (2013). Race, gender, class, and sexuality (RGCS) and hypertension. *Social Science and Medicine, 89*, 16-24.

Veenstra, G., & Patterson, A. C. (2016). Black-White Health Inequalities in Canada. *J Immigrant Minority Health, 18*, 51-57.

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and Health: Evidence and Needed Research. *Annual Review of Public Health, 40*, 105-125.

ARTICLE 2: "BUT…I SURVIVED": A PHENOMENOLOGICAL STUDY OF THE HEALTH AND WELLBEING OF AGING BLACK WOMEN IN TORONTO, CANADA.

Foster, N. Kapiriri, L. Grignon, M. and McKenzie, K. (2022). "But…I survived": A phenomenological study of the health and wellbeing of aging Black women in Toronto, Canada. Journal of Women and Aging, https://doi.org/10.1080/08952841.2022.2079925

Abstract:

Studies that assess the association between race and health have focused intently on the cumulative impact of continuous exposure to racism over an extended period. While these studies have contributed significantly to the general understanding of the life experiences and health status of racialized people, few studies have explicitly bridged the experiences of aging with gender and the wide structural barriers and social factors that have shaped the lives of racialized older women. This study aimed to investigate the origins of health inequities to highlight factors that intersect to affect the health and wellbeing of older Black women across their life course. Descriptive phenomenology was used to describe older Black women's health and wellbeing, and factors that impact their health across their life course. Criteria-based sampling was used to recruit study participants (n=27). To be eligible women needed to be 55 years or older, speak English, self-identify as a Black female, and live in the Greater Toronto Area. Data analysis was guided by phenomenology. Themes identified demonstrated that participants' health and wellbeing were influenced by gender bias, racism, abuse, and retirement later in life. Participants reported having poor mental health during childhood and adulthood due to anxiety and depression. Other chronic illnesses reported included hypertension, diabetes, and cancer. Qualitative methods provided details regarding events and exposures that illuminate pathways through which health inequities emerge across the life course.

Key Words: Gender, Race, Phenomenology, Aging, Disparities

Introduction

There are opportunities in gerontology to further explore how identity categories such as race/racialization intersect with life events across the life course to affect health and wellbeing. Race has been used as a proxy for other variables that are either known or believed to correlate with socioeconomic status, discrimination, cultural factors, etc. (LaVeist T. A., 1994). Veenstra (2009) highlights the social importance of race in the measurement of health as it is meant to capture the process of racialization, which is expressed in the form of racism embedded in institutional and state policies as well as displayed by individuals in day-to-day interactions (LaVeist T. A., 1994; Williams, Lawrence, & Davis, 2019). In 2015, Phelan and Link expanded their 1995 (Link & Phelan, 1995) study that conceptualized social conditions as "fundamental causes" of disease to include racism as a structural factor that could be described as a fundamental cause of health inequalities. They demonstrated multiple racial inequalities in mortality and other health outcomes between Black and White people, which were still present when socioeconomic factors were controlled (Phelan & Link, 2015). Racism as a fundamental cause of health inequalities was attributed to several factors such as prestige (i.e., status – present in occupational structures), power, beneficial social connections, and stress (physiological and health deterioration due to cumulative stress from discrimination – also known as "weathering" – quality of care and neighbourhood effects) (Phelan & Link, 2015).

Some of the literature notes that the persistence of racial inequities in health are understood in the context of relatively stable racialized social structures that determine differential access to risks, opportunities, and resources that drive health (Williams, Lawrence, & Davis, 2019). Structural approaches to health have been significant in informing interventions that not only address material differences that impact health, but also the broader social spectrum including

education and the physical environment inhabited by individuals (Phelan & Link, 2015). Though there are studies that focus intently on the cumulative impact of continuous exposure to racism over an extended period, very few also bridge the personal stories of aging with wider structural barriers and the unique realities and histories that shaped the lives of racialized older women. Consequently, this study aimed to bridge the experiences of aging with gender by investigating the origins of health inequities to highlight factors that intersect to affect the health and wellbeing among Black women aged 55 and older in the Greater Toronto Area, Canada.

Race and health inequalities in Canada

This study focuses on "race" rather than ethnicity as it is designed to understand the effects of racialization on health from the perspective of older Black women. The definition of "race" that has been adopted within the context of this study reflects the consensus among the social sciences that race is a sociopolitical construct with strong cultural and ethnic components that is often used to classify differences between people (Williams, 1997). Race has become socially important in the measurement of health as it is meant to capture the process of racialization, expressed in the form of racism embedded in institutional and state policies as well as displayed by individuals in day-to-day interactions (LaVeist T. A., 1994). This understanding of race and its application in research has been leveraged for this study.

Canada is one of the most diverse countries in the world with over 5.1 million Canadians (or 14% of the population) who self-identify as a visible minority, 50% of whom are women (Hudon, 2016). More than half of the Black population are immigrants. Before 1981, 83% of these immigrants were from Haiti and Jamaica, a percentage which was later reduced to 27% between 2011 to 2016 (Statistics Canada, 2019). Most of this population reside in large urban areas such as Toronto, which has the largest Black population (36.9% of Canada's Black population) in the

country (Statistics Canada, 2019). Despite Canada's diversity, little is known about changes in, or exposures to, disease risk factors over time among groups such as Black women who represent 15% of all visible minority women in Canada.

Many of the previous studies that have investigated differences in health by race in Canada use methods that rely on data from nationally representative cross-sectional surveys such as the Canadian Community Health Survey (CCHS) and intersectionality as an analytical framework. As an analytical framework, the intersectional framework assumes that our society has multiple systems of social stratification and that no social group is homogeneous (Kaushik & Walsh, 2018). Intersectionality has been used as a systematic approach to understanding human life and behaviour that is rooted in the experiences and struggles of marginalized people (Kaushik & Walsh, 2018). It proposes that axes of inequality brought about by discriminatory acts stemming from racism, sexism and agism are contingent upon one another rather than analytically distinct systems (Patterson & Veenstra, 2016).

Veenstra (2013) conducted a study using the CCHS and intersectionality as an analytical framework to investigate the degree to which race, gender, class, and sexuality manifest distinct and interconnected associations with self-reported hypertension. Findings demonstrated that Black respondents who were poor and possessed less than a high school level of education were significantly more likely than White, wealthier, and university-educated respondents, respectively to report hypertension. The study demonstrated that Canadians experience health effects of education differently by their genders, and the health effects of income differently by the identities defined at the intersection of race and gender (Veenstra G. , 2013). In another study, Veenstra and Patterson (2016) used the CCHS to investigate health inequalities between Black and White Canadians. The results demonstrated that Black men and women were more likely than their White

counterparts to report hypertension and diabetes. Also, Black women were less likely than White women to report cancer and Black men were less likely than White men to report heart disease.

Like race, gender is a social construct that is comprised of cultural distinctions between males and females. Gender influences risks, health-seeking behaviours, and health outcomes, and as well as individual access to healthcare systems and the response of those systems. When compared to men, women live longer but often suffer from more chronic, disabling conditions (Crimmins, Kim, & Sole-Auro, 2010).

Etowa, Wiens, Bernard and Clow (2007) used a participatory action research approach to identify the determinants of Black women's health. A total of 237 in-depth one-on-one interviews were conducted with Black Canadian women residing in rural and remote regions of Nova Scotia. Themes emerged that emphasized Black women's multiple roles and experiences with the healthcare system as factors that affect their health. Black women discussed their experiences with racism and expressed that it caused significant stress which contributed to issues such as low self-esteem and chronic conditions (Etowa, Wiens, Bernard, & Clow, 2007).

In the United States, the use of racial and ethnic variables in biomedical and public health research have been instrumental in highlighting health disparities (Rodney & Copeland, 2009). A comparative study conducted by Siddiqi and Nguyen (2010) measured inequities in health by race between Canada and the US. Results demonstrated that, compared to the US, racial inequities in health were less in Canada. These results could be explained as being context driven as Canada has a higher proportion of Black immigrants and so results may be subject to the "healthy immigrant" effect which suggests that recent immigrants are healthier than long-standing residents (Siddiqi & Nguyen, 2010). Further, Black Americans are far more likely than Black Canadians to be descendants of ancestors who had been exposed to the American system of plantation-based

slavery, widespread government sanctioned segregation, and ongoing discrimination and racism reinforced by institutional policies (Ramraj, et al., 2016).

Life course and the study of health among Black women

Literature on aging and health disparities investigates whether social inequality decreases, remains the same, or increases with age, i.e., the life course perspective (Brown, Richardson, Hargrove, & Thomas, 2016). The life course perspective is a multi-theoretical conceptual framework that has been used extensively to study various events individuals experience over the course of their lives. It suggests that events experienced earlier in life create changes in patterns of thoughts and actions later in life as the result of adaptation through the processes of socialization, stress and coping, and human development (Burton-Jeangros, Cullati, Sacker, & Blane, 2015). A life course approach is used to study the physical and social hazards during the 'critical periods' of life, or more specifically during childhood, adolescence, young adulthood, and late life. The framework emphasizes the need to consider how non-physiological issues such as how the transmission of wealth and/or educational attainment across generations may contribute to health disparities; also conversely, how experiencing favourable material and social conditions from preconception to old age can contribute to better health in an individual's lifetime and in subsequent generations (Braveman P. , 2014).

Life course research on health has shown the cumulative effects on outcomes of race/ethnicity and gender among Black women. Ailshire and House (2011) used an intersectional approach and the longitudinal and nationally representative American's Changing Lives study (1986-2011/2002) to study social disparities in body mass index (BMI) trajectories. Results showed that the greatest increase in BMI was among individuals aged 25-39 to 45-54 as well as among low-educated and low-income Black women while highly educated and high-income white men

experienced the least BMI growth during the study period (Ailshire & House, 2011). These results were consistent with an earlier study conducted by Geronimus, Bound, Keene and Hicken (2007) that described age patterns of hypertension prevalence in young through middle-aged adults and to test the hypothesis that hypertension prevalence rises more rapidly with age among Black people than White people in the US. Study outcomes demonstrated that Black/White odds of hypertension increased with 1.71 to 3.12 between ages 15 and 65 (Geronimus, Bound, Keene, & Hicken, 2007). Odds for women increased faster, from 2.11 to 4.04 with Black women having the highest hypertension rates by age 40. Adjustment for income did not change the results (Geronimus, Bound, Keene, & Hicken, 2007). Other studies on the aging experiences of women suggest that there is cumulative disadvantage since women take time off from work for childbearing and maternity leave and thus experience losses in salary and other financial benefits (Craciun & Flick, 2016). This situation often leads to economic inequality in old age. While overall poverty rates for the elderly have declined, the relation between gender differences in late-life poverty and income persists. In Canada, women aged 65 and over are more likely to live in low-income households than their male counterparts (Fox & Moyser, 2018). These reports are limited in their analysis as results are not shown by race/ethnicity though there is evidence linking socioeconomic status to poor health outcomes (Bartley, 2004). Canada's collection and reporting on race are through broad categories such as "racialized" and "visible minority" status as surrogates for race and ethnicity, which can hide disparity. Consequently, research that fills this gap in knowledge surrounding the health and wellbeing of racialized and other people marginalized by gender, age and socioeconomic status can illuminate pathways through which inequities can emerge during the aging process.

Theoretical Framework

This study uses the intersectional life course perspective (Ferrer, Grenier, Brotman, & Koehn, 2017). The intersectional life course perspective is a comprehensive framework that integrates the structural forces and diverse pathways of aging of the life course approach with that of intersectionality to analyze experiences of aging among older people from racialized groups (Ferrer, Grenier, Brotman, & Koehn, 2017). The framework has four main components. Firstly, key life course events, the timing of these events, and the structural forces that have contributed to these moments are considered. This would include key transitions such as im/migration that can significantly shape experience. Secondly, the idea of linked lives is expanded from individuals and families to families across generations and national/international borders. Individual trajectories are rarely experienced in isolation, and implicate multiple family members, intergenerational relationships, and transnational contexts. This intersectional life course perspective considers how people organize their lives, and formulate their identities based on relationships that occur with family, ancestors, between generations and across transnational contexts. Thirdly, the framework accounts for identities and the categories/processes of difference/differentiation as defined through structural and institutional relations that shape experiences and identities. Finally, the framework contextualizes experience within the wider systems of domination (e.g., racism, colonialism, sexism, patriarchy).

The intersectional life course perspective provides an opportunity for a more integrated analysis of the interplay between identity categories, individual chronological life events and the impact of institutions, policies, and broader histories and systems that shape identities over a lifetime (Ferrer, Grenier, Brotman, & Koehn, 2017). Qualitative research is particularly suitable for examining the complex intersectionality of race, class, and gender (Gueta, 2017, p. 156).

Intersectionality-informed qualitative analysis can assist researchers to have a more nuanced understanding of factors and processes that shape an individual's health across their life course (Hunting, 2014).

Present study

This paper is a part of a research study completed as a part of a doctoral studies program requirement. The present study aimed to answer the following question: what are the factors that have affected the health and wellbeing of older Black women aged 55+ in Toronto, Canada? How have these factors intersected to affect the health and wellbeing of older Black women in Toronto, Canada over their life course? The objectives of this study are to bridge the experiences of aging with gender and race by investigating the origins of health inequities to highlight factors that intersect to affect the health and wellbeing of Black women aged 55 and older in Toronto, Canada across their life course.

To address the study's objectives a qualitative research design using descriptive phenomenology was deemed appropriate to describe the origins of health inequities and highlight areas of intersections that affect the health and wellbeing of the study's population. Phenomenology requires the researcher to set aside their experiences, as much as possible, to take a fresh perspective toward the phenomenon under investigation (Mayoh & Onwuegbuzie, 2015). Ultimately, with descriptive phenomenology, the researcher emerges with a description uninfluenced by the researcher's presuppositions of a phenomenon (Matua & Van Der Wal, 2015). Phenomenology facilitates a richly descriptive analysis of the origins of inequities told in the research participants' own voice and settings that are familiar and comfortable to them. Such rich descriptions of experiences cannot be told through surveys such as the CCHS. Health was used to describe the physical and mental health status of the study population and wellbeing was used to

describe the overall quality of life of participants. Phenomenology was used to frame the interview questions as well as in the analysis of the qualitative data.

Materials and Methods

Participants and Recruitment

Guided by phenomenology, purposive sampling methods were used to recruit study participants who met the study criteria and could provide a diverse range of perspectives. To be eligible for this study, women needed to be 55 years or older, speak English, self-identify as a Black female, and live in the census defined borders of the Greater Toronto Area. A total of 27 women, who met the previously outlined criteria. were recruited. Most participants were immigrants (23), who emigrated from either the Caribbean (20) or the United Kingdom (3). Participants were recruited using a mix of active and passive recruitment strategies that were implemented through partnerships with community health centres (2), local churches (3), and various ethnic (20) and professional associations (2). Active recruitment included the researcher attending meetings or events to recruit participants by discussing the study objectives. Passive recruitment included distributing posters through community partners. Recruitment continued until saturation was achieved. Participants were compensated with a $25 Tim Hortons gift card.

Research ethics approval

This study received ethics approval from the Research Ethics Board (REB) of McMaster University in Hamilton, Ontario, Canada (MREB #2370). Ethics approval was also received from Carefirst Seniors and Community Services Associations and Scarborough Centre for Healthy Communities. Participants were asked to review and sign a written consent form which outlined the study purpose, associated risks, privacy, and timelines for completion.

Data Collection

Semi-structured interviews were conducted with all participants between October 2019 and May 2020. An interview guide informed by phenomenology and the intersectional life course approach was developed. Phenomenology enabled the researcher to ask questions about the participants' lived experiences to generate a detailed description of participants' common experiences. Five categories of questions were outlined based on the intersectionality life course perspective to further the identification of life events, timing, and structural forces outlined that have impacted the women's health and wellbeing. Specifically, categories used were demographics, health and wellbeing, aging, race, and gender. Critical periods were identified within each category; specifically, childhood (from birth up to age 11), adolescence (ages 12-16 years), adulthood (ages 18-64) and late life (age 65 and older). Interview questions were developed to obtain rich, vital, and substantive descriptions of the participants' experience. One question, for example: "As an adult, tell me about a time when you felt being a Black woman impacted your experiences at work? How did that make you feel?" Each interview was opened by asking general demographic questions to describe the sample population. Participants were then asked questions about their experiences with race and gender, their perception of their health and wellbeing and the relation to these experiences during their childhood, adolescence, adulthood and then later in life. The interviews were conducted in English as open conversations. Interviews followed the interview guide for initial direction and to ensure that the same categories of questions were covered with each participant.

