

Black Women's Health: A Synthesis of Health Research Relevant to Black Nova Scotians

Josephine Enang, RM, RN, IBCLC, MN
Health Association of African Canadians
(formerly the Black Women's Health Network)

With support from:

Susan Edmonds, DCC, RN
Health Association of African Canadians

Carol Amaratunga, PhD
Maritime Centre of Excellence for Women's Health

Yvonne Atwell
Maritime Centre of Excellence for Women's Health

With editorial assistance from:
Susan Rolston, MA

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PO Box 3070
Halifax, Nova Scotia
B3J 3G9 Canada

Telephone 902-420-6725
Toll-free 1-888-658-1112
Fax 902-420-6752

mcewh@dal.ca
www.medicine.dal.ca/mcewh

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Josephine Enang
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Executive Summary

People of African descent settled in Nova Scotia in the early 1600s. However, research and literature in various domains, including health, have virtually ignored this population. One consequence of their absence in mainstream health literature is marginal representation of their issues in the research and policy making arenas. This often results in a lack of understanding of the historical and racial contexts that influence the health of Blacks living in Nova Scotia.

The research presented in this report is a synthesis of literature relevant to the health of Nova Scotia's Black population. The goal was to promote an understanding of the current state of knowledge about the health of Nova Scotians of African descent and to identify ways of enhancing the health and well-being of Black women and their families. The project was conducted as a partnership initiative between the Health Association of African Canadians (formerly the Black Women's Health Network) and the Maritime Centre of Excellence for Women's Health. It used a synthesis research methodology to review and analyze past research relevant to Black health and to consult researchers to ascertain specific gaps and health issues within the Nova Scotian Black community.

The literature referenced in the report comes from local research reports, Canadian studies and African American literature on those conditions that disproportionately affect people of African descent. Information was also gathered through consultations with community researchers and academics interested in this area of research. A two-day workshop was used as a forum to raise awareness of the issues and the determinants of health, and to validate the preliminary research findings as well as to identify strategies for addressing these issues. Recommendations for future initiatives on Black health in Nova Scotia were also developed at the workshop.

The information collected during this study was grouped into four major themes: access to health services, preventive health issues, behavior and lifestyle, and health status.

Access to health services: The issue of access to health care services or, more accurately, lack of access include physical location of services and transportation, limited research, lack of knowledge by professionals, under-representation of people of African descent in health professions, racism, cultural insensitivity, and language barriers.

Preventive health: Issues include physical health examinations, perinatal health care and birth outcomes, employment and environmental conditions. The under-utilization of routine preventive health assessments such as Pap smears, breasts self-exams, mammograms and routine physical examinations among Black women accounts for the late diagnosis of diseases like breast cancer in this population.

Behavior and lifestyle: The choices Black women make in exercise, nutrition, smoking, alcohol consumption and use of illicit drugs can negatively or positively influence their health. The prevalence of these lifestyle choices have been known to vary along racial lines. However, research has not adequately examined the contextual factors that account for these disparities.

Health status: Canadian studies exploring health issues within the context of race, gender, and ethnicity are limited in number. However, available literature from other jurisdictions demonstrates that certain health conditions affect Black women disproportionately, in particular diabetes mellitus, cardiovascular diseases, cerebrovascular diseases, cancer, HIV/AIDS, lupus, sickle cell disorder, and sarcoidosis. Each of these conditions is examined in turn.

Key messages articulated throughout the literature review and workshop and this report lead to recommendations in four areas: policy, education, research and community capacity building. The research findings demonstrate that the interplay among culture, gender and ethnicity are important determinants of health. The findings identified in this report provide a clear understanding of the health needs and status of African Nova Scotians and should lead to improved health outcomes for African Nova Scotian women and their families.