Interviews were conducted by the study's principal investigator. Each interview was digitally recorded with written permission from the participants. Supplementary notes were taken by the interviewer during the interviews. Interviews lasted between one to two hours. To maintain

privacy, interview records were anonymized and saved to a password protected USB drive that was accessible only by the study's principal investigator. Participants were assigned pseudonyms for purposes of reporting. Twenty-six of the 27 interviews were conducted in-person as they were scheduled prior to the beginning of lock-down measures implemented by the Ontario government in response to the Coronavirus pandemic. The last interview was conducted over the phone. All in-person interviews were conducted in locations that were convenient for the participants including public places such as in coffee shops or their ethnic association's facility, or private spaces such as their homes.

Analysis

This study used a phenomenological approach to qualitative data analysis as outlined by Clarke Moustakas, that was a modification of the Stevick-Colaizzi-Keen method of analysis of phenomenological data (Moustakas, 1994). Moustakas recommended that phenomenologists ask the following questions: "What are the individuals' experiences, and in what context did they experience them?" Moustakas' approach focuses on the wholeness of the experience and its essence (Phillips-Pula, Strunk, & Pickler, 2011).

Interview recordings were transcribed verbatim and reviewed by the researcher using NVIVO data analysis software. Coding and analysis were completed in several stages. Moustakas (1994) outlined several steps that were to be taken in using a phenomenological approach to data analysis. These steps were implemented sequentially. First, each statement was considered with respect to the significance for description of the women's life experiences and how their race and gender have impacted their health and wellbeing across their life course. Relevant statements were then recorded. Nonrepetitive and nonoverlapping statements were listed as "meaning units" of the women's experiences. The meaning units were then linked and clustered into themes. These

meaning units and themes were further synthesized into a "description of the textures of experience" with verbatim examples included. Finally, a composite description of participants' experiences that incorporates both the textural and structural descriptions were developed.

Reflexivity and research quality

An essential component of intersectionality is reflexivity. Throughout the study, care was taken to maintain the general quality standards of qualitative research through a series of reflexive practices which included journaling. First, as part of the intersectional perspective, the researcher acknowledged her own values and positions of privilege as an academic researcher as well as shared experiences with the participants, such as being an immigrant Black woman from the Caribbean. To ensure the credibility of the study, active recruitment approaches were used that enabled the researcher to discuss the study at length and create a pleasant atmosphere during the interview to permit participants to speak freely. Qualitative peer debriefing was also used by presenting the preliminary findings to three independent academic researchers and asking them for feedback. Edits were made based on their comments.

Results

Table 2.1. Demographic description and self-reported health outcomes of study participants

	n (%)
Total number of respondents	27
Age groups	
55-64	7 (26%)
65-74	8 (30%)
75-84	11 (39%)
≥85	1 (4%)
Highest Level of Education Achieved	
Elementary	4 (15%)
High School	8 (30%)
Undergraduate Degree	12 (45%)
Graduate Degree	3 (10%)
Postgraduate	--
Immigrant Status	

	n (%)
Immigrant	23 (85%)
Canadian born	4 (15%)
Employment status	
Employed (Part-time/Full-time)	6 (22%)
Unemployed	1 (4%)
Retired	20 (74%)
Health outcomes reported	
PTSD	3 (11%)
Diabetes	10 (37%)
Hypertension	12 (44%)
Cancer	1 (4%)
Heart disease	2 (7%)
Arthritis	11 (41%)
Anxiety and depression	8 (30%)
Other (including, dermatological disorders, neurological, respiratory, etc.)	5 (19%)

Table 1 provides an overview of the demographic characteristics and self-reported health outcomes of the study population. Based on the life course perspective, results are presented as themes outlined chronologically to highlight key events that occurred during the critical periods of study participants' lives, namely during childhood, adolescence, adulthood and late in life. Themes are further distilled for intersections related to categories of identities and the systems of domination that have shaped the lives and experiences of participants. These themes are further explored in greater detail in the sections below.

Life events during childhood and adolescence: The intersection of gender and race with education and immigration early in life

Participant's descriptions of life events that affected their health and wellbeing during their childhood and adolescence were related to gender bias rooted in patriarchy and structural racism reinforced by the education system. The impact of these events was described as both indirect and direct. Indirectly, factors related to gender bias affected women's life trajectories by limiting their career choices which affected their socioeconomic status and ability to participate in the labor

market. Directly, factors such as racism manifested as chronic stress and anxiety that affected participant's mental health and perceptions of self-worth.

Gender roles and responsibilities were ascribed to participants early in life and were particularly dominant among immigrant women. Gender was described in terms of cultural expectations of and differences between men and women within their societies and was influential in shaping participants' career trajectories during adulthood. This was further reinforced structurally through access to education and employment largely because of patriarchy. For instance, Veronica, a 75-year-old immigrant woman, highlighted that as a child in her family advanced training was reserved for the boys while the girls were expected to marry or enter the workforce soon after graduating from high school:

…went to high school, but what my father did was…six girls and four boys. All the girls will go to high school, but he didn't let us go further on to university because we're going to get married…So it was like the girls going to get a high school education, they'll find a job, but that's enough. They don't need anymore. The boys went to go on to university and things like that and get an engineering degree and whatever, because they are the breadwinner for their family when they get married. So, my father didn't really focus on me doing more than in other words, equivalent to grade 13 in Canada, after that, find a job, which is what I did… [Veronica]

As a result, many women who immigrated to Canada as adults did not have education or training beyond high school and acquired employment in unskilled areas that were in many cases physically demanding and caused injuries. Several participants made the decision to continue their education once they immigrated to Canada and were able to greatly benefit from this decision.

Participants who were able to continue post-secondary education were streamlined by their family to pursue traditionally female oriented careers, such as nursing, secretarial, or teaching. Sharon, a 70-year-old immigrant woman who came to Canada from the Caribbean in her early 20s, described the experience of her parents choosing her courses as an adolescent:

> *Your parents decided where you would be going…secretary because I think at that time, that's what most females, the area most females went into is either teaching [or secretary] …and so yeah, that was the most common job area. Professionally, that would have been the most common one would be secretarial. [Sharon]*

This was further reinforced by education programs with experiential components. Dorothy, a 71-year-old Black Canadian woman who was born in Toronto, described her experience as a high school student, seeking a placement opportunity with a technology firm that offered summer placements for students. Male students were recruited to learn programming, whereas female students were assigned data entry or processing responsibilities.

Another factor that impacted the health and wellbeing of older Black women was experiences of racism. These experiences, which occurred during childhood and adolescence, were described as playing a more direct role in affecting participants' mental health through feelings of anxiety and insecurities. Though immigrant women generally described their childhood positively without experiences of racism, some differences were noted between women who emigrated from the Caribbean and women who emigrated from the United Kingdom (UK). Immigrant women from the UK had experiences of racism in childhood that were very similar to those of Canadian born women. Immigrant women from the Caribbean on the other hand had no reported experiences of racism in childhood until they immigrated to Canada.

Experiences of racism were usually encountered in school, causing feelings of inadequacies, self-doubt, and anxiety. Carmen, a 55-year-old woman who was born in the UK and immigrated to Canada as a young adult described her experiences of racism while in school when she was living in the UK:

"Like, you say words differently because you have immigrant parents. So, you know, you might say instead of film you say flim, because that's what you grew up with, you know, and I had a friend, she was English, and she would kind of like teach me certain words. But also, you have racism from the teachers. Because one day, I didn't come to school because I had a crick neck. We said a crick neck. And the teacher says, what is a crick neck? And so, she pulled me up in front of the class. And she said, this is not a crick neck it's a stiff neck. And so, they would embarrass you like that. And so, you'd always know that you were different. You know. So, in some ways, I think I grew up having an inferiority complex, that I wasn't good enough or that you could never know, I just had an inferiority complex." [Carmen]

Dorothy, a 59-year-old woman who was also born in the UK noted that having these experiences of racism caused her to think negatively about herself, but she was able to cope given that she and her family were having similar experiences:

…I certainly felt negative about myself, you know, about being a young black girl, it would be so much easier not to experience this. But we're all experiencing this as a family. So, it was just like, you know, deal with it… [Dorothy]

Canadian born women also had their first encounter with racism in school through their interactions with teachers or course content that was being taught during that time. Dorothy also remembered being called a "monkey" as a child in school and being taught course materials that used racist or derogatory language to describe Black people such as "little Black Sambo". Other

participants felt that there was very little encouragement or supports for Black children to advance or do well. Charlene, a 75-year-old Canadian born Black woman, described a system that had different expectations for Black students and as a result students felt that they were being directed into more technical education streams rather than traditionally academic:

> *You know, there was definitely I think, you know, there was racism. I would say, you know, not supporting me to do better. And the expectations were there. Like, you know, they just didn't think that, you know, a Black kid was going to go to university or anything like that. Yeah. So, yeah, like I can speak for my husband as well. He's 81. But, you know, like you were stream sort of into the commercial more than the academic if you did not have parents to push. And you know, this is minus the Canadian Underground Railroad loyalist family. And, you know, whereas I think the Jamaican parents, they pushed their kids, too. They had higher expectations. And so, they pushed teachers to, you know, to do better for their kids. And so, you know, my expectation was to go to commercial school and then become a clerk or, you know, something like that. [Charlene]*

Similarly, other participants described other challenges as they felt 'dismissed' when they tried to interact with the teachers. Maureen stated:

> *…when you tried to interact with a teacher, I just felt rather dismissed. So, it's just like, okay, now why are you dismissing me? Because then as I got older, I started to be really, as somebody would say, smell yourself, and so I think it's a racial thing. You know, I know my stuff. I'm asking questions that I think are really appropriate, why are you responding to me this way or not responding to me at all. So, so if anything, I felt completely dismissed by a majority of the teachers for the classes I took… [Maureen]*

Participants expressed feeling that they were treated differently because of their learning challenges. As a result of these perceived learning challenges, more than one participant reported being held back in elementary school. Being held back meant not progressing to a higher grade, often more than once. For many participants who experienced these challenges in school, there was a sense of frustration and often helplessness because of the absence of appropriate resources to support them or their parents. Charlene, a 67-year-old immigrant woman, reported that she "just stopped going to school", without parental permission, because of the daily challenges she faced while at school interacting with her teachers.

Life events during adulthood: The intersections of gender and race with marriage, employment, public services, and social supports

As adults, participants described traumatic life events that they linked to cognitive outcomes such as the onset of Post-Traumatic Stress Disorder (PTSD), and trauma-related memory loss as well as chronic conditions such as hypertension, diabetes, and cancer. These life events included abuse and racism. Like gender, the impact of abuse and racism were both direct and indirect. Women described a direct connection between their mental health and abuse and racism. Conversely, the connection between abuse and racism to chronic health outcomes to their health and wellbeing was indirect.

Abuse experienced by participants was financial, physical, verbal, and emotional in nature. Women who were abused sought assistance and protection through the courts and shelters that proved to be ineffective in some cases. Marie described her experience being financially abused by her then husband to support his drug and alcohol addiction:

"I was married to the devil. I had to run…it was very bad. When you're sleeping he would take your money. He had to buy drugs and drink alcohol so his money was not enough he would take everything in the house and sell-it. But I survive..." [Marie]

Olivia, a 74-year-old immigrant woman described her experiences with seeking assistance while being physically abused by her husband:

Through all that. I've been to the police. I've been to the shelter; I've been to the family court. There was a time when we went to the family court and they put him on a probation to say, okay, keep the peace for a year. And as soon as the year finish, he started again with his craziness. So yeah…In those days, they didn't arrest people. If it was now, for sure you would be in jail. Yeah. But in those days in the 70s, the police come, and they tell you to keep the peace, and they let you sign a peace bond and blah, blah, blah, wasn't like now. Now, it doesn't matter. I am so happy to know for what the domestic…even if you call the police and you're gonna change your mind and as long as they know that you're abused, they will take it from there, you know, but in those days in the 70s, it wasn't like now. It was really different from now. Somebody could kill you and they go and get a year or two years in jail, and it's like, you know what I mean it's like a piece of cake. So…I didn't have a good life. [Olivia]

Three participants described needing to transition from their abusive households into women's shelters with their children. They were later able to access additional social services and supports through these women's shelter. Claire, a 69-year-old immigrant woman, was able to receive income support and housing large enough for her and her son within three-weeks of coming to the shelter. These social supports did not come without their challenges, however. The housing she received was described as inadequate with detrimental environmental factors identified including rust, roach infestations, and mold. Further, the income support was insufficient to cover her basic

needs. Where income from social assistance was insufficient, three participants described accessing additional support through local food banks and the Salvation Army for clothing.

While eight of the women described feeling intense moments of stress and mental anguish, very few participants reported accessing professional mental health or other health services to support them with their trauma or mental distress. Participants often cited religion as a source of comfort, with their religious leaders being not only their spiritual guide but also their counselors in times of need and periods of emotional distress.

Racism was a factor that was discussed during more than one critical period across participant's life course. Gendered racism was described only among Canadian born Black women. Immigrant women were less likely to report feeling any associations between the racism they experienced and their gender and were more likely to associate their negative experiences with either race or gender. Canadian born women reported experiences of gendered racism during adulthood in the workforce in industries such as finance and healthcare. Experiences of racism in the workplace were interpersonal between coworkers as well as reflected in other areas such as work processes and systems for advancements in terms of receiving job promotions. For instance, Claire, a 69-year-old immigrant woman, described her experience seeking a promotion in the workplace:

> *So, I got a job…as a mail clerk, and the supervisors said, after six months…we all get a promotion. Well, after six months, all the White workers got a promotion. And I worked delivering the mail, interoffice mail for a year and a half. So, when I asked her when am I gonna get my promotion? Oh, it's coming soon. It's coming soon. [When would I get a raise?] Oh…it's coming soon. I wasn't moving up. So, me and another girl…made the mistake of going to the union. Now because we're supposed to have a so-called union went to the union and say*

everybody got a promotion how come I didn't get a promotion and didn't realize that the union and the supervisor was friends. And then one morning I went in to work and the woman fired me on the spot. Up until this day, I don't know why. [Claire]

Participants who worked in healthcare environments reported experiencing racism from both co-workers as well as from patients and residents that they cared for. Isabel, an 82-year-old immigrant Black woman, reported being told at work that she should go back to where she came from and repeatedly being reminded by the residents that "Blacks were enslaved". While hearing these words would provoke feelings of annoyance, rarely did they evoke feelings of anger among the women. Although, there were no feelings of anger, participants felt compelled to work twice as hard to compensate for the perceived differences in opportunities they were afforded because of their background and race.

Experiences later in life: Intersections of retirement, immigration, social networks, and financial and social supports

Participants reported chronic health conditions such as heart disease, arthritis, hypertension, and diabetes later in life. Three participants linked their diagnosis of hypertension to experiences of stress from abuse; two participants linked their hypertension to anxiety and depression from experiencing racism. Other chronic conditions were considered to be a normal part of aging.

Women aged 65 and older described many changes to their social lives as many of their friends and family had died. To account for changes in their social networks, participants fostered relationships through day programs offered for older adults through ethnic associations, community health centres and religious institutions. Though there were changes in their social networks, 18 of the women were still living independently in condos or apartments either alone or

with their spouses. Participants who were no longer independent lived with their immediate or extended families.

Retirement and retirement planning was an important focus of participant's experiences later in life largely because of retirement's impact on their access to resources that would impact their quality of life. Almost all participants aged 65 and older, except for two women, were retired. Some of these women were forced into early retirement because of workplace injuries sustained while working in settings such as factories or long-term care facilities. When asked about retirement planning, participants 65 years and older expressed retirement was a source of stress for them as they felt both mentally and financially unprepared for that phase of their life. This stress was consistent between women who immigrated as young adults and spent more time in the Canadian labor market, and women who immigrated after age 55 and had worked less than 10 years in Canada.

One of the biggest impediments to retirement described was income. Retired women felt that the public pension was insufficient for their retirement. Very few of the women who were interviewed, had access to private pension plans or pensions through their employers. One participant described her pension being impacted by her time away from work due to a workplace injury she sustained while working in a factory. Sue, a 69-year-old participant who retired at 65, expressed frustration with government deductions on her already small income:

I wish they would do better with pension because they're sure not doing too well with pensions for seniors… And you know, I was getting $909 from one and they cut it down and take $5 off. They took $100 off my CPP saying I got investment. When I was working every two weeks, I got paid and they would put $88 into RRSP for each worker and so it builds up into $30000 and so when I leave plus, I was paid into some myself so I end up with about $33,000 or

$35,000 but you can't get it until you turn 70 or 71. But I can only get $1,000 a year or I can get it every month. So, every month I get $145. But then they took $100 off my pension telling me that I have investment. They say you're supposed to have this for your healthcare when you retire. Then they took a whole $100 off my pension. So, they need to do better with pension for seniors. [Sue]

In addition to income, housing was one of the main area of concerns for participants when planning for retirement. Housing was discussed in terms of access, affordability, and safety. In preparation for retirement, three participants sold their homes largely because of their inability to afford their mortgages and ongoing upkeep. Marie, a 70-year-old Black woman who moved to Canada at age 23 and had one adopted child with her husband described her challenges with income and reasons for selling her home:

…we did have a house…but we didn't buy early in life, we buy it late in life. So, you know the mortgage was a little too much and everything was too much. So, [my husband] stopped working and I was getting sick. So, we agree that we should go into an apartment where he don't have to clean snow and do things like that. And with the money we are getting…I don't get workplace pension…I was working for XX for 20 years and they went under according to them. So, we lose. When we call on the government for help the government said, they can't do anything. So, we lose, 200 of us. [Marie]

These women moved into smaller apartments, some of which were subsidized. Two participants reported that they were on a waiting list for public housing. Karine, a 71-year-old immigrant woman, noted that she has been on a waiting list for senior’s housing for several years and is currently living in a rented apartment with rust and insects:

…I can survive now but the only thing I worry about now is the rent...I applied for senior housing...I've been on the waiting list since 2008 and this is the first time, they are calling me [for a place]. The [previous tenant] just died, and they didn't even move her stuff out. And the reason why I wouldn't take it is because the kitchen doesn't have any cupboard it just has a little pantry. Half is for food and half is for dishes. Nowhere to eat cause the living room cannot take…because I have a dining table. I had a condo and I had to give it up. So, I gave away half my stuff and I couldn't give away anything else because I can't afford to buy. So, I had to turn it down. So, she said I have two more choices and if I turn them down, I have to go back to the end. I said madame, I don't know if I will live to see tomorrow and then goodbye. It's so hard now… [Karine]

She also complained about the impact of paying rent on her ability to afford necessities such as food. She goes to the food bank as her income is not sufficient to cover all her basic needs. Feeling a sense of embarrassment at having to go to the Food Bank, she opts to travel to a location in a neighboring community to avoid being seen by members of her community.

Discussion

The aim of this study was to provide a more detailed explanation regarding the origins of health inequities and highlight areas of intersections that affect health and wellbeing among Black women aged 55 and older in Toronto. The life course approach not only highlighted how different social elements intersected to impact the wellbeing of Black women at different points in their lives, but also how individual resilience to cope with trauma and mitigate the cumulative long-term impact of stress are fostered through community and social institutions such as churches.

This study suggests that the experiences of older Black women cannot be accurately understood by prioritizing one single factor as they are dynamic, interrelated, and co-constructed.

The current findings support similar results regarding factors that impact Black women's health and wellbeing (Etowa, Wiens, Bernard, & Clow, 2007; Richardson & Brown, 2016; Etowa J. , Bernard, Oyinsan, & Clow, 2007b). Continued exposure to racism and sexism over an extended period accumulated to affect participants' access to opportunities such as employment to improve their life circumstances as adults both before and after retirement (Crystal, Shea, & Reyes, 2017). Further, exposure to chronic stress greatly impacted participant's mental health and was perceived to have caused chronic illnesses such as hypertension, which is supported by studies that have sought to understand racial disparities in hypertension (Spruill, 2010; Sims, Glover, Gebreab, & Spruill, 2020; Barksdale, Farrug, & Harkness, 2009)

From a theoretical perspective, the findings refined understanding of the intersectional nature of the factors that were identified over time. Since its introduction by Crenshaw (1989), intersectional scholarship has produced knowledge on race, class, and gender particularly in relation to labor markets (Collins, 2015). This study expands intersectional research into areas of aging, which is a growing area of focus for intersectional researchers. It also contributes to the use of intersectional frameworks to rethink violence against women. Intersectionality approaches to violence against women recognize that all oppressions exist simultaneously, and that categories of oppression mutually construct each other to create unique experiences of violence for women (Imkaan, 2019). For many of the participants, their experience of violence was compounded by their socioeconomic status. These factors were combined to produce a unique experience of violence and marginalization. The use of the life course approach provides further details by facilitating a deep and nuanced exploration of each stage of the critical period. This allowed participants to provide extensive descriptions of factors that affected their life trajectory during

childhood and how they manifested later in life. These explanations illuminated pathways through which the origin of inequalities in health were identified.

Descriptive phenomenology provided a richly descriptive database of text that made it possible to identify significant life events and points of exposures during the critical periods of people's lives. Many of the women who participated in this study were immigrants between the ages of 55 and 80 years old from a variety of socioeconomic backgrounds. The advantage of this study and the sample included was that they were able to show a diversity of experiences and challenges among women later in life, both before and after significant life events such as retirement. Further, the impact of context in this study is a critical reflection of phenomenology's description of the link between context and the individual's subjective experience (Moustakas, 1994). Immigrant women from the Caribbean were less likely to experience racism as children or ascribe their experiences to their race and their gender simultaneously owing to the social, cultural, and political context in which they were raised where the shaping of an individual's identity was less reliant on race. Rather, the demographic makeup and long history of slavery and colonization of Caribbean countries added an extra layer of complexity to the participants' interpretation of their experiences. The aging experiences of participants changed because of their immigration to Canada and differs from those of other immigrant women from other parts of the world. One study of the social dimensions of health across the life course of Arab immigrant women in Canada was varied however had a similar theme of the need to stay strong during adversity (Salma, Keating, Ogilvie, & Hunter, 2017)

Some limitations of this study should be noted. First, the participants recruited were all from the Caribbean or of Caribbean descent, largely because of the demographic makeup of Toronto's Black population. This sample, while presenting a unique set of experiences, highlights

experiences from only one cultural perspective among Black women. Further, while self-reported qualitative data are considered appropriate to provide rich, multi-layered accounts of human experiences, it relies on participants' memories which are often selective.

The findings of this research have implications for research and practice. Firstly, health and social services agencies often work together to achieve their common goals of women's health and wellbeing. An important aspect of this is understanding the social and historical context that has contributed to the needs of these women, particularly older women who access their services. This can be accomplished through strengthening integrative services between health and social services to facilitate information sharing and collaboration in the development of tools, resources, and programming as interventions to appropriately address the health and social services needs of older women.

In conclusion, aging is a diverse and complex experience. More studies that apply phenomenology as an analytical lens for aging related topics are needed. This study adds to the growing scholarship of aging and diversity as it expands the theoretical boundaries of gerontology by using phenomenology with the intersectional life course perspective in aging research.

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References

Ailshire, J. A., & House, J. S. (2011). The unequal burden of weight gain: An intersectional approach to understanding social disparities in BMI Trajectories from 1986 to 2001/2002. *Social Forces, 90*(2), 397-423.

Barksdale, D. J., Farrug, E. R., & Harkness, K. (2009). Racial discrimination and blood pressure: perceptions, emotions, and behaviors of black American adults. *Issues Mental Health Nurse, 30*(2), 104-111. doi:10.1080/01612840802597879

Bartley, M. (2004). *Health inequality: An introduction to theories, concepts and methods.* Cambridge, UK: Polity Press.

Braveman, P. (2014). What is health equity: And how does a life-course approach take us further toward it? *Journal of Maternal Child Health, 18*, 366-372.

Brown, T. H., Richardson, L. J., Hargrove, T. W., & Thomas, C. S. (2016). Using multiple-hierarchy stratification and life course approaches to understand health inequalities: The intersecting consequences of race, gender, SES and age. *J Health Soc Behav, 57*(2), 200-222. doi:10.1177/0022146516645165

Burton-Jeangros, C., Cullati, S., Sacker, A., & Blane, D. (2015). *A life course perspective on health trajectories and transitions.* New York: Springer International Publishing.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology, 41*, 1-20. doi:10.1146/annurev-soc-073014-112142

Craciun, C., & Flick, U. (2016). Aging in precarious times: Exploring the role of gender in shaping views on aging. *Journal of Women & Aging, 28*(6), 530-539.

Crenshaw, K. (1989). Demarginalizing the intersection fo race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*(1), 139-167.

Crimmins, E. M., Kim, J. K., & Sole-Auro, A. (2010). Gender differences in health: Results from SHARE, ELSA and HRS. *The European Jounral of Public Health, 21*(1), 81-91.

Crystal, S., Shea, D. G., & Reyes, A. M. (2017, March 20). Cumulative advantage, cumulative disadvantage, and evolving patterns of late-life inequality. *The Gerontologist, 57*(5), 910-920.

Etowa, J., Bernard, B., Oyinsan, B., & Clow, B. (2007b). Participatory action research (PAR): An approach for improving Black women's health in rural and remote communities. *Journal of Transcultural Nursing, 18*(4), 349-357.

Etowa, J., Wiens, J., Bernard, W. T., & Clow, B. (2007). Determinants of Black women’s health in rural and remote communities. *CJNR, 39*(3), 56-76.

Etowa, J., Wiens, J., Bernard, W. T., & Clow, B. (2007). Determinants of Black women's health in rural and remote communities. *CJNR, 39*(3), 56-76.

Ferrer, I., Grenier, A., Brotman, S., & Koehn, S. (2017). Understanding the experiences of racialized older people through an intersectional life course perspective. *Journal of Aging Studies, 41*, 10-17.

Fox, D., & Moyser, M. (2018). *Women in Canada: A gender-based statistical report.* Ottawa: Statistics Canada. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89-503-x/2015001/article/54930-eng.pdf?st=zZokWX6n

Geronimus, A. T., Bound, J., Keene, D., & Hicken, M. (2007). Black-White difference in age trajectories of hypertension prevalence among adult women and men, 1999-2002. *Ethnicity & Disease, 17*(1), 40-48.

Gueta, K. (2017). A qualitative study of barriers and facilitators in treating drug use among Israeli mothers: An intersectional perspective. *Social Science and Medicine, 187*, 155-163.

Hudon, T. (2016). *Women in Canada: A Gender-based Statistical Report.* Ottawa: Statistics Canada.

Hunting, G. (2014). *Intersectionality-informed qualitative research: A primer.* Burnaby: The Institute for Intersectionality Research and Policy. Retrieved from https://www.ifsee.ulaval.ca/sites/ifsee.ulaval.ca/files/b95277db179219c5ee8080a99b0b91276941.pdf

Imkaan. (2019). *The value of intersectionality in understanding vilence against women and girls (VAWG).* United Kingdom: Imkaan. Retrieved from https://www2.unwomen.org/-/media/field%20office%20eca/attachments/publications/2019/10/the%20value%20of%20intersectionality%20in%20understanding%20violence%20against%20women%20and%20girls.pdf?la=en&vs=3339

Kaushik, V., & Walsh, C. A. (2018). A critical analysis of the use of intersectionality theory to understand the settlement and integration needs of skilled immigrants to Canada. *Canadian Ethnic Studies, 50*(3), 27-47.

LaVeist, T. A. (1994, Apr). Beyond dummy variables and sample selection: What health services researchers ought to know about race as a variable. *Health Services Research, 29*(1), 1-16.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*(Extra Issue), 80-94.

Matua, G. A., & Van Der Wal, D. M. (2015). Differentiating between descriptive and interpretive phenomenological research approaches. *Nurse Researcher, 6*, 22-27.

Mayoh, J., & Onwuegbuzie, A. J. (2015). Toward a conceptualization of mixed methods phenomenological research. *Journal od Mixed Methds Research, 9*(1), 91-107.

Moustakas, C. (1994). Transcendental phenomenology: Conceptual framework. In C. Moustakas, *Phenomenological Research Methods* (pp. 25-44). Thousand Oaks, CA: SAGE Publications, Inc.

Patterson, A. C., & Veenstra, G. (2016). Black-white health inequalities in Canada at the intersection of gender and immigration. *Canadian Journal of Public Health, 107*(3), e278-e284.

Phelan, J. C., & Link, B. G. (2015). Is racism a fundamental cause of inequalities in health? *Annual Review of Sociology, 41*, 311-330.

Phillips-Pula, L., Strunk, J., & Pickler, R. (2011). Understanding phenomenological approaches to data analysis. *Journal of Pediatrics Health Care, 25*, 67-71.

Ramraj, C., Shahidi, F. V., Darity Jr., W., Kawachi, I., Daniyal, Z., & Siddiqi, A. (2016). Equally inequitable? A cross-national comparative study of racial health inequalities in the United States and Canada. *Social Science and Medicine, 161*, 19-26.

Richardson, L. J., & Brown, T. H. (2016). (En)gendering racial disparities in health trajectories: A life course and intersectional analysis. *SSM-Population Health, 2*, 425-435.

Rodney, P., & Copeland, E. (2009). The health status of Black Canadians: Do aggregated racial and ethnic viarables hide health disparities? *Journal of Health Care for the Poor and Underserved, 20*, 817-823.

Salma, J., Keating, N., Ogilvie, L., & Hunter, K. F. (2017). Social dimensions of health across the life course: Narratives of Arab immigrant women ageing in Canada. *Nursing Inquiry, 25*(2), e12226. doi: https://doi.org/10.1111/nin.12226

Siddiqi, A., & Nguyen, Q. C. (2010). A cross-national comparative perspective on racial inequities in health: the USA versus Canada. *J. Epidemiol. Commun Health, 64*(1), 29-35.

Sims, M., Glover, L. M., Gebreab, S. Y., & Spruill, T. M. (2020). Cumulative psychosocial factors are associated with cardiovascular disease risk factors and management among African Americans in the Jackson Heart Study. *BMC Public Health, 20*(1), 566. doi:10.1186/s12889-020-08573-0

Spruill, T. M. (2010). Chronic psychosocial stress and hypertension. *Current Hypertension Reports, 12*(1), 10-16.

Statistics Canada. (2019). *Diversity of the Black population in Canada: An overview.* Ottawa: Government of Canada.

Veenstra, G. (2013). Race, gender, class, and sexuality (RGCS) and hypertension. *Social Science and Medicine, 89*, 16-24.

Veenstra, G., & Patterson, A. C. (2016). Black–White health inequalities in Canada. *J Immigrant Minority Health, 18*, 51-57.

Veentra, G. (2009, Aug). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science and Medicine, 69*(4), 538-542.

Williams, D. R. (1997). Race and Health: Basic Questions, Emerging Directions. *Ann Epidemiol, 7*, 322-333.

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and Health: Evidence and Needed Research. *Annual Review of Public Health, 40*, 105-125.