Black Women’s Health: A Synthesis of Health Research Relevant to Black Nova Scotians

1.0 Summary of the Research Project

Historically, the Black population living in Nova Scotia has not always had the benefit of, or access to, the most essential health services. Barriers to health care include the lack of statistics or indicators on Black Nova Scotians’ health, transportation challenges, and lack of health care services and resources in rural Black communities. As well, the design and delivery of health services that are culturally sensitive to the unique needs of the population remains a challenge. There have been few health interventions specifically geared or targeted to Nova Scotia’s Black population or health policies that are informed by their voices or needs. To borrow a phrase from the Maritime Centre of Excellence for Women’s Health (MCEWH), as a “forgotten population” in Atlantic Canada, we believe that the emotional and physical health experiences of Black Nova Scotians continues to lag behind the mainstream population. Evidence-based information is needed to set health priorities for the Black community and to provide a solid and reasoned basis for a comprehensive design of policy and delivery of health care services.

In January 2001, the Population and Public Health Branch of Health Canada (PPHB), Atlantic Region, awarded a grant to the Health Association of African Canadians (HAAC, formerly the Black Women’s Health Network) and the MCEWH to conduct “Black Women’s Health: A Synthesis of Health Research Relevant to Black Nova Scotians”. This Project is hosted by the MCEWH whose work on social inclusion has been informed and supported by leaders from the Black Nova Scotian community. This work on inclusion is creating a shift in thinking away from a concentration on child poverty towards an analysis of the social and economic exclusion of women, children and their families. The Black Women’s Health Project has provided a voice to those who have been largely excluded from policy dialogue, and has also contributed another piece of evidence to the social inclusion “puzzle” in Atlantic Canada and to ongoing research on social and economic inclusion and health in general.

The Project is comprised of two components: a) synthesis research to review and analyze past research relevant to Black health (Appendix A), and b) a two-day workshop to share the research findings, raise awareness of specific Black health issues and the determinants of health, identify strategies for addressing these issues, and develop recommendations for future initiatives. A separate report has been prepared for the workshop component (Appendix B). This report encompasses the synthesis research as informed by the workshop findings of the Black Women’s Health Project.

1.1 Goal and Objectives of the Research

The goal of the Black Women’s Health Project is to prepare a report on the current state of knowledge about the health of Nova Scotians of African descent in order to identify ways of enhancing the health and well-being of Black women and their families. For the purpose of this research, “Black women” refers to all women of African descent, recognizing that there is diversity within this population.

The objectives of the Project are:

1. To increase awareness about Black health issues in Nova Scotia.
2. To develop a foundation for future study and advancement of evidence-based social policies relevant to Black health.

3. To translate research findings into clear policy language for decision makers and the public at large.
4. To disseminate research findings to a wide audience, including community members, researchers and various levels of government.

1.2 Historical Context and Background

The following section discusses background related to the state of current knowledge and issues of African Nova Scotians' health and the Health Association of African Canadians.

1.2.1 Historical Context

There is a need to place health in a historical and racial context in order to understand the present situation of Blacks living in Nova Scotia and to improve their health and well being. People of African descent settled in Nova Scotia in the early 1600s and are often considered to be among the founding peoples of Nova Scotia (Pachai 1991). Documents on record identify Matthew Decosta, a former slave of the Portuguese, as one of the first to arrive in 1606. He came as a navigator for the French colonists and served as an interpreter of the Mi'kmaq language. The extension of the African diaspora into Nova Scotia came in three waves. The first migration, and the largest (3,000 men, women and children), came to Nova Scotia in 1776 with the promise of freedom and land in return for their service during the American Revolution. The second migration involved the Maroons. This was followed by the next migration wave of African Americans coming to Nova Scotia as "loyalist" refugees during the British American War of 1812. Out migrations to the Caribbean or West Africa claimed the most skilled and educated youth and laborers, leaving behind women and children and those with lower skills and less education.

It is common knowledge through oral history that health care services were not available for several generations. Family members, especially women, became the main care providers in the Black communities and their main medicinal resource involved herbal preparations.

Due to the largely rural distribution of the population, there is still limited health service infrastructure available to the Black community. As a result, the African Nova Scotian community has increased vulnerability and is at risk for disease conditions such as cancer, hypertension, cardiovascular disease and diabetes, to name but a few. In the Black Nova Scotian community, poor health, intersected with other variables such as limited education, residence in rural communities, isolation and racism, have had a cumulative and devastating impact on peoples' lives. For the Black woman and her family, issues of gender and culture also add to the complexity of her situation resulting in both real and perceived poor health and low self-esteem.