ARTICLE 3: ACCESSING ADEQUATE HOUSING FOR OLDER BLACK WOMEN IN TORONTO: A DOCUMENT REVIEW OF HOUSING RELATED GOVERNMENT STRATEGIES AND ACTION PLANS

Abstract

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The International Bill of Human Rights and the International Covenant on Economic, Social and Cultural Rights include recommendations and protections for housing as a human right. The rising costs of housing has created difficulties for many individuals, particularly older adults/seniors. This study aimed to determine whether Ontario housing related policies and strategy documents address access to adequate housing for older racialized women, specifically older Black women. The theory of intersectionality and the stages model were used as analytical frameworks to review provincial and municipal government documents in Ontario, Canada to determine the degree to which they address adequate housing for older Black women. A thematic content analysis was completed for eight policy documents that were both municipal and provincial. The results suggest that access to adequate housing was not considered to the full scope and housing policies do not reflect the complex social reality of racialized older women. Addressing the housing challenges for older racialized women would require an increased focus on policies that are all encompassing.

Key words: Toronto, adequate housing, racialization, gender, aging

Introduction

There are growing numbers of women who are homeless or "vulnerably" housed globally. The Ontario Human Rights Commission notes the importance of adequate housing to an individual's sense of dignity, safety, inclusion, and ability to contribute to society (Ontario Human Rights Commission, 2008). "Adequate housing" encompasses more than a habitable physical space, but also includes adequacy in terms of safety, location, transportation, social integration, affordability and age-friendly (Cawley, 2019).

The connections between housing and human rights are protected under the Ontario Human Rights Code, enacted in 1962, which outlines accommodations/housing as a protected social area. International conventions such as the International Bill of Human Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR) include recommendations and protections for housing as a human right. Canada has recognized that adequate housing is a fundamental human right by ratifying both the ICESCR and has agreed to take appropriate steps towards realizing the rights set out in both. Section 2 of the Ontario Human Rights Code (also known as the *Code)* recognizes the right to equal treatment with respect to the occupancy of accommodation. The Centre for Equality Rights in Accommodation (CERA) interprets section 2 of the *Code* as providing protection against discriminatory treatment in applying for and living in housing, and a right to adequate housing without discrimination.

This study aims to determine whether Ontario housing related policies and strategy documents address access to adequate housing for older racialized women, particularly older Black women. The study encompasses a literature review on the intersection of gender, race and housing, and an overview of the Ontario housing policy context. A description of the document review, using intersectionality and the stages model, is also presented, followed by the study's findings.

Intersection of gender, race, and housing

Some of the most significant housing issues for women arise because of poverty and discrimination. Housing insecurity for older Black women is often a result of a lifelong process that involves exposure to gender-based disadvantages in family life, work, and welfare (Foster, Kapiriri, Grignon, & McKenzie, 2022). In general women earn less, work fewer years since they take time off work for childbearing and maternity leave, are more likely to work part-time, and thus experience losses in salary and other financial benefits that impact their pensions later in life (Washington, Moxley, & Taylor, 2010; Craciun & Flick, 2016). This places them at a great disadvantage when preparing for and after retirement (Homeless Hub, 2021). In America, more than 30% of older African Americans live in poverty compared with 10% of elderly Whites (Washington, Moxley, & Taylor, 2010). Older women who are at risk for poverty often live alone and are more likely to become homeless (Washington, Moxley, & Taylor, 2010). Similarly, the 2016 Canadian Census showed that 20.8% of racialized or visible minorities (Statistics Canada uses 'visible minority' as surrogates for race and ethnicity) were low-income compared to 12.2% of non-racialized people (Colour of Poverty-Color of Change, 2019).

In addition to economic barriers, cultural differences, and discrimination by landlords and real estate agents also reinforce racial and ethnic segregation in the urban housing market (Teixeira, 2008). Prospective tenants who are Black document discriminatory experiences with landlords during the rental application process, such as harassment from landlords or refusing to rent to certain ethnic groups in cities such as Toronto (Walks & Bourne, 2006). This discrimination often leaves them with only poor-quality housing options and extends beyond renting and impacts home ownership. Darden and Kamel (2000) conducted a study to determine the extent to which the difference between Black and White home ownership rates can be explained by race in Toronto.

The study showed that, despite the positive and cultural incentives towards home ownership in Canada at that time, Black people maintained lower home ownership rates than White people at every socioeconomic level. The inequality persisted in the housing market even after limiting the analysis to Black Canadian citizens who have been residents in Toronto for more than 5 years with earnings above the low income cut off (Darden & Kamel, 2000). Race was determined to have a strong effect on the chances of home ownership among Black and White people with equal age, marital status and household type, immigration status, educational level, occupational level, and income level (Darden & Kamel, 2000).

Discrimination in the housing market based on race has been well documented in the United States (US). African Americans historically have worse outcomes than Whites in terms of housing unit quality and quality of neighborhood. For instance, data from the 2007 American Housing Survey showed that African Americans were two times more likely than White Americans to have recently seen a rat in their unit; 30% more likely to report that the water in their unit is unsafe for drinking and cooking; 60% more likely to report a serious crime occurring in their neighborhood in the previous year; and two times as likely to report being dissatisfied with the neighborhood elementary school (Hanson & Hawley, 2011, p. 99). There is also documented discrimination in mortgage lending (Hanson, Hawley, Martin, & Liu, 2016; Bocian, Ernst, & Li, 2008; Quillian, Lee, & Honore, 2020). During the 2004-2008 housing boom, Home Mortgage Disclosure Act (HMDA) data released by the Federal Financial Institutions Examination Council shows a 27-basis point difference (favoring Whites) in contract mortgage rates (Hanson, Hawley, Martin, & Liu, 2016, p. 48). Discrimination was also found in the initial information gathering stage for borrowers in response to simple email inquiries about assistance with obtaining a mortgage, where agents

were less likely to respond to inquiries from clients with African American names or will write preferential emails to White clients (Hanson, Hawley, Martin, & Liu, 2016).

Aging and Housing Policy in Ontario

In 2016, 16.9% of Canadians were aged 65 years or older, representing a 20% increase in these age groups since 2011 (Statistics Canada, 2017). This number is expected to increase by 20% by 2024 and double by 2037 (Statistics Canada, 2015). In anticipation of the increase in the need for health and social services that will come with an aging population, the Canadian government embraced an "aging in place" approach, which allows seniors to stay in their homes as they age, instead of living in hospitals or long-term care facilities (Ontario Non-Profit Housing Association, 2016). While aging in place approaches are popular with seniors who want to remain in their homes and maintain their independence, they can impact low-income seniors who live on fixed incomes and are unable to afford adequate housing. The Ontario Non-Profit Housing Association reported that the proportion of seniors on the waitlist for social housing, where rent is typically subsidized equal 30% of household income, has increased from 21% in 2006 to 33% in 2014 (Ontario Non-Profit Housing Association, 2016). Older people often face discrimination in rental housing as landlords perceive them to be at greater risk of injury and death or unable to pay and carry out proper maintenance (Ontario Human Rights Commission, 2008).

Ontario, like the US, largely uses a market-based approach in its housing policies with market-based public policies operating through price incentives as opposed to mandates, standards, or other non-price-based approaches. Canadian politicians are often unwilling to fully commit to market-based approaches as they are typically not supported by their constituents who do not trust that market-based approaches can adjudicate fairness and equitable access to public goods and services or a resource that individual's need such as housing (Jacobsen, 2020).

Canadian housing policy has historically focused on the ownership sector. The Canada Mortgage and Housing Corporation (CMHC), established in 1946, focused public funds almost exclusively on the ownership sector in the first 20 years of its launch. Although federal legislation in 1949 allowed federal and provincial subsidies for public housing, only 12,000 units were built by the early 1960s (Hulchanski, 2007). There was never a policy of tenure neutrality, specifically a policy that assists owners and renters equally although the social need for housing exists mainly among renters. The rising costs of housing in Ontario has created difficulties for many Ontarians. Senior renters are at a significant disadvantage as they are twice as likely to spend more than they can afford on rent than senior homeowners (Ontario Non-Profit Housing Association, 2016).

Gender, race, and age have all been documented as barriers to adequate housing. There are very few studies related to inequity in home ownership by race in Canada. The paucity of research related to the Black experience and housing in the Canadian context presents a challenge for evidence informed policy and program development. Additional research can strengthen the evidence base for policy interventions that address inequities among racialized women.

Intersectionality

The term intersectionality references the critical insight that race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities (Collins P. H., Intersectionality's definitional dilemmas, 2015). Intersectionality has emerged as a widely respected research and policy paradigm. It is concerned with bringing about a conceptual shift in how researchers, civil society, public health professionals and policy actors understand social categories, their relationships, and interactions. Within a policy context, it provides a strong framework to identify and address "the way specific acts and policies address the inequalities

experienced by various social groups" (Bishwakarma, Hunt, & Zajicek, 2011). Intersectionality can reveal the limitations and exclusionary nature of traditional methods of creating policy as it recognizes that to address complex inequities, a one-size-fits-all approach does not work (Hankivsky, 2012).

Emerging methods for operationalizing intersectionality in policy acknowledge the inherent difficulties of this work. Bishwakarma, Hunt and Zajicek (2011) developed a method to facilitate intersectionality policy analysis by using a typical policy cycle. Their process argues that "since governing bodies, both national and international, as well as different nongovernmental organization have a vested interest in developing social policies leading to inclusion of the most marginalized groups, they must integrate intersectionality at all phases of the policymaking process" (Bishwakarma, Hunt, & Zajicek, 2011; Hankivsky & Cormier, 2011). Consequently, pairing intersectionality with a policy framework such as the stages model facilitates the application of intersectionality to the complex process of public policy.

Methods and Materials

This is a qualitative study designed to determine the degree to which housing related policies address the housing needs for older black women. A document review of policy related documents was completed to track change and development over time in policy (Bowen, 2009). As is common for document reviews, additional literature was used to contextualize the information that was extracted from the documents reviewed.

The review adapted Bishwakarma, Hunt, and Zajicek (2011) intersectionality policy process analysis by incorporating the theory of intersectionality and the Stages Model to identify the stages of the policy cycle and apply it to the analysis where feasible (National Collaboration Centre for Healthy Public Policy, 2013):

- *Agenda setting/problem definition*: process through which a policy and the problem it intended to address are acknowledged to be of public interest.
- *Policy formulation*: examination of various policy options to identify a possible solution. This is usually influenced by advocacy and stakeholder engagement.
- *Adoption*: decisions are made at the governmental level, resulting in a decision that favours one or more approaches to addressing a given problem.
- *Implementation*: the policy's implementation parameters are established, which can directly affect the eventual outcome of the policy.
- *Evaluation*: the policy is evaluated to verify whether its implementation and its effects are aligned with the objectives that were explicitly or implicitly set out.

Ontario government and City of Toronto websites were manually searched to identify policy documents that included a focus on older adults and/or housing. A Google search was further executed following the search of the Ontario government and City of Toronto websites to capture any older/previous versions of the policy documents that may have been archived. Search terms included: "Older Adults", "Seniors" AND "Women" OR "Older Women" AND "Black", "African Canadian", Afro-Canadian" AND "Ontario", "Toronto" AND "Housing" AND "Aging in place", "Seniors Strategy", "Social Housing", "Affordable Housing", "Housing Plan", "Housing Strategy", "Housing Policy". In total, 20 policy documents were selected for further review and analyzed, eight of which were selected for extraction.

Data Collection

To be included, documents needed to specifically address older adults and/or their housing needs as well as published within the last 10 years. To be considered, government documents needed to provide guidance, recommendations on strategies or a plan for Ministries and

stakeholders to address specific issues related to housing and/or older adults. The scope of the documents was also focused on the application of legislations and their regulations. Documents were excluded if they were not housing related, provincial, or Ontario based policy documents or were not published by the City of Toronto within the last 10 years.

The documents identified were reviewed in detail to classify relevant information regarding housing and older adults. Using an excel sheet, data was captured for each document to create an inventory with key details in the following categories:

- Document source: where the document was found.
- Year Published: what year the document was made available online or released.
- Level of government: what level of government published the document, i.e., provincial, or municipal.
- Funding: does the document note the amount to be invested within a specific timeframe?
- Social identities: does the document highlight social identities such as race, gender, and age for housing?
- Focus on adequate housing: Does the document mention safety, location, transportation, social integration and/or being age-friendly in providing housing?
- Policy cycle: how was the problem defined? Is there evidence of stakeholder engagement in the policy's formulation? Are the policy's implementation parameters clearly defined? Is there evidence that the policy has been evaluated or has monitoring mechanisms? What are the main actions of the policy? What effects (intended or unintended) can they have on older Black women?

Analysis

A thematic content analysis was completed for policy documents that were included for extraction (Figure 1). A coding scheme was then developed based on initial review of the documents and mapped to each of the relevant stages identified in the stages model where possible. To facilitate an intersectional analysis, codes and themes were then organized and synthesized to highlight whether the document explicitly articulated how it intends to address social categories and inequities in the framing and construction of the problem and solutions.

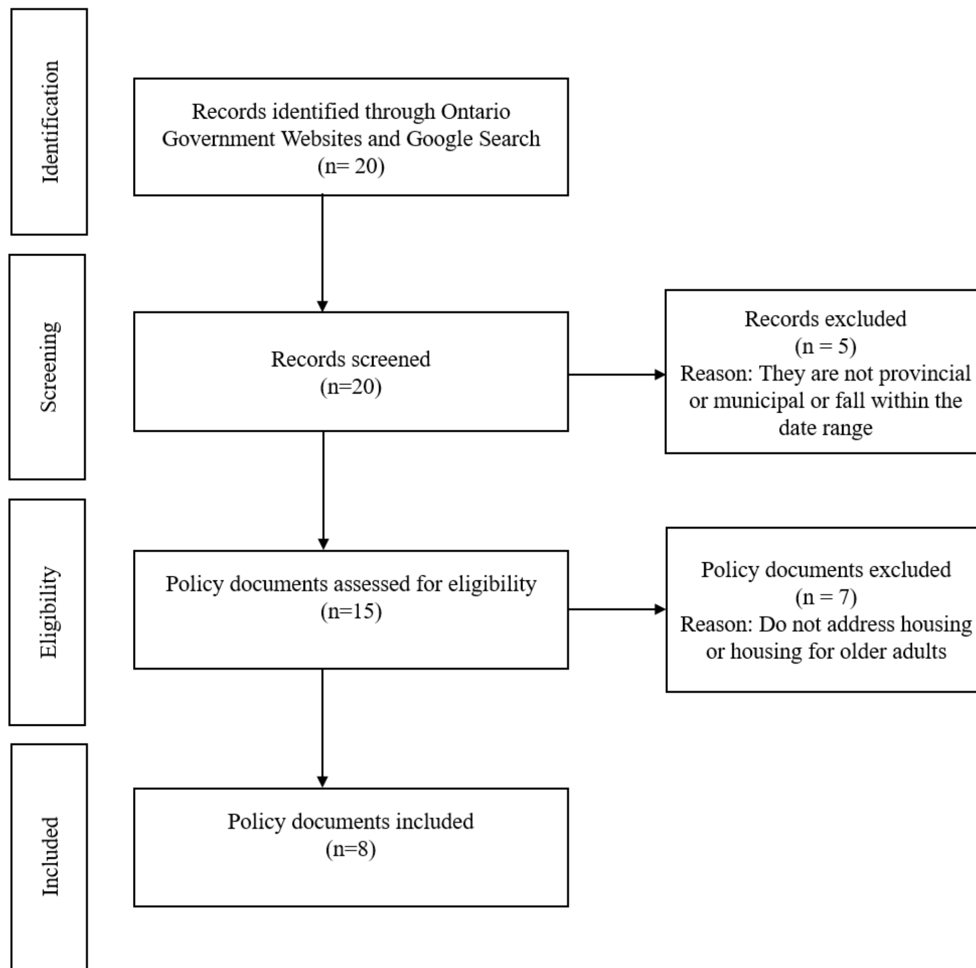

Figure 1. Data extraction flowchart for housing related policy documents

Results

Results are presented under four themes based on the stages model: problem definition and framing, policy formulation, implementation, and social identities. Some sections of the Stages Model were not applied due to the study's scope and timeframe. A summary of the final documents used for the extraction is presented in Table 3.1. Overall, the focus of each document was to highlight the government's commitment to improve access by increasing the supply of housing, with minimal reference to inequities or gaps in access to adequate housing for racialized women.