The legacy of Blacks in Canada is complicated and emotional; and little research is available to document the extent and effects of racism on the overall physical and mental health of Blacks. These effects impact upon unemployment, work and social environments, genetics and child development. Racism needs to be addressed as a determinant of health in the Black community and considered in the delivery of health services to African Nova Scotians. Over the last twenty years, research within the health, education and justice systems in Nova Scotia has begun to demonstrate that racism has existed and still exists. Systemic barriers limit or deny access to job opportunities for Blacks and even if one is successful in gaining entry to an organization, Blacks may be confronted with an uncomfortable or hostile environment. In terms of health outcomes, the effects of racism have so deeply impacted on the community that many Black people do not access formal health services in a timely manner, instead they use these services in times of crisis and emergencies.

For the government to develop public policy that ensures the social inclusion of the most vulnerable and high risk populations in our society, the perspective of those affected by such policy must be considered. There is a need to build health profiles about Blacks living in Nova Scotia in order to develop the appropriate policies to address their health needs. A targeted plan consistent with a population health approach is needed to engage Black people in improving their health status, particularly in the areas of health promotion and prevention. Overall, there is a need to increase awareness about Black health issues, to develop health promotion and illness prevention initiatives, and to implement programs and policies that address the interplay among the determinants of health, including culture and race, in the Black Nova Scotian community.

1.2.2 The Health Association of African Canadians

The Health Association of African Canadians (formerly the Black Women’s Health Network) was formed in April 2000 to address the numerous and complex health concerns of African Nova Scotians. The group evolved from “Lunch and Learn” sessions on Black women’s health facilitated by the MCEWH. The MCEWH recognizes that the perceptions and voices of Black Nova Scotians are required to help government develop policies that ensure inclusion of the most vulnerable and high risk populations in our society. The MCEWH offered facilitation services to the Black health research community in an effort to foster links, networks, and partnerships across the Atlantic region. This inclusive approach aims to inform public policy and to raise critical consciousness about the need to move beyond discussions about poverty and to focus on the underlying factors which exclude populations such as Black Nova Scotians from mainstream society, civil governance and health service delivery.

The HAAC is comprised of volunteers and researchers from academic, community, public policy and clinical agencies who are interested in advancing the current state of health knowledge about African Nova Scotians. The goal of the HAAC is to promote the health of Black Nova Scotian women and their families through community mobilization, development and research. Research on Black health will provide the much needed information to support evidence-based decision making, citizen engagement, increased community capacity, early health intervention, partnership building, and better health outcomes among African Nova Scotians.

2.0 Methodology

This synthesis study proceeded in three phases: secondary literature review and synthesis, consultations with researchers in the Black community, and a workshop.

2.1 Literature Review

It is difficult to determine those health conditions that specifically affect Nova Scotians of African descent because specific evidence-based health information and data are not readily available. Provincial and federal data collection systems do not provide statistics on African Nova Scotians in regard to illnesses prevalent in this population. The literature review focused on literature relevant to the health of Nova Scotians of African descent with special focus on local research reports, Canadian studies and African American literature on those conditions that disproportionately affect people of African descent (see Appendix A, Selected Bibliography). Review of the literature has been an ongoing process throughout all phases of the project. An annotated bibliography (Appendix C) summarizes the local research reports which were reviewed.

2.2 Research Consultations

Several community and academic researchers were consulted to validate the synthesis and their research findings in the area of Black health. To the extent that it was possible, researchers were identified from across the province, e.g., Digby, the Prestons, and Halifax. The themes identified from these interviews were analyzed according to the major themes discussed in this report.

2.3 Workshop

“Health for the Black Community: A two-day research workshop” provided a unique forum to ascertain the issues, to promote a sense of community and to collectively identify strategies for addressing Black health issues. Integral to the workshop was the discussion of the inequities that affect the health of African Nova Scotians and the interplay among the broad determinants of health. These include education, employment/working conditions, social, physical and geographic environments, lifestyle, healthy child development, culture and race, access to services, gender, health services, biology and genetic endowment. Participants from across the province included community members, researchers, and both federal and provincial government representatives. The workshop report is reproduced in Appendix B. Comments from workshop presenters and participants related to the research findings and the determinants of the health have been integrated into the Research Findings section of this report, and are also presented in the insert boxes.