Policy Documents	Level of Government	Year	Investment	Description
Housing Opportunities Toronto: An Affordable Housing Action Plan	Municipal	2010	*	The Housing Opportunities Toronto (HOT) Action Plan 2010-2020 is a road map to steer the work and investment decisions of the City of Toronto as they relate to housing in partnership with federal and provincial governments, as well as the public and private housing sectors over this decade.
Ontario Long-Term Affordable Housing Strategy	Provincial	2016	$443.5 million	Ontario Long-Term Affordable Housing Strategy aimed to make investments for housing that benefit survivors of domestic violence, increase access to supportive housing, support homelessness initiatives and support housing related research and evaluation initiatives.
Aging at Home Strategy	Provincial	2017	$1.1 billion	The goal of the strategy is to enhance healthy aging and independent living for people at home and in their communities as they as get older.

Policy Documents	Level of Government	Year	Investment	Description
				The program provides a continuum of community-based services for seniors and their caregivers to allow them to stay healthy and live independently and with dignity in their homes.
Aging with Confidence: Ontario's Action Plan for Seniors	Provincial	2017	$3 billion	Aging with Confidence: Ontario's Action Plan for Seniors builds on the success of the 2013 Ontario Action Plan for Seniors and aims to create a place where seniors feel supported in living independent, healthy, and active, safe, and socially connected lives.
Ontario Community Housing Renewal Strategy	Provincial	2018	$5 billion	Ontario's Community Housing Renewal Strategy is focused on affordable housing for low-income households and the non-profit, co-operative, and municipal housing sector.
Toronto Seniors Strategy 2.0	Municipal	2018	*	Toronto Seniors Strategy commits to ensuring all seniors having equitable access to City services and programs. The strategy is made up of 27 recommendations, each of which identifies a City Division or Agency responsible and a timeline for implementation.
HousingTO 2020-2030 Action Plan	Municipal	2019	$23.4 billion	The HousingTO 2020 -2030 Action Plan provides a blueprint for action across the full housing spectrum – from homelessness to rental

Policy Documents	Level of Government	Year	Investment	Description
				and ownership housing to long-term care for seniors.
Ontario Housing Supply Action Plan	Provincial	2019	$30 billion	Ontario Housing Supply Action Plan aims to help all Ontarians to find a home that meets their needs and their budget. The plan will cut the red tape to make it easier to build the right types of housing in the right places, make housing more affordable and help taxpayers keep more of their income.

Problem definition and framing. In defining adequate housing, all documents, except for the *Ontario Action Plan for Seniors* and *Ontario's Housing Supply Action Plan*, included the expanded definition that emphasized the built and social aspects of adequate housing. Inclusive design elements relating to physical features of buildings may benefit people protected under the *Code* such as older people, particularly those with disability. Both the *Ontario Action Plan for Seniors* and the *Housing Supply Action Plan* made references to safety, transportation, and access to other services. The *Ontario Action Plan for Seniors* made direct reference to building senior-friendly communities that enhance the well-being and participation of older adults. Similarly, the discussion of The *Ontario Community Renewal Strategy* specifically highlights the physical infrastructure of the buildings and the need to invest in improving infrastructure of social housing that could include creating or improving structures for accessibility such as ramps to facilitate the use of mobility devices for older adults.

The framing of the policy issue varies among documents. In cases where housing issues for older adults are framed as a social problem, the issue is framed around the need to understand and

remove barriers such as cost to enable people to be housed within a reasonable timeframe. For instance, the *Ontario Community Housing Renewal Strategy* highlights the need to:

"*...modernize the rules to make it easier for tenants to go to school and work, use income tax information to calculate rent, filling vacant units faster and helping people with the greatest need...*"

Similarly, the *Ontario Housing Supply Action Plan* emphasized the affordability of homes acknowledging the cost of housing is rising faster than the average income of Ontarians similar to other areas of the world. Some documents included mention of health care utilization such as emergency department visits and an increase in focus on supporting healthy aging and improving the quality of life of older people making a clear link to housing and health. For instance, while the *Aging at Home Strategy* refers to the need to decrease the number of avoidable visits to the emergency department, it also notes that *"...building culturally competent services that can enable older adults to age at home is the best way to achieve this objective..."*

Policy formulation. All documents reviewed highlighted the stakeholders involved in defining the problem. The *Ontario Action Plan for Seniors, HousingTO 202-2030, Ontario Community Housing Renewal Strategy* and *Ontario Housing Supply Action Plan* made note of a public consultation and the involvement of end users in their development. In addition to the lead Ministry, stakeholders such as community agencies and service providers were engaged in the problem definition. However, though the documents mention of stakeholder involvement, it was unclear who the specific community stakeholder participants were. No reference was made to age, race, or socio-economic status.

Implementation. Policy documents such as the *Aging at Home Strategy* and the *HousingTO 2020-2030 Action Plan* noted that there were implications for access to health and community

services in their implementation. For instance, the *Aging at Home Strategy* aimed to enable older people to live at home independently by investing in community services that older adults can access in their homes. Access to these community services is impacted by location and the housing situation. The *Aging at Home Strategy* was implemented through regional health authorities. The *Strategy's* implementation through the regional health authorities supported the creation of several effective initiatives designed to provide care to older adults in their homes, such as a program for homebound seniors designed to provide care to seniors living in their own homes. Access to this program is limited regionally and type of housing (public versus private housing or nursing versus long-term care).

A desired outcome of the policies implementation is increased access to affordable housing. Three policy documents defined housing as a social problem linked to affordability and access based on supply or wait times for suitable and community housing. The *Ontario Long-Term Affordable Housing Strategy* made note of the need to find a simplified method to calculate household assistance. The *Ontario Housing Supply Action Plan* acknowledged the rising cost of home prices and rent in large and mid-sized cities in the province that have risen faster than incomes. While the prices of housing are increasing, only 7% of the new homes built over the past 20 years were intended for rentals. The lengthy approval processes and increasing costs have slowed down the building of new housing and rentals thereby impacting supply and availability.

Social identities. The most recognized identities in all reviewed document were age, income/class, and disability. The *Ontario Housing Supply Action, Ontario Community Housing Renewal* Strategy and *HousingTO 2020-2030 Action Plan* made brief references to race/ethnicity/culture/language. Social identities were primarily focused on socio-economic status based on income levels. None of the policy documents reviewed highlighted older women as a

priority group. Neither Black people nor older Black women were identified as specific target groups for housing related policies but would fall in broad categories such as racialized communities that were referenced in two of the documents.

Discussion

This document review was undertaken to study the degree to which housing related policies address access to adequate housing for older women, particularly older Black women. The findings suggest that while access to housing for older adults is considered in some policies, the problem of adequate housing was not fully considered or defined in terms of safety, location, and social integration for older adults across all documents. The general literature on women and housing uses an intersectional approach to understand the housing challenges of older women, particularly women who are older and racialized (Schwan, et al., 2020). However, this study's findings suggest that experiences of individuals who require housing are constructed from a unitary or additive lens and do not capture the disadvantages arising from an interplay of multiple forms of marginalization as espoused by intersectionality. This type of approach is inadequate for addressing the layered interrelationships between wider social inequalities and individual experiences of discrimination. In the context of Ontario housing policy, policymakers have identified specific categories and address them in isolation, without paying close attention to how they intersect with other social divisions.

While policies focus on addressing barriers related to supply and affordability, there is hardly any effort to identify or address attitudinal barriers such as prejudice and discriminatory attitudes among landlords or real estate agents which prevent full access to suitable housing. It may be that the market-based policies that are used in the housing market are not sufficiently equipped to address these attitudinal barriers. Historically, targeted policies in gender equity and race have

been used to address racial prejudice and discrimination in schools or private organizations with the goal of addressing implicit bias that create barriers to individual's accessing high quality education or employment opportunities (Johnson & Bornstein, 2021; Robyn, 2018). Affirmative action is one example of an approach used in the US to actively improve employment, educational and other opportunities for members of groups that have been historically subjected to discrimination. Similarly, the 1995 Employment Equity Act in Canada was enacted to increase the representation of designated marginalized groups in certain occupational settings. Like approaches adopted for employment and education, prejudice and discrimination may need to be articulated as policy goals with the right tools and resources provided to support implementation to inspire change.

The policy documents were relatively transparent with regards to the process of decision-making. The voices of recipients were incorporated into the formulation of the policies. However, it was unclear whether stakeholder representatives of intersectionally-defined target populations were incorporated in other phases of the process, which is an important part of Bishwakarma, Hunt and Zajicek's approach to intersectionality policy analysis to avoid policies that are created for rather than with politically excluded constituencies. This is particularly problematic as housing expenditure for low-income and poor older adults, who are often racialized, form a larger part of their income, than older adults with access to multiple streams of income. Including intersectionally-defined target populations at the beginning of the process would facilitate a more clear and complete definition of the problem requiring a policy intervention.

The stages model facilitated the application of the Bishwakarma, Hunt, and Zajicek (2011) method to intersectionality policy analysis as it allowed for the systematic integration of intersectionality in the policy-making process and an assessment of how relationships among the

different dimensions of power should be conceptualized in decision-making. Addressing the housing challenges for older racialized women, and Black women in particular, would require the use of an intersectional lens that acknowledges the layered interrelationships between wider social inequities. The results suggest a more proactive approach is required to address inequity in the housing market to address access to adequate housing for older racialized people.

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References

Bishwakarma, R., Hunt, V., & Zajicek, A. (2011). Intersectionality and public policy: Some lessons from existing models. *Political Research Quarterly, 64*(1), 217-229.

Bocian, D. G., Ernst, K. S., & Li, W. (2008). Race, ethnicity and subprime home loan pricing. *Journal of Economics and Business, 60*, 110-124.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40.

Cawley, G. D. (2019). Law and inclusive urban development: Lessons from Chile's enabling markets housing policy regime. *The American Journal of Comparative Law, 67*, 587-636.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology, 41*, 1-20.

Colour of Poverty-Color of Change. (2019). *An introduction to racialized powerty.* Toronto: Color of Poverty-Color of Change. Retrieved from https://colourofpoverty.ca/wp-content/uploads/2019/03/cop-coc-fact-sheet-2-an-introduction-to-racialized-poverty-3.pdf

Craciun, C., & Flick, U. (2016). Aging in precarious times: Exploring the role of gender in shaping views on aging. *Journal of Women & Aging, 28*(6), 530-539.

Darden, J. T., & Kamel, S. M. (2000, December). Black and white differences in homeownership rates in the Toronto Census Metropolitan Area: Does Race Matter? *The Review of Black Political Economy, 28*(2), 53-76.

Foster, N., Kapiriri, L., Grignon, M., & McKenzie, K. (2022, May 30). "But...I survived": A phenomenological study of the health and wellbeing of aging Black women in the

Greater Toronto Area, Canada. *Journal of Women and Aging*. doi:https://doi.org/10.1080/08952841.2022.2079925

Hankivsky, O. (2012). *An Intersectionality-Based Policy Analysis Framework.* Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.

Hankivsky, O., & Cormier, R. (2011). Intersectionality and public policy: Some lessons from existing models. *Political Research Quarterly, 64*(1), 217-229.

Hanson, A., & Hawley, Z. (2011). Do landlords discriminate in the rental housing market? Evidence from an internet field in the US cities. *Journal of Urban Economics, 70*, 99-114.

Hanson, A., Hawley, Z., Martin, H., & Liu, B. (2016). Discimination in mortgage lending: Evidence from a correspondence experiment. *Journal of Urban Economics, 92*, 48-65.

Homeless Hub. (2021, Apr 26). *About Homelessness*. Retrieved from Homeless Hub: https://www.homelesshub.ca/about-homelessness/population-specific/racialized-communities

Hulchanski, J. D. (2007). *Canada's dual housing policy assisting owners, neglecting renters.* Toronto: Centre for Urban and Community Studies: University of Toronto. Retrieved 04 04, 2021, from http://www.urbancentre.utoronto.ca/pdfs/researchbulletins/CUCSRB38Hulchanski.pdf

Jacobsen, G. D. (2020). Market-based policies, public opinion, and information. *Economics Letters, 189*, 109018.

Johnson, D. D., & Bornstein, J. (2021). Racial equity policy that moves implicit bias beyond a metaphor for individual prejudice to a means of exposing structural opporession. *Journal of Cases in Educational Leadership, 2*, 81-95.

National Collaboration Centre for Healthy Public Policy. (2013). *Public policy models and their usefulness in public health: The stages model.* Monteal: Collaborating Centre for Healthy Public Policy. Retrieved from http://www.ncchpp.ca/docs/modeleetapespolpubliques_en.pdf

Ontario Human Rights Commission. (2008). *Right at Home: Report on the Consultation on Human Rights and Rental Housing in Ontario.* Toronto: Ontario Human Rights Commission. Retrieved from http://www3.ohrc.on.ca/sites/default/files/attachments/Right_at_home%3A_Report_on_the_consultation_on_human_rights_and_rental_housing_in_Ontario.pdf

Ontario Non-Profit Housing Association. (2016). *Aging in place in social housing.* Retrieved February 21, 2021, from https://www.ighhub.org/sites/default/files/FocusON%2520Aging%2520in%2520place%2520in%2520social%2520housing.pdf

Quillian, L., Lee, J. J., & Honore, B. (2020). Racial discrimination in the US housing and mortgage lending markets: A quantitative reviews of trends, 1976-2016. *Race and Social Problems, 12*, 13-28.

Robyn, S. I. (2018). The housing challenges of low-income older adults and the role of federal policy. *Journal of Aging and Social Policy, 30*(3-4), 227-243.

Schwan, K., Versteegh, A., Perri, M., Caplan, R., Baig, K., Dej, E., . . . Chaleshtari, T. P. (2020). *The state of women's housing need and homeless in Canada: A literature review.* (A. Hache, A. Nelson, E. Kratochvil, & J. Malenfant, Eds.) Toronto: Canadian Observatory on Homelessness Press.

Statistics Canada. (2015). *Canada's population estimates: Age and sex, July 1, 2015.* Retrieved from http://www.statcan.gc.ca/daily-quotidien/150929/dq150929b-eng.pdf

Statistics Canada. (2017). *Age and sex, and type of dwelling data: Key results from the 2016 Census.* Retrieved from http://www.statcan.gc.ca/daily-quotidien/170503/dq170503a-eng.pdf

Teixeira, C. (2008). Barriers and outcomes in the housing searches of new immigrants and refugees: A case study of "Black" Africans in Toronto's rental market. *Journal of Housing and the Built Environmenta, 23*, 253-276.

Walks, R. A., & Bourne, L. S. (2006). Ghettos in Canada's cities? Racial segregation, ethnic enclaves and poverty concentration in Canadian urban areas. *The Canadian Geographer, 50*(3), 273-293.

Washington, O. G., Moxley, D. P., & Taylor, J. Y. (2010). Enabling older homeless minority women to overcome homelessmess by using a life management enhancement group intervention. *Issues in Mental Health Nusing, 30*(2), 86-97. doi:10.1080/01612840802597580

DISCUSSION AND GENERAL SUMMARY

Three papers were presented as a part of this dissertation. Each paper aimed to address one of the three study objectives outlined below:

1. To describe, analyze, and compare the self-reported health status and needs of older Black women in Canada relative to those of their male counterparts and White men and women in Canada.
2. To understand the factors that affect the health and wellbeing of older Black women aged 55+ and how they intersect to affect their health and wellbeing across their life course.
3. To understand whether existing policies and strategies address the needs expressed by aging Black women.

Intersectionality and the life course perspective were used as theoretical frameworks to inform the qualitative and quantitative methods used. A summary of the key findings, their implications for policy and research, study limitations, and a reflexive discussion on the study process and the researcher's experience carrying out the study are offered in the subsequent sections.