3.0 Research Findings

There is an increasing body of knowledge about what keeps people healthy and why some populations are healthier than others. In this synthesis report which examined the literature on the experience of health and health service delivery for Black women (Appendix A), it is evident that several factors influence Black health. Although each of these factors is significant in itself, they are interwoven in complex ways. For example, the experience of racism may be linked with other determinants of health such as a low education level and poverty. All of the findings in this report, as analyzed from the literature and validated by the workshop discussions, demonstrate the obvious connections between these themes and Health Canada’s determinants of health framework. The key determinants of health include: income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture (Health Canada 2001).

In local studies and the workshop discussions, the issue of limited access to health services was identified as a significant barrier to appropriate health care services. A number of reasons were given for lack of access which include, racism, transportation difficulties, language barriers, inadequate representation of racial minorities within the health professions, and lack of knowledge about Black health. These issues and others discussed in this report are directly related to the key determinants of

health. For example, living in a remote rural community may influence one’s health in terms of physical location of health facilities, especially when the situation is compounded by low education and unemployment. These factors, in turn, may be linked with vulnerability to poor working and living conditions as well as negative coping mechanisms. The literature shows that paid work

Culture

A new challenge facing community development is to reflect the cultural diversity of immigrants of African descent in our communities. We have to work inclusively to appreciate our diversity.

Dr. Norman Cook

provides not only money, but a sense of purpose in life and opportunities for personal growth. The similarities between the research findings of this project and the key determinants of health as stated by Health Canada (2001) demonstrate that policies based on the determinants of health and a social inclusion framework may help address the complex Black health issues discussed below. These health issues are discussed under four themes: access to health services, preventive health, behavior and lifestyle, and health status.

3.1 Access to Health Services

It is well documented in the American and British literature, and to a lesser extent in the Canadian literature, that Black people are less likely to use health services in a timely manner than their White counterparts. The issues of access to health care services, or more accurately lack of access, identified in this research are related to the physical location of services, transportation difficulties, limited research, lack of knowledge by professionals, under-representation of people of African descent in the health professions, racism, cultural insensitivity, and language barriers. Each of these issues is examined briefly below as they impact on African Nova Scotians.

3.1.1 Location of Services and Transportation

There are limited health resources located within Black communities in Nova Scotia. Community members have to travel long distances to receive basic health care services such as dental care, prenatal care, and breast examinations. This poses a challenge to rural African Nova Scotians living in communities with inadequate access to public transportation services.

For members of rural Black communities, using health care services regularly is dependent on one's ability to afford a means of transportation to travel Halifax (or other regional centres) where centralized health care services are located (WADE 2000). In families with young children, there is an additional need to make childcare arrangements in order to attend to another family member's health care needs. Accessing health services outside one's community is often identified as a source of increased stress and cost. The high level of unemployment in Black Nova Scotian communities means many cannot afford transportation and other costs associated with traveling to urban areas for health appointments. As a result, these Nova Scotians do not use appropriate health services (Enang 1999). Although the IWK Health Centre is currently providing a Well Women's Clinic in East Preston, funding for this clinic will be terminated at year's end.

Health Services

- Establish satellite sites with community representation and staff
- Develop a list of "do's" and "don'ts" for your community that can be used by health professionals
- Advocate and develop policies for accountability
- Develop individual strategies for your personal situation, e.g., take along list of questions to medical appointments or a companion to translate or for emotional support

Workshop Participants

3.1.2 Language Barriers

Language barriers impede the ability of non-English speaking Black women to access appropriate health care services (Howard 1997). The use of medical language or terminology without adequate explanation limits a Black woman's ability to participate in decisions affecting her health care (Enang 1999; Fraser and Reddick 1997). Limited resources are directed to addressing health communication needs.

3.1.3 Racism

Racism interferes with Black women's access to services in ways such as differential treatment which often leads to delay or avoidance of service utilization (Underhill 1998). Services are sometimes not effective because they do not recognize the racial, educational and socio-economic backgrounds which shape the health care experiences of Black women (Bhopal 1997). Differential treatment on the basis of race, class and gender is a common health concern of Black women identified in both Canadian and American literature (Enang 1999; Murrell et al. 1996). In a study by Enang (1999), Black Nova Scotian women describe their experience of being stereotyped as single mothers, unemployed and on social assistance. The effect of this experience of racism is sometimes internalized and may lead to decreased confidence in one's self and other Black people, and a passive acceptance of the stereotypes created for Black people by the dominant society (Benton 1997).

Racism and Racial Stereotypes

Black women are often not offered an epidural during childbirth as they are perceived as stoic and strong and able to withstand the pain without medical assistance.

Workshop Participant

3.1.4 Under-Representation of Blacks in the Health Professions

Under-representation of Black people in the health professions is a barrier to appropriate health care. According to Anderson (1991), the lack of appropriate representation of racial minorities in the health care professions, especially in senior leadership positions where policies are set, may lead to badly planned health services for this population. Black women perceive the unwelcoming attitude within a predominantly White health care system and some turn to family members and friends, rather than to professional health care providers, for support and information (Atwell 2001; Crawley 1998; Downey 1999). The low numbers of Blacks in the health professions may be attributed to unfriendly school environments to minorities. A 1997 study of race relations at a leading Canadian medical school revealed the presence of racism within the school (Watson 1997). Robb (1998) also noted that insensitive remarks and racial stereotypes are sometimes present within curriculum in professional training schools.

Education

Young people are not encouraged to take sciences, and there is not enough career counselling.

Workshop Participant

3.1.5 Lack of Knowledge by Professionals

It is not surprising that the low numbers of Blacks in the health professions is accompanied by a lack of knowledge by professionals of the specific health needs of Black people. Lack of knowledge about illnesses and diseases that disproportionately affect Black people is a barrier to appropriate health care for Black Nova Scotians (Douglas 1995). Black women who participated in local research projects noted that access to evidence-based information is one of the steps toward empowerment of Black women (Fraser and Reddick 1997). Conditions affecting Black people are sometimes misdiagnosed because most standard medical texts do not include discussions of the way skin color may

Social Support Networks

The health of African Canadian women is integral to their communities as they are the caregivers in the family.

Dr. Norman Cook

affect the clinical manifestation of a disease (Douglas 1995). For example, jaundice may manifest itself differently in darker skin toned individuals.

Many health care professionals graduate from training schools with limited knowledge on how to care for people with diverse cultural backgrounds. Basic discussions of Black health issues such as skin and hair care, assessment of dark skin, communication patterns within different cultures, etc. are not routine in many health professions training schools or health service delivery institutions. The lack of appropriate education on Black health issues available in health care professional schools affects the quality of care that Black people receive in the health care system.

3.1.6 Cultural Insensitivity

The lack of respect, understanding and acceptance of diverse cultural values, beliefs and socio-economic issues affecting members of the Black community by health care providers may lead to inappropriate care. Local studies have identified the lack of culturally relevant resources within health service delivery institutions as a barrier to appropriate health care for African Nova Scotians (Enang 1999; van Rooseman and Loppie 1999; Skinner 1998). A 1995 study conducted by the Registered Nurses Association of Nova Scotia (RNANS) identified several health barriers encountered by African Nova Scotians and other ethnic minorities including a lack of accommodation of specific cultural needs and discrimination. Most health organizations in Nova Scotia do not have a multicultural and anti-racism policy to guide the provision of culturally relevant health services.

Social Environment

Medical professionals must validate an Afrocentric approach and use of traditional healing practices.

Workshop Participant

3.1.7 Limited Research

The lack of research in the area of Black Nova Scotian's health poses a challenge to both care providers and care recipients. A health care professional faces the challenge of not being able to provide appropriate care to Black patients because of a lack of data and information in the mainstream literature on specific Black health issues. For example, in Nova Scotia there is no routine screening for sickle cell disease or traits in Black newborns despite the fact that Nova Scotia has the largest indigenous Black population in Canada. The lack of newborn screening for sickle cell is often attributed to the lack of research on the percentage of Nova Scotians of African descent who carry this disease or trait.