Key Findings

The first objective of this study was designed to describe, analyze, and compare the self-reported heath status and unmet health needs of older Black women in Canada relative to those of their male counterparts as well as White men and women. The study used White men as the reference category to provide a focus and basis for comparison across the categories included in the analysis. Using the Canadian Community Health Survey (CCHS), several binary logistic regression models informed by intersectionality were executed. Findings from the models demonstrated that, in comparison to health inequalities in the United States, inequalities between groups in Canada are smaller and have an additive rather than a multiplicative effect in most cases.

There were no major differences between the results that were seen in the additive models versus those in the multiplicative models even after controlling for confounders. There were however differences observed based on gender. This would suggest that the impact of factors such as education, income, and modifiable risk factors are additive rather than multiplicative, unlike what has been reported in the American literature and some of the Canadian studies that use the intersectional approach in their analysis. The difference in results could be attributed to several factors, including the high proportion of immigrants in the study, the age of the study population, as well as the type of intersectional analysis that was completed. Future research could include additional between-group and within-group analyses that further stratify the population by different identities to explore in greater detail the depths of the differences and similarities that were observed. To accomplish this, a larger sample size for older Black women and men would be needed, which could be supported by pooling an additional five years of CCHS survey cycles.

The second objective of this study sought to understand the factors that affect the health and wellbeing of older Black women aged 55+ and how they intersect across their life course from the participant's perspectives. Descriptive phenomenology was used to complete semi-structured interviews among 27 older Black women aged 55 years or older. The findings highlighted that the health and wellbeing of aging Black women were influenced by factors related to gender bias rooted in patriarchy, structural racism, traumatic events such as abuse, and individual's preparation for retirement. Findings presented in this second paper were consistent with findings from other qualitative studies that discussed Black women's experiences of racism and the resulting impact on their mental health (Etowa, Wiens, Bernard, & Clow, 2007). Religion and belonging to a religious community were effective in enabling women to navigate the more stressful periods of their adult lives, which included experiences of abuse and racism in the workplace. The

effectiveness of religion described in mitigating the effects of stress was consistent with previously published studies on the subject (Blank, Mahmood, Fox, & Guterbock, 2002; Assari & Lankarani, 2018; Hankerson & Weissman, 2012; Ramirez-Johnson, Park, Wilson, Pittman, & Diaz, 2014). Overall, it was clear that understanding the wellbeing of Black women in Canada cannot be accurately understood by prioritizing one single factor as they all appeared to be dynamic, interrelated, co-constructed, and influenced by the women's social and historical contexts, as described in the theory of intersectionality.

The third objective sought to understand the degree to which policies and strategies overlap with the needs expressed by the aging Black women who participated in the second phase of the study. Several needs were identified by study participants, however housing emerged as one of the most pervasive. Women's housing needs were discussed as a need not only during the later half of their life but also earlier during adulthood when most women were experiencing major transitions in their life. The women described this need in terms of access to adequate housing that is free of environmental hazards such as rodents and accessible for the mobility needs of women who were frail and used mobility devices. A document review of key government documents that were released within the last 10 years revealed that housing policies did not define or address problems using the Stages Model. It was clear that identities of individuals who require housing were constructed from a unitary or additive lens and did not capture the disadvantages arising from an interplay of different and multiple forms of oppression. Further, while there have been documented experiences of discrimination against Black people who were either trying to rent or purchase homes, the policies did not identify or address attitudinal barriers such as prejudice and discriminatory attitudes among landlords or real estate agents which prevent Black people from

accessing suitable housing that would address all the needs that they had identified in the phenomenological interviews.

Typically, individuals who complete surveys are those who are educated and have the capacity to consent to participate based on their understanding of the process. Study one provided great insight into the health and wellbeing of older Black women. Black women were more likely than their male counterparts and White Canadians to perceive their health as fair or poor. The limitation of the study prevents us from drawing any concrete conclusions regarding the health of older Black women in Canada or whether the effects are truly only additive and not multiplicative. Regardless, study two does provide us with some insights into pathways that lead to inequalities. Based on the results of study two, one can hypothesize that Black women's perception of poor health stemmed from experiences of trauma such as abuse, and experiences of racism from childhood to adulthood that caused anxiety and stress. Participants from study two reported several chronic health conditions that all aligned with data from study one. For instance, diabetes and hypertension were the two chronic health conditions that had the highest number of self-reports among the studies' participants. Study two was better able to highlight how gender and race intersected to impact women's health across their life course. This was particularly true for experiences of racism. The CCHS does not include measures of discrimination that could be used to quantitatively determine the association between racialization and health. Consequently, the qualitative methods used in study two were effective in providing nuanced details of the link between racism and health.

The stress reported in study two stemmed not only from racism but also in relation to issues later in life from the participant's level of preparedness for retirement. Many women reported not being happy with their income after retirement and having challenges with accessing adequate housing that was safe, affordable, and age friendly. The Canadian government recognizes that the

Canadian population is aging and will require more resources to age healthily. Policy is one of the most effect means through which the needs of older adults can be addressed. Policymakers have increasingly focused on the need for evidence-based policies and approaches. Given the paucity of evidence related to the health and wellbeing older Black women, the document review carried out in study three revealed that housing-related policies are often constructed from a unitary lens, rarely incorporate different identities, and do not address attitudinal barriers to accessing adequate housing.

Implications for Policy and Practice

The findings of this research have implications for policy and research. Firstly, health and social services agencies often work together to achieve their common goals of women's health and wellbeing. An important aspect of this is understanding the social and historical context that has contributed to the existing needs of these women, particularly older women who access their services. This understanding can be accomplished by including funding mechanisms that incentivize healthcare organizations to strengthen integrative services between health and social settings to facilitate information sharing and collaboration in the development of tools, resources, and programming as interventions to appropriately capture the social history of these women. This information can be used to address the health and social services needs of older women, some of which were identified through this study. The case for increased integration between health and social services can be strengthened by a greater recognition of the social determinants of health and the role they play in impacting the overall health and wellbeing of individuals across their life course as well as the potential for savings for the health system over the long term. Some primary healthcare programs in Toronto – such as those offered through St Michael's Hospital as well as specialist services offered by the Geriatrics program at Sinai Health – are at the forefront of

integrating interventions that address the social determinants of health into their care processes. Such collaborations can be effective in removing structural barriers and addressing the women's psychological needs by acknowledging their experiences through intersectional approaches that address interlocking systems of oppression.

As intersectionality is a growing area of research, more studies that apply intersectionality as an analytical lens for aging-related topics are needed. Patricia Hill Collins (2015) identified several opportunities to produce new knowledge using intersectionality as an analytical strategy. One area identified was in the expansion of the study of race, class, and gender to incorporate factors such as aging as a category of analysis. While there are many studies that explore race, class, gender, and aging in the American context, this is not the case for the Canadian context, which is one of the unique features of this study. There is a need to increase the number of studies in aging that focus on race and capturing the experiences of aging individuals through the application of intersectionality, particularly in Canada where the discussions of diversity are not as prominent in academic research as in the US.

Another opportunity for research and expansion of knowledge is furthering the use of intersectionality as a form of critical praxis. This can be furthered through the increasing use of intersectionality in policy in the Intersectional Based Policy Analysis (IBPA) model that was developed by Hankivsky (Hankivsky, 2012). By using IBPA, a greater understanding of the varied equity-relevant implications of policy can be achieved which can then be used as a springboard to promote equity-based improvements and social justice within an increasingly diverse world. This is particularly relevant within the Canadian context as Canada becomes increasingly diverse. Currently there are limitations in the use of the framework for policy analysis. Consequently, more work is required to refine the framework.

Limitations

Some limitations of this study should be noted. Multiple cycles of the CCHS were merged to produce large enough sample sizes of Black men and women in study one. Even after combining these available cycles of the CCHS, the sample of Black men and women were still smaller than the White racial category. Combining multiple years makes interpretation of prevalence rates less clear-cut and the estimates less reliable, particularly since the results were unweighted. Secondly, this study examined self-reported responses to various health-related questions, rather than actual medical diagnoses. There may be concerns about recall or acquiescence bias if respondents in the sample remembered or perceived their health behaviours and health status incorrectly.

Study two presented the qualitative in-depth interviews that were conducted with older Black women across Toronto. There were also limitations with implementing this component of the study that should be noted. Firstly, the participants recruited were predominantly from the Caribbean or of Caribbean descent. This sample, while presenting a unique set of experiences, mostly highlights experiences from one cultural perspective among Black women. As such, caution should be taken in generalizing the findings to other groups of Black women. Future research that includes older Black women from other cultural and geographical backgrounds may reveal other salient themes. Further, while self-reported qualitative data is considered appropriate to provide rich, multi-layered accounts of human experiences, some may view it as creating a potential threat to the validity of the findings because they rely on participants' memories which are often selective. To mitigate this challenge, participants were guaranteed confidentiality and were free to respond to or skip any questions.

Study three presented a document review of policy documents that were relevant to the need for adequate housing noted by the women who participated in the qualitative interviews from the

second paper. The findings reflected that there was much to be addressed in terms of expanding the definition of adequate housing, particularly as it related to the needs of older racialized women who were often immigrants. The review was restricted to eight documents. With more time and resources, an expanded review that incorporates annual investments from budget reviews, documents, and reports from over the last 10 years, augmented by key informant interviews, could allow for a more comprehensive discussion about housing policy and the extent to which market-based approaches can facilitate access to necessities such as housing.

Overall, some limitations were caused by the study design using both the qualitative and quantitative methods concurrently. Conducting the qualitative interviews and the quantitative analyses sequentially may have supported greater integration of findings across all three papers. However, given the financial resources that were available, taking a concurrent approach for these two analyses was more feasible. Further, the qualitative and quantitative methods used were effective in balancing the theoretical limitations presented by both.

Reflexivity

Positionality

The practice of reflexivity in social inquiry has been described as one of the most difficult methodological issues in qualitative research (Macbeth, 2001). The consensus among researchers is that the practice of reflexivity can be an important tool in achieving a level of objectivity when conducting research because it allows researchers to assess their values, beliefs, and attitudes before beginning their study. Reflexivity is particularly useful in understanding positionality in research where the researcher may be a member of the community and so considered an "insider."

Using reflexivity is a novel practice in this study as it uses both quantitative and qualitative methods. Further, discussions regarding "insider/outsider" positions in research are particularly

important given that I am a Black woman; although I am younger than the target population of this study, I am a member of the community, nevertheless. The insider/outsider debate has generated questions such as: "Does the identity and profile of the researcher (i.e., their race, class, gender, sexual identity, and history) privilege or disqualify their claims of knowledge? Are knowledge claims based in identities and profiles just another version of 'identity politics' or do researchers with an intimate and implicit knowledge of a group create knowledge that is more authentic…?" (Griffith, 1998, pp. 361-362).

Going into this study, I considered myself an insider, being a Black immigrant woman of Jamaican heritage. I recognized that like many of the study participants, I was also situated at several corners of intersecting identities that could shape my perspective and the way I interacted with the participants. While I am an insider, I was still acutely aware that study participants were much older than I was while conducting the study. While I could identify with some experiences described that were focused on race or gender, I identified less with descriptions of experiences related to age and aging. My already heightened awareness of the age difference between me and my study participants was further complicated by my position as a PhD candidate learning how to independently conduct phenomenological research while critically reflecting on the paradigmatic and theoretical tenets that inform discussions of values, subjectivity, and objectivity in social science research. In some ways, the decision to use a mixed methods approach was driven by a desire both for each to complement the other's weaknesses and to also address my ambiguous thoughts methodologically about subjectivity and objectivity in research.

What I viewed as a conflicting positionality made me reflect on Merton's assertions regarding the insider/outsider debate. In 1972, Robert Merton framed the insider/outsider issue as structural, stating: "Insiders are the members of specified groups and collectivities or occupants of specified

social statuses; Outsiders are the non-members" (Merton, 1972, p. 21). According to Merton, the insider has a "monopolistic" or "privileged access to particular kinds of knowledge" (Merton, 1972, p. 11). Merton criticizes the insider's position, arguing that it limits the work of the researcher within the groups of which he/she is a member. He described this as a new criterion for evaluating knowledge based on the credential of the researcher being a member being born to the group being studied (Merton, 1972). At the same time, it is important to note that groups that claim insider status are not homogeneous. For example, "women" can be stratified by social categories such as race, class, and, in my case, age. Regardless of my conflicting thoughts, ultimately recognizing my position as an insider did lend itself to the debate regarding the character of knowledge that would be produced from this study and whether, as Merton describes, this could cause a corrupting influence. Although one might argue that discussions of validity and bias in qualitative research is more reflective of the influence of positivist paradigms in health research, given that this study used a mixed methods approach, it was my belief that his assertions warranted some considerations. Similarly, one can argue that my knowledge as an insider lends itself to providing a richer, more textured account of my research subjects and even in the selection of the variables that were analyzed as a part of the quantitative research. Having insider knowledge of certain cultures and customs could facilitate a more nuanced description of the women's experiences, ideas about chronic illnesses that are predominant in the community, and factors that contribute to ill health and their needs. However, I am more of the frame of mind that I can occupy both spaces as a young Black woman and as a researcher conducting research among older Black women. I also believe that incorporating the community's perspective into the research enterprise is an important step towards addressing a degree of inequality, which has existed in social and anthropological research for several years where members of marginalized communities were the

subject of research but typically never the researcher/investigator. In this case, knowledge is produced about the community, for the community, by a member of the community, thereby reversing the power imbalance and further redefining researcher-subject relationships and roles.

Role in study and research process

I believe that research is an important tool for community empowerment through which health and wellbeing can be improved. The limited availability of peer-reviewed literature on aging Black women in Canada is a serious gap in aging research that should be addressed. Empirical evidence is the most effective tool to advocate for policy changes and design interventions or to offer services that can mitigate long-term effects, particularly in marginalized communities where inequities are often un/underreported.

Going into the study, I understood my position as not only the researcher but also an insider conducting research on her own community to fill a gap in evidence and incorporate diversity in aging theory and research, specifically as it relates to objective two of this study. Studies of diversity are often concerned with interlocking hierarchies of power (McMullin, 2000). The use of intersectionality and the life course approach as frameworks for the analysis in this study facilitated an investigation of the interlocking sets of marginalization that impact the lives of older Black women over their entire life course. I was acutely aware of the responsibility I had taken on to tell the stories of these women and felt the need to capture the true essence of their experiences while maintaining the integrity of the research process. To do that I needed to recognize that, while being a member of the community, I still had a disproportionate amount of power as the researcher compared to my research subjects. To address this imbalance, I sought to engage in reflexive practices that I previously used very early in my career as a public health practitioner. I also met with participants in settings where they felt most comfortable to mitigate this imbalance.

Comfortable settings for participants included their homes and public spaces such as cafes and food courts. Participants were made to feel as comfortable as possible.

As the interviews started it became clear that for many women telling their story was therapeutic and offered them some release as they felt safe enough to recount some of their most traumatic experiences. This was particularly true in the case of women who went through significant traumatic experiences as children and/or adults but had never accessed formal mental health services to address their trauma. Women often became very comfortable telling their stories and were quite open and forthcoming with specific details of their experiences throughout their life. This could also be a result of them seeing me as a member of their community and so they were more willing to share their information. Seeing how relieved and determined the women were to tell their stories further strengthened my feelings of responsibility in ensuring that the stories shared were conveyed as accurately and concisely as possible. I also felt an enormous responsibility in pushing the study forward to be published in academic journals to increase the visibility of their experiences.

Theory and method

At the very beginning of this study, I started with a post-positivist philosophical perspective, however, very soon after adopted a pragmatic worldview. Post-positivists hold a deterministic philosophy in which causes determine effects or outcomes. As such, the problems that are typically studied by post-positivists reflect the need to identify and assess the causes that influence outcomes (Creswell J. W., 2014). Pragmatism as a worldview arises out of actions, situations, and consequences rather than antecedent conditions (Creswell J. W., 2014). Pragmatism is not committed to any one system of philosophy and reality, which also applies to mixed methods research. Pragmatists do not see the world as an absolute unity. In a similar way, mixed methods

researchers use many approaches for collecting and analyzing data rather than subscribing to only one way.