Biology and Genetic Endowment

Inclusion of the community, and Black people in particular, in the human genome research process goes far beyond a social imperative and is central in deciphering genetic variation.

Dr. Georgia Dunston

As Spigner (1994) states, Black people often play a limited role in the health research process. Their role is often defined by their participation as subjects rather than as active researchers. A local study by Enang (1999) concluded the lack of active participation of members of the Black community in health research precludes the sharing of intimate knowledge of the issues affecting that community. Another local study by the Black Women's Health Program noted that Black women's access to health care is limited by the lack of evidence-based information on their health needs (Fraser and Reddick 1997).

3.2 Preventive Health Issues

This section briefly examines three preventive health issues: physical examinations, perinatal health care, and employment and working conditions, as they relate to African Nova Scotians. Although a sizable proportion of all women miss routine preventive health assessments, the proportion is generally higher for Black women. A high proportion of Black women are not able to avail themselves of preventive health tests such as Pap smears, breasts exams and routine physical examinations. This disparity between minority groups and mainstream society is also exhibited in perinatal health and birth outcomes. Employment status and the physical and psychosocial conditions at work have been found to have significant impact on people's health and well-being. Each of these issues is examined in terms of health outcomes and the implications for health service use and provision for Blacks in Nova Scotia.

3.2.1 Physical Health Exams

Qualitative studies and needs assessments in Nova Scotia have documented that Black women are less likely to utilize preventive health services such as breast cancer screening programs, Pap smears and regular visits to a physician for routine assessment and health care (Atwell 2001; Crawley 1998; Downey 1999; Fraser and Reddick 1997). Some of these studies attributed this reluctance to use health services to the negative attitudes of health professionals toward Black people. Several studies in the United States have also noted the disparity in the use of preventive health services between Black and White women. A study by Brown et al. (1996) reported that 52% of Black American women did not have their Pap smear within a two-period compared to 44% of White women.

3.2.2 Perinatal Health and Birth Outcomes

Initiating perinatal care early in pregnancy is believed to foster better health outcomes for both mothers and infants. However, some studies have shown that approximately one third of Black American mothers-to-be do not initiate prenatal care during the first trimester of pregnancy (NCHS 1996; Martin 1995). Birth outcomes in terms of birthweight and infant mortality vary considerably by ethnicity and race, with African American women having the highest incidence of low birth weight babies (James 1993; Wise 1993). According to some United States data, Black women have a 13% incidence of low birth weight babies compared to other ethnic groups, e.g., Korean 4%, Chinese 5%, White 6% and Asian Indian 10% (NCHS 1996; Martin 1995).

Infant mortality rates also mirror the health of mothers and babies. Studies show that disorders associated with low birthweight are a leading causes of infant deaths (Mathews, Curtin and MacDorman 2000).

The mortality rate of infants born to Black mothers is more than double the rate of White mothers, e.g., 17 per 1,000 live births for Black women and seven per 1,000 live births for White women with an average for all mothers of nine per 1,000 births (NCHS 1996). A 1998

report from the U.S. National Center for Health Statistics, Center for Disease Control, shows similar findings. According to this report, infants born to Black mothers had the highest rate of infant mortality at 13.8 per 1,000 live birth, while those born to other ethnic group mothers had lower rates, e.g., Japanese 3.6, Chinese 4.0, American Indian 9.3, Filipino 6.2, and non-Hispanic White 6.0, while the overall average infant death rate was 7.2 in 1998 (NCHS/CDC 2000).

Healthy Child Development

For example, the signs used in APGAR scores to assess the health of babies may be inappropriate. A baby that is "pink" is considered "normal", while healthy Black babies may not necessarily be "pink" due to variation in skin colour.

Josephine Enang

In Canada, Arbuckle et al. (2000) note that although infant mortality rates have declined significantly over the last decade, some disparity still exists among sub-populations, and socio-economic status remains a determinant of perinatal health. Low income groups experience a 1.6 times greater risk of infant death compared with high income groups (Wilkins 1995). There is a need to compare the infant mortality rate of African Nova Scotians with the rate in other parts of Canada and other countries.

Breast feeding gives babies the best start for a healthy life. Following upon several international studies demonstrating the many benefits of breast feeding to maternal, child and family health, the World Health Organization issued the Declaration on the Protection, Promotion and Support of Breast Feeding (WHO/UNICEF 1990). Despite wide dissemination of research showing the benefits of breast feeding, Nova Scotia has one of the lowest rates of breast feeding in Canada (53% initiation rate for Atlantic region compared to 87% for British Columbia). The national breast feeding initiation rate is 73% (Health Canada 1998). American studies demonstrate variation in breast feeding rates along ethnic lines. One study that examined adolescent mothers' intention to breast feed revealed that only 15% of African American participants intended to breast feed compared to 45% of their Caucasian and 55% of their Mexican-American counterparts (Wiemann, DuBois and Berenson 1998). Although there are no comparable local statistics for Nova Scotia, discussions with community researchers indicate that these findings may be similar to the current practice of breast feeding initiation in Nova Scotia.

3.2.3 Employment and Environment

There is evidence that people who are unemployed, underemployed or work in stressful or unsafe working conditions have poorer health. Studies show that socio-economic conditions such as poverty, a low education level, and unemployment and underemployment affect Black people disproportionately (Skinner 1998). A recent local study by Colman (2000) identified four health impacts of low income that affect women's health:

Income and Social Status

Poverty means more than a low income – it means lack of education, poor health, powerlessness, voicelessness, vulnerability and fear.

World Bank

1. Poverty and inequality have been identified as reliable predictors of health outcomes.
2. Low-income earners have higher rates of hospitalization and health services usage.
3. Women earn less and have higher rates of low-income status and physician visits.
4. Low-income families pass on poverty and lower functional health to their children.

Galabuzi (2001) shows a wide economic gap along racial lines in Canada. The figures clearly reveal the significant disparities that exist between minorities and the rest of society in the areas of income earnings and unemployment rates. For example, Galabuzi indicates that in 1995, Statistics Canada reported that a large number of people from minority groups earned almost 30 percent less income than the rest of the Canadian population. This figure is similar to those reported for underemployment and unemployment. Statistics Canada 1996 census data shows that a large percentage of individuals from minority groups work in low paying jobs compared to the total Canadian population. Minority women have an unemployment rate of 15.5 percent compared to 9.4 percent for other women (Statistics Canada 1998).

Statistics Canada's profile "Visible Minorities: Atlantic Provinces" (1995) reports that 15% of Black Nova Scotians have a less than Grade nine education; the provincial average is ten percent. Black Nova Scotians have a disproportionately higher unemployment rate of 16.6% as compared to the provincial average of 12.7%. The average annual income of Black Nova Scotians is also less than the provincial average (Skinner 1998).

Living and working environments have also been linked with the incidence of various disease conditions. For example, studies in other jurisdictions have shown a relationship between hazards such as landfills located within a predominately poor Black neighborhood and higher rates of lung cancer and pulmonary disease (Brown 1995).

All of these findings point toward African Nova Scotians as being at higher risk for poor physical health outcomes.

The issues of socio-economic instability have also been associated with mental health problems and other social problems. Symptoms of depression have been found with greater frequency among young Black women than White women (Somerveil et al. 1989). Women in Atlantic Canada report higher levels of stress and lower levels of psychological well-being (Colman 2000). One of the concerns raised during interviews with community researchers was the increase in the rate of suicide attempts by Black Nova Scotian youths.

According to Lawrence (2000), this is particularly a problem in rural communities such as Digby where the resources to manage youth-related concerns are limited. According to Thomas Bernard (2000), a critical analysis of the factors (i.e., racism) which contribute to mental health is necessary, especially among populations such as African Nova Scotians who not only have limited resources, but often under-utilize available mental health services.

3.3 Behavior and Lifestyle

The choices an individual makes in regard to exercise, nutrition, smoking, alcohol consumption, use of drugs, and sexual behavior can negatively or positively influence their health in both the short and long term. For some Black people, their choices may involve a negative coping mechanism to deal with feelings of frustration, helplessness and low self-esteem that comes from their everyday experience of systemic discrimination. According to Benton (1997), the experience of racism often denies Black youth the opportunity for full psycho-social development. This impact continues into adulthood where it is further complicated by the overall socio-economic exclusion of minority people as discussed above. The impact of each of these lifestyle choices on health outcomes for African Nova Scotians is discussed below.