I was acutely aware of the weaknesses of both quantitative and qualitative methods when used on their own. I was critical of quantitative methods because of the lack of opportunity to capture nuances and many important characteristics of participants such as their identities, perceptions, and beliefs. These are all factors that cannot be reduced to numbers or understood without reference to the context in which people live (Choy, 2014). Additionally, qualitative research often relies on participants to recollect their experiences, which can result in recall bias. Using a mixed methods approach allowed me to address the weaknesses identified in both. The decision to use the approach sequentially, with quantitative and qualitative methods being followed by another qualitative method, came later in the study because of time and resources and the policy objective.

Intersectionality, the life course approach, and descriptive phenomenology were incorporated into the methods of this study. Intersectionality is typically applied in either quantitative or qualitative studies, but rarely both. By applying intersectionality in this study, I was able to test the compatibility of the framework with the mixed methods paradigm. Interestingly, when applied to the quantitative component, the results did not completely support the intersectional hypothesis but still offered a strong and effective theoretical framework when combined with the life course perspective to assess the health and social services needs of older Black women, as well as the policies that were developed to address these needs. Reflexivity is an important part of intersectionality as it encourages the researcher to reflect on the importance of power at all levels, that is from the individual level to the societal level (Hankivsky, 2012). Similarly, in phenomenological research, researchers are encouraged to set aside their experiences through a process known as bracketing, as much as possible, to take a fresh perspective toward the

phenomenon under investigation (Creswell, 2007). Bracketing can be useful in supporting reflexive practices when carrying out phenomenological research. Reflexive practices are highly compatible with phenomenological and intersectional research.

Given my position as an insider, a Black woman, it was challenging to completely set aside or bracket my experiences to understand the experiences of older women from my community. Moustakas himself admitted that the complete bracketing of the researcher's experience is a state that is seldom perfectly achieved (Moustakas, 1994). As such, I engaged in reflexive practices as means to be critical given my position as an insider conducting research in my community and to remain aware of how my values, beliefs, and perceptions could influence the research process. Achieving reflexivity in my research was facilitated by a conscious attempt to explicitly reflect and bracket my experiences prior to starting the study. Qualitative researchers have implemented bracketing at various points throughout their studies. For instance, researchers have performed bracketing as a pre-reflective exercise; others have used bracketing prior to beginning data collection and/or the analysis process in research. Others have recommended that bracketing should take place throughout the research process and should not be restricted to certain points in time during the study. This is achieved through a reflexive diary to write down thoughts, feelings, and perceptions. By maintaining a diary, I was able to re-examine my position when issues that might affect the research process arose.

The Study of Race, Gender, and Aging in Canada

To conclude, despite the limitations of this study, the use of an intersectional approach combined with the life course framework to investigate the health of older Black women in Canada can support the development of a strong evidence base to support the development of responsive interventions that address the needs of vulnerable groups. Results demonstrate that social factors

such as race, gender, and class cannot be dissentangled from one another in the study of health. The life course perspective helps to identify points in time where exposures to different risk factors are highest and as such can be points for interventions.

While the use of the life course perspective is not new, combining the life course approach with intersectionality is still relatively novel and has a growing body of evidence. This study contributes to this growing body of evidence. Evidence of the cumulative effect of persistent social inequality that produce health disparities among Black women, despite interventions and different life events, would suggest the need for greater understanding of the factors that lead to disparate outcomes. This is important as aging brings new challenges both physically and socially, especially after retirement. With Canada's aging population and increasing diversity, retirement income policy and healthcare debates have focused less on inequality and its effects on benefit programs. Age-specific impacts of growing inequality need to be better understood, particularly in mid to late life when individuals are likely to be subject to the effects of elevated risks and are seeking opportunities to retire or find comfort in retirement. Identifying these challenges would support the development of comprehensive strategies that can reduce inequalities over extended periods.

REFERENCES

Acheson, R. M. (1978). The definition and identification of need for care. *Journal of Epidemiology and Community Health, 32*, 10-15.

Ailshire, J. A., & House, J. S. (2011). The unequal burden of weight gain: An intersectional approach to understanding social disparities in BMI Trajectories from 1986 to 2001/2002. *Social Forces, 90*(2), 397-423.

Anand, S. (2002). The concern for equity in health. *Journal epidemiology community health, 56*, 485-487.

Arber, S., McKinlay, J., Adams, A., Marceau, L., Link, C., & O'Donnell, A. (2006). Patient characteristics and inequalities in doctor's diagnostic and management strategies relating to CHD: A video-simulation experiment. *Social Science and Medicine, 62*(1), 103-115.

Assari, S., & Lankarani, M. M. (2018, May). Secular and Religious Social Support Better Protect Blacks than Whites against Depressive Symptoms. *Behavioral Sciences, 8*(5), 46.

Barksdale, D. J., Farrug, E. R., & Harkness, K. (2009). Racial discrimination and blood pressure: perceptions, emotions, and behaviors of Black American adults. *Issues Mental Health Nurse, 30*(2), 104-111. doi:10.1080/01612840802597879

Bartley, M. (2004). *Health inequality: An introduction to theories, concepts and methods.* Cambridge, UK: Polity Press.

Benoit, F. (2013). *Public Policy and Their Usefulness in Public Health: The Stages Model.* Montreal: National Collaborating Centre for Healthy Public Policy.

Bierman, A. S., Johns, A., Hyndman, B., Mitchell, C., Degani, N., Shack, A. R., . . . Parlette, V. (2012, Jan 01). *Project for an Ontario Women's Health Evidence-Based Report: Volume 2.* Retrieved Dec 19, 2018, from Project for an Ontario Women's Health Evidence-Based

Report: http://www.powerstudy.ca/power-report/volume2/social-determinants-of-health-populations-at-risk/

Bishwakarma, R., Hunt, V., & Zajicek, A. (2011). Intersectionality and public policy: Some lessons from existing models. *Political Research Quarterly, 64*(1), 217-229.

Blank, M. B., Mahmood, M., Fox, J. C., & Guterbock, T. (2002). Alternative Mental Health Services: The Role of the Black Church in the South. *American Journal of Public Health, 92*(10), 1668-1672. doi:10.2105/ajph.92.10.1668

Bocian, D. G., Ernst, K. S., & Li, W. (2008). Race, ethnicity and subprime home loan pricing. *Journal of Economics and Business, 60*, 110-124.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40.

Braveman, P. (2014). What is health equity: And how does a life-course approach take us further toward it? *Journal of Maternal Child Health, 18*, 366-372.

Brown, T. H., Richardson, L. J., Hargrove, T. W., & Thomas, C. S. (2016). Using Multiple-hierarchy Stratification and Life Course Approaches to Understand Health Inequalities: The Intersecting Consequences of Race, Gender, SES, and Age. *J Health Soc Behav., 57*(2), 200-222. doi:10.1177/0022146516645165.

Burton-Jeangros, C., Cullati, S., Sacker, A., & Blane, D. (2015). *A life course perspective on health trajectories and transitions.* New York: Springer International Publishing.

Cameron, R. (2009). A sequential mixed model research design: Design, analytical and display issues. *International Journal of Multiple Research Approaches, 3*(2), 140-152.

Cawley, G. D. (2019). Law and inclusive urban development: Lessons from Chile's enabling markets housing policy regime. *The American Journal of Comparative Law, 67*, 587-636.

Centre for Equality Rights in Accommodation. (2008). *Sorry, it's rented.* Toronto: Centre for Equality Rights in Accommodation. Retrieved from https://static1.squarespace.com/static/5e3aed3ea511ae64f3150214/t/5e7b7922dfdbdb3c5ec89a23/1585150243155/Sorry%2C%2Bit%27s%2Brented.pdf

Chiu, M., Maclagan, L. C., Tu, J. V., & Shah, B. R. (2015). Temporal trens in cardiovascular disease risk factors among white, SOuth Asian, Chinese and black groups in Ontario, Canada, 2001 to 2012: a population-based study. *BMJ, 5*(e007232). doi:10.1136/bmjopen-2014-00732

Collins, P. H. (2015). Intersectionality's definitional dilemma. *Annual Review of Sociology, 41*(1), 1-20.

Colour of Poverty-Color of Change. (2019). *An introduction to racialized powerty.* Toronto: Color of Poverty-Color of Change. Retrieved from https://colourofpoverty.ca/wp-content/uploads/2019/03/cop-coc-fact-sheet-2-an-introduction-to-racialized-poverty-3.pdf

Committee on Assessing Interactions Among Social, B. a. (2006). *Genes, Behavior, and the Social Environment* . Institute of Medicine. Washington: The National Academies Press.

Cooper, M. M. (1997). Distinguishing Critical and Post-Posivist Research. *College Composition and Communication, 48*(4), 556-561.

Corti, M.-C., Guralnik, J. M., Ferrucci, L., Izmirlian, G., Leveille, S., Pahor, M., . . . Havlik, R. J. (1999). Evidence for a Black-White crossover in all-cause and coronary heart disease mortality in an older population: the North Carolina EPESE. *American Journal of Public Health, 89*(3), 308-314.

Craciun, C., & Flick, U. (2016). Aging in precarious times: Exploring the role of gender in shaping views on aging. *Journal of Women & Aging, 28*(6), 530-539.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feministy critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1), 139-167.

Creswell, J. W. (2007). *Qualitative Inquiry and Research Design: Choosing Among five Approaches* (2nd ed.). Thousand Oaks, California: Sage Publications, Inc.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, California: SAGE Publications Ltd.

Creswell, J. W., Plano Clark, V. L., Gutmann, M., & Hanson, W. (2003). Advanced mixed-methods researh designs. In A. Tashakkori, & C. Teddlie, *Hanbook on mixed-methods in the behavioral and social sciences* (pp. 209-240). Thousand Oaks, CA: Sage.

Crimmins, E. M., Kim, J. K., & Sole-Auro, A. (2010). Gender differences in health: Results from SHARE, ELSA and HRS. *The European Jounral of Public Health, 21*(1), 81-91.

Crystal, S., & Shea, D. (2003a). Cumulative advantage, public policy, and late-life inequality. In S. Crystal, & D. Shea, *Economic outcomes in later life: Pulic policy, health, and cumultive advantage* (pp. 1-13). New York: Springer.

Crystal, S., Shea, D. G., & Reyes, A. M. (2017, March 20). Cumulative advantage, cumulative disadvantage, and evolving patterns of late-life inequality. *The Gerontologist, 57*(5), 910-920.

Darden, J. T., & Kamel, S. M. (2000, December). Black and white differences in homeownership rates in the Toronto Census Metropolitan Area: Does Race Matter? *The Review of Black Political Economy, 28*(2), 53-76.

Dodgson, J. E. (2019). Reflexivity in Qualitative Research. *Journal of Human Lactation, 35*(2), 220-222.

Dryden, O., & Nnorom, O. (2021). Time to dismantle systemic anti-Black racism in medicine in Canada. *CMAJ, 193*(2), E55-E57.

Duncan, G., Daly, M., McDonough, P., & WIlliams, D. (2002). Optical indicators of socioeconomic status for health research. *American Journal of Public Health, 92*(7), 1151-1157.

Else-Quest, N., & Hyde, J. S. (2016). Intersectionality in Quantitative Psychological Research: 1. Theoretical and Epistemological Issues. *Psychology of Women Quaterly, 40*(2), 155-170.

Etowa, J., Bernard, B., Oyinsan, B., & Clow, B. (2007b). Participatory action research (PAR): An approach for improving Black women's health in rural and remote communities. *Journal of Transcultural Nursing, 18*(4), 349-357.

Etowa, J., Wiens, J., Bernard, W. T., & Clow, B. (2007). Determinants of Black women’s health in rural and remote communities. *CJNR, 39*(3), 56-76.

Ferrer, I., Grenier, A., Brotman, S., & Koehn, S. (2017). Understanding the experiences of racialized older people through an intersectional life course perspective. *Journal of Aging Studies, 41*, 10-17.

Foster, N., Kapiriri, L., Grignon, M., & McKenzie, K. (2022, May 30). "But...I survived": A phenomenological study of the health and wellbeing of aging Black women in the Greater Toronto Area, Canada. *Journal of Women and Aging*. doi:https://doi.org/10.1080/08952841.2022.2079925

Fox, D., & Moyser, M. (2018). *Women in Canada: A gender-based statistical report.* Ottawa: Statistics Canada. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89-503-x/2015001/article/54930-eng.pdf?st=zZokWX6n

Geronimus, A. T., Bound, J., Keene, D., & Hicken, M. (2007). Black-White difference in age trajectories of hypertension prevalence among adult women and men, 1999-2002. *Ethnicity & Disease, 17*(1), 40-48.

Government of Canada. (2010). *Women's Health Strategy.* Health Canada. Ottawa: Government of Canada.

Government of Canada. (2022, February 2). *Cardiovascular Disease: Are Women at Risk of Heart Disease*. Retrieved from Public Health Agency of Canada: https://www.canada.ca/en/public-health/services/chronic-diseases/cardiovascular-disease/women-risk-heart-disease.html

Government of Canada. (2022, January 23). *Funding: Employment Assistance for Older Workers*. Retrieved from Employmnt and Social Development Canada: https://www.canada.ca/en/employment-social-development/programs/training-agreements/older-workers.html

Government of Ontario. (2021, July 21). *2018-2019 Investment in affordable housing annual public reports*. Retrieved from Ontario: https://www.ontario.ca/page/2018-2019-investment-affordable-housing-annual-public-reports

Griffith, A. (1998). Insider / Outsider: Epistemological Privilege and Mothering Work. *Human Studies, 21*, 361-376.

Gueta, K. (2017). A qualitative study of barriers and facilitators in treating drug use among Israeli mothers: An intersectional perspective. *Social Science and Medicine, 187*, 155-163.

Gur, R. E., & Gur, R. C. (2002, June). Gender differences in aging: cognition, emotions, and neuroimaging studies. *Dialogues in Clinical Neuroscience, 4*(2), 197-210.

Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: a review. *Psychiatric Services, 63*(3), 243-249. doi:10.1176/appi.ps.201100216

Hanson, A., & Hawley, Z. (2011). Do landlords discriminate in the rental housing market? Evidence from an internet field in the US cities. *Journal of Urban Economics, 70*, 99-114.

Hanson, A., Hawley, Z., Martin, H., & Liu, B. (2016). Discimination in mortgage lending: Evidence from a correspondence experiment. *Journal of Urban Economics, 92*, 48-65.

Havinsky, O., & Cormier, R. (2011). Intersectionality and public policy: Some lessons from existing models. *Policy Research Quarterly, 64*(1), 217-229.

Havinsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., . . . Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International Journal for Equity in Health, 13*, 119.

Healthcare of Ontario Pension Plan. (2017). *Seniors and poverty: Canada's next crisis.* Toronto: Healthcare of Ontario Pension Plan. Retrieved from https://hoopp.com/docs/default-source/newsroom-library/research/hoopp-research-article---senior-poverty---canada-next-crises.pdf

Hernandez, L. M., & Blazer, D. G. (2006). *Genes, Behavior, and the Social Environment.* Washington, DC: The National Academies Press.

Holton, E., Gogosis, E., & Hwang, S. (2010). *Housing Vulnerability and Health: Canada's Hidden Emergency.* Toronto: St. Michael's Hospital. Retrieved from https://www.homelesshub.ca/resource/housing-vulnerability-and-health-canada%E2%80%99s-hidden-emergency

Homeless Hub. (2021, Apr 26). *About Homelessness*. Retrieved from Homeless Hub: https://www.homelesshub.ca/about-homelessness/population-specific/racialized-communities

Hudon, T. (2016). *Women in Canada: A Gender-based Statistical Report.* Ottawa: Statistics Canada.

Hulchanski, J. D. (2007). *Canada's dual housing policy assisting owners, neglecting renters.* Toronto: Centre for Urban and Community Studies: University of Toronto. Retrieved 04 04, 2021, from http://www.urbancentre.utoronto.ca/pdfs/researchbulletins/CUCSRB38Hulchanski.pdf

Hunting, G. (2014). *Intersectionality-informed qualitative research: A primer.* Burnaby: The Institute for Intersectionality Research and Policy. Retrieved from https://www.ifsee.ulaval.ca/sites/ifsee.ulaval.ca/files/b95277db179219c5ee8080a99b0b91276941.pdf

Huston, J. B. (2016). Advancing health equity in improving health: The time is now. *Canadian Communicable Disease Report, 42-Suppl 1*, S1-6. doi:https://doi.org/10.14745/ccdr.v42is1a01

Hwang, S., Wilkins, R., Tjepkema, M., O'Campo, P., & Dunn, J. R. (2009). Mortality among residents of shelters, rooming houses and hotels in Canada: An 11 year follow-up study. *BMJ*, 339: b4036.

Hyman, I., O'Campo, P., Ansara, D. L., Siddiqi, A., Forte, T., Smylie, J., . . . McKenzie, K. (2019). *Prevalence and predictors of everyday discrimination in Canada: Findings from the Canadian Community Health Survey.* Toronto: Wellesley Institute. Retrieved May 10, 2021, from https://www.wellesleyinstitute.com/wp-content/uploads/2019/10/Prevalence-and-Predictors.pdf

Imkaan. (2019). *The value of intersectionality in understanding vilence against women and girls (VAWG).* United Kingdom: Imkaan. Retrieved from https://www2.unwomen.org/-/media/field%20office%20eca/attachments/publications/2019/10/the%20value%20of%20intersectionality%20in%20understanding%20violence%20against%20women%20and%20girls.pdf?la=en&vs=3339

Irvin, R. A., & Stansbury, J. (2004). Citizen participation in decision making: Is it work the effort? *Public Administration Review, 64*(1), 55-65.

Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006, February). Using mixed-methods sequential explanatory design: From theory to practice. *Field Methods, 18*(1), 3-20.

Jacobsen, G. D. (2020). Market-based policies, public opinion, and information. *Economics Letters, 189*, 109018.

Johnson, D. D., & Bornstein, J. (2021). Racial equity policy that moves implicit bias beyond a metaphor for individual prejudice to a means of exposing structural opporession. *Journal of Cases in Educational Leadership, 2*, 81-95.

Johnson, N. (2000). The racial crossover in comorbidity, disability, and mortality. *Demography, 37*(3), 267-283.

Johri, M., & Norheim, O. F. (2012, Apr). Can cost-effectiveness analysis integrate concerns for equity? Systematic review. *Int J Technol Assess Health Care, 28*(2), 125-132.

Kakar, I. S., Peden, M., & Jagnoor, J. (2021). Inersectionality based policy analysis: Equity in mobility in India. *Transport Policy, 101*, 14-22.

Kaushik, V., & Walsh, C. A. (2018). A critical analysis of the use of intersectionality theory to understand the settlement and integration needs of skilled immigrants to Canada. *Canadian Ethnic Studies, 50*(3), 27-47.

Lasser, K. E., Himmelstein, D. U., & Woolhandler, S. (2006). Access to care, health status and health disparities in the United States and Canada: Results of a cross-national population-based survey. *American Journal of Public Health, 96*(7), 1300-1307.

LaVeist, T. A. (1994, Apr). Beyond Dummy Variables and Sample Selection: What Health Services Researchers Ought To Know about Race as a Variable . *Health Services Research, 29*(1), 1-16.

LaVeist, T., Thorpe, J. R., Pierre, G., Mance, G., & Williams, D. (2014). The relationships among vigilant coping style, race, and depression. *Journal of Social Issues, 70*(2), 241-255.

LeBrun, L. A., & LaVeist, T. A. (2013). Health status among Black Canadians: Results from a National Survey. *Canadian Ethnic Studies, 45*(1-2), 143-155.

Lebrun, L., & LaVeist, T. (2011). Black/White racial disparities in health: A cross-country comparison of Canada and the United States. *Archives of Internal Medicine, 171*(17), 1591-1593.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*(Extra Issue), 80-94.

Lu, C., & Ng, E. (2019). *Healthy immigrant effect by immigrant category in Canada.* Ottawa: Statistics Canada. Retrieved from https://www150.statcan.gc.ca/n1/pub/82-003-x/2019004/article/00001-eng.htm

Lynch, S., Brown, J., & Harmsen, K. (2003). Black-white differences in mortality compression and deceleration and the mortality crossover reconsidered. *Research on Aging, 25*(5), 456-483.

Macbeth, D. (2001). On "Reflexivity" in Qualitative Research: Two Readings, and a Third. *Qualitative Inquiry, 7*(1), 35-68.

Matua, G. A., & Van Der Wal, D. M. (2015). Differentiating between desriptive and interpretive phenomenological research approaches. *Nurse Researcher, 6*, 22-27.

Mayoh, J., & Onwuegbuzie, A. J. (2015). Toward a conceptualization of mixed methods phenomenological research. *Journal od Mixed Methds Research, 9*(1), 91-107.

McCall, L. (2005). The Complexity of Intersectionality. *Signs: Journal of Women in Culture and Society, 30*(3), 1771-1880.

McFadden, E. S., & Lucio, J. (2014). Aging in (Privatized) Places: Subsidized Housing Policy and Seniors. *Journal of Housing for the Elderly, 28*, 268-287.

McKinlay, J. (1996). Some contributions from social system to gender inequalities in heart disease. *Journal of Health and Social Behavior, 37*(1), 1-26.

McMullin, J. A. (2000). Diversity and the State of Sociological Aging Theory. *The Gerontologist, 40*(5), 517-530.

Merton, R. K. (1968). The Matthew Effect in Science. *Science, 159*, 56-63.

Merton, R. K. (1972, July). Insiders and Outsiders: A Chapter in the Sociology of Knowledge. *American Journal of Sociology, 78*(1), 9-47.

Milan, A., & Tran, K. (Spring 2004). Blacks in Canada: A long history. *Canadian Social Trends*, pp. 1-6.

Ministry for Seniors. (2013). *Ontario's Action Plan for Seniors.* Toronto: Queen's Printer for Ontario.

Moustakas, C. (1994). Transcendental phenomenology: Conceptual framework. In C. Moustakas, *Phenomenological Research Methods* (pp. 25-44). Thousand Oaks, CA: SAGE Publications, Inc.

Mullings, L., & Wali, A. (2001). *Stress and resilience: The social context of reproduction in Harlem.* New York: Kluwer Academic/Plenum Publishers.

National Collaboration Centre for Healthy Public Policy. (2013). *Public policy models and their usefulness in public health: The stages model.* Monteal: Collaborating Centre for Healthy Public Policy. Retrieved from http://www.ncchpp.ca/docs/modeleetapespolpubliques_en.pdf

Ng, E. (2011). The healthy immigrant effect and mortality rates. *Health Reports, 22*(4), 1-5. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2011004/article/11588-eng.pdf?st=CkNcBPYz

Ontario Human Rights Commission. (2008). *Right at Home: Report on the Consultation on Human Rights and Rental Housing in Ontario.* Toronto: Ontario Human Rights Commission. Retrieved from http://www3.ohrc.on.ca/sites/default/files/attachments/Right_at_home%3A_Report_on_the_consultation_on_human_rights_and_rental_housing_in_Ontario.pdf

Ontario Non-Profit Housing Association. (2016). *Aging in place in social housing.* Retrieved February 21, 2021, from https://www.ighhub.org/sites/default/files/FocusON%2520Aging%2520in%2520place%2520in%2520social%2520housing.pdf

Patterson, A. C., & Veenstra, G. (2016). Black-white health inequalities in Canada at the intersection of gender and immigration. *Canadian Journal of Public Health, 107*(3), e278-e284.

Phelan, J. C., & Link, B. G. (2015). Is racism a fundamental cause of inequalities in health? *Annual Review of Sociology, 41*, 311-330.

Phillips-Pula, L., Strunk, J., & Pickler, R. (2011). Understanding phenomenological approaches to data analysis. *Journal of Pediatrics Health Care, 25*, 67-71.

Public Health Agency of Canada. (2011). *Diabetes in Canada: Facts and Figures from Public Health Perspective.* Ottawa. Retrieved from https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/pdf/facts-figures-faits-chiffres-eng.pdf

Public Health Agency of Canada. (2020, December 24). *Rheumatoid arthritis in Canada*. Retrieved from Government of Canada: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/rheumatoid-arthritis.html

Public Health Agency of Canada. (2021, 10 13). *Surveillance of heart diseases and conditions*. Retrieved from Government of Canada: https://www.canada.ca/en/public-health/services/diseases/heart-health/heart-diseases-conditions/surveillance-heart-diseases-conditions.html

Purdie-Vaughns, V., & Eibach, R. (2008). Intersectional invisibility: the distinctive advantages and disadvantages of multiple subordinate-group identities. *Sex, 59*, 377-391.

Quillian, L., Lee, J. J., & Honore, B. (2020). Racial discrimination in the US housing and mortgage lending markets: A quantitative reviews of trends, 1976-2016. *Race and Social Problems, 12*, 13-28.

Ramirez-Johnson, J., Park, J., Wilson, C., Pittman, S., & Diaz, H. L. (2014). "Deeply woven roots": health initiatives and community social services of faith-based organizations of the Hidalgo County, Texas. *Journal of Religion and Health, 53*(4), 1199-1213. doi:10.1007/s10943-013-9807-x

Ramraj, C., Shahidi, F. V., Darity Jr., W., Kawachi, I., Daniyal, Z., & Siddiqi, A. (2016). Equally inequitable? A cross-national comparative study of racial health inequalities in the United States and Canada. *Social Science and Medicine, 161*, 19-26.

Rawls, J. (1971). *A theory of justice.* Cambridge, United States: Belknap.

Richardson, L. J., & Brown, T. H. (2016). (En)gendering racial disparities in health trajectories: A life course and intersectional analysis. *SSM-Population Health, 2*, 425-435.

Robyn, S. I. (2018). The housing challenges of low-income older adults and the role of federal policy. *Journal of Aging and Social Policy, 30*(3-4), 227-243.

Rodney, P., & Copeland, E. (2009). The health status of Black Canadians: Do aggregated racial and ethnic viarables hide health disparities? *Journal of Health Care for the Poor and Underserved, 20*, 817-823.

Salma, J., Keating, N., Ogilvie, L., & Hunter, K. F. (2017). Social dimensions of health across the life course: Narratives of Arab immigrant women ageing in Canada. *Nursing Inquiry, 25*(2), e12226. doi: https://doi.org/10.1111/nin.12226

Schwan, K., Versteegh, A., Perri, M., Caplan, R., Baig, K., Dej, E., . . . Chaleshtari, T. P. (2020). *The state of women's housing need and homeless in Canada: A literature review.* (A. Hache, A. Nelson, E. Kratochvil, & J. Malenfant, Eds.) Toronto: Canadian Observatory on Homelessness Press.

Shapiro, D. (2002, August 16). Egalitarianism and welfare-state redistribution. *Social Philosophy and Policy, 19*(1), 1-35.

Sheets, D. J., & Gallagher, E. M. (2013). Aging in Canada: State of the Art and Science. *The Gerontologist, 53*(1), 1-8.

Shemirani, F. S., & O'Connor, D. L. (2006). Aging in a Foreign Country: Voices of Iranian Women in Aging in Canada. *Journal of Women and Aging, 18*(2), 73-90.

Shier, M. L., & Graham, J. R. (2014). Social Policy in Canada. *Encyclopedia of Social Work*, 1-18. doi:https://doi.org/10.1093/acrefore/9780199975839.013.947

Siddiqi, A. A., Wang, S., Quinn, K., Nguyen, Q. C., & Christy, A. D. (2016). Racial disparities in access to care under conditions of universal coverage. *American Journal of Preventative Medicine, 50*(2), 220-225.

Siddiqi, A., & Hertzman, C. (2007). Towards an epidemiological understanding of the effects of long-term institutional changes in population health: A case study of Canada vs the US. *Social Science and Medicine, 64*, 589-603.

Siddiqi, A., & Nguyen, Q. C. (2010). A cross-national comparative perspective on racial inequities in health: the USA versus Canada. *J. Epidemiol. Commun Health, 64*(1), 29-35.

Siddiqi, A., Shahidi, F. V., Ramraj, C., & Williams, D. R. (2017). Associations between race, discrimination and risk for chronic disease in a population-based sample from Canada. *Social Science and Medicine, 194*, 135-141.

Sims, M., Glover, L. M., Gebreab, S. Y., & Spruill, T. M. (2020). Cumulative psychosocial factors are associated with cardiovascular disease risk factors and management among African Americans in the Jackson Heart Study. *BMC Public Health, 20*(1), 566. doi:10.1186/s12889-020-08573-0

Spruill, T. M. (2010). Chronic psychosocial stress and hypertension. *Current Hypertension Reports, 12*(1), 10-16.

Statistics Canada. (2010). *Projections of the diversity of the Canadian population 2006 to 2031.* Ottawa: Statistics Canada. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/91-551-x/91-551-x2010001-eng.pdf?st=AF1eKZYH

Statistics Canada. (2012, Jan 01). *Average female and male earnings and female-to-male earnings ratio*. Retrieved Dec 19, 2018, from Statistics Canada: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110014301

Statistics Canada. (2015). *Canada's population estimates: Age and sex, July 1, 2015.* Retrieved from http://www.statcan.gc.ca/daily-quotidien/150929/dq150929b-eng.pdf

Statistics Canada. (2017). *Age and sex, and type of dwelling data: Key results from the 2016 Census.* Retrieved from http://www.statcan.gc.ca/daily-quotidien/170503/dq170503a-eng.pdf

Statistics Canada. (2019). *Diversity of the Black population in Canada: An overview.* Ottawa: Government of Canada.

Statistics Canada. (2021, 02 21). *Table: 11-10-0135-01 (formerly CANSIM 206-0041) low income statistics by age, sex and economic family type*. doi:https://doi.org/10.25318/1110013501-eng

Statistics Canada. (2022, January 5). *Income Highlight Tables, 2016 Census*. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/inc-rev/index-eng.cfm

Teixeira, C. (2008). Barriers and outcomes in the housing searches of new immigrants and refugees: A case study of "Black" Africans in Toronto's rental market. *Journal of Housing and the Built Environmenta, 23*, 253-276.

van der Heden, C. (2017). The process of racialization from the colonial period to the present time. *Journal of Social and Psychologgical Sciences, 10*(1), 33-40.

Veenstra, G. (2011). Race, gender, class, and sexual orientation: intersecting axes of inequality and self-rated health in Canada. *International Journal of Equity in Health, 10*(3), 1-11.

Veenstra, G. (2013). Race, gender, class, and sexuality (RGCS) and hypertension. *Social Science and Medicine, 89*, 16-24.

Veenstra, G., & Patterson, A. C. (2016). Black–White Health Inequalities in Canada. *J Immigrant Minority Health, 18*, 51-57.

Walks, R. A., & Bourne, L. S. (2006). Ghettos in Canada's cities? Racial segregation, ethnic enclaves and poverty concentration in Canadian urban areas. *The Canadian Geographer, 50*(3), 273-293.

Washington, O. G., Moxley, D. P., & Taylor, J. Y. (2010). Enabling older homeless minority women to overcome homelessmess by using a life management enhancement group

intervention. *Issues in Mental Health Nusing, 30*(2), 86-97. doi:10.1080/01612840802597580

Williams, D. R. (1997). Race and Health: Basic Questions, Emerging Directions. *Ann Epidemiol, 7*, 322-333.

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and Health: Evidence and Needed Research. *Annual Review of Public Health, 40*, 105-125.

Women's Health in Women's Hands. (2011). *Every women matters: A report on accessing primary health cre for Black women and women of colour in Ontario.* Toronto: Women's Health in Women's Hands.

World Health Organization. (2007). *Women, Ageing and Health: A Framework for Action.* Geneva: World Health Organization.

World Health Organization. (2015). *World Report on Ageing.* Geneva: World Health Organization. Retrieved from World Health Organization: https://www.who.int/ageing/healthy-ageing/en/