Employment/Working Conditions

We must build a database so that we have research capacity at the national and local levels to see where Black communities stand in areas such as health, income, education, occupations, and employment levels. At present, we lack control over what we should know to protect our people and to ensure their well-being.

Dr. Norman Cook

Physical Environment

Historically, Black communities in rural Nova Scotia have been located near landfill sites, but there has been no research on the environmental health impacts in these communities.

Workshop Participant

3.3.1 Exercise and Nutrition

There is a racial divide in the prevalence of obesity, poor diet and level of physical exercise. Studies show Black women are two times more likely to be obese than White women (Brown et al. 1996; Douglas 1995; NIH 1999). Obesity is also influenced by socio-economic status, a factor which further increases the incidence rate among Black women. One U.S. study reported that 50% of young Black women are overweight compared to 31 percent of White women (Kann et al. 1996). Although genetic researchers are exploring the possibility that people of African ancestry have a gene pool that places them at an increased risk for obesity, it is well documented that obesity is influenced by lifestyle issues such as diet and exercise (Diabetes Forecast 1991). Further, foods higher in fat are more affordable for the poor than vegetables and fruits, thus food choices are also associated with income status.

A 1995 U.S. national study found engaging in exercise varies by age and sex, as well as by race. While White adult women exercise less than their younger counterparts, Black women are less likely to engage in vigorous physical activity than White women (Kann et al. 1996). A high number of Black women are reported to have high cholesterol levels, a factor often associated with being overweight and an indicator for cardiovascular disease. Further, Black women also self-report themselves to be in poor health more frequently than White women (Hartmann et al. 1996).

3.3.2 Smoking

Smoking is widely acknowledged as a preventable cause of death and illness. Lung cancer is the most predictable outcome of smoking as well as increased risk levels for other cancers (oral, larynx, etc.) and coronary disease. Although smoking rates vary by age group among women of all backgrounds, a high percentage of Black women smoke (Brown et al. 1996). Poor Black and White women both have a greater tendency to smoke. A 1996 study by the National Center on Addiction and Substance Abuse reported that 27 percent of Black women smoked compared to 24 percent of White women. In another U.S. study, White youths aged 18-24 from families with lower educational attainment reported higher smoking rates than Black and Mexican-American youths with similar educational backgrounds (Stamler et al. 1999). This study further noted that 77 percent of young White men and 61 percent of young White women smoke as compared to 35 percent of minority youth.

According to Colman (2000), excluding Quebec, the Atlantic provinces have the highest rate of smoking in Canada (31% of the population 12 years and older). Further, Nova Scotia and Quebec have the country's highest rate smoking rates for women, 20% above the national average (Colman 2000). Among young people in Nova Scotia, statistics reveal that the smoking rate is growing at a faster rate for girls than boys (Colman 2000). In Nova Scotia, 38 percent of girls in grades 7, 9 and 11 were smokers in 1998 as compared to 34 percent of boys (Colman 2000). Participants in the study cited stress relief and losing weight as the main reasons for smoking. Given the evidence linking lung cancer to smoking, further investigation of the understanding and addressing the issues associated with smoking as they impact on Black Nova Scotians is required.

3.3.3 Alcohol Consumption

Racial differences in death rates related to alcohol consumption requires further research. A U.S. study found that although the mortality rate associated with alcoholism among women is highest in Native American Indian women, the death rate among Black women is still higher than that of White women (i.e., the alcohol-induced death rate for Black and White women was six per 100,000 and three per 100,000 respectively) (NCHS 1996).

3.3.4 Illicit Drug Use

Like alcohol, the use and impact of illicit drugs on the Black community and society as a whole requires further exploration. Research in other jurisdictions points to some disparity along racial lines in terms of those who experiment with drugs and those who use them on a regular basis. For example, 1993 U.S. data indicates that although more White women have tried cocaine, more Black women use it regularly, i.e., 52% Black and 23% White women (NCASA 1996). Research focusing on African Nova Scotian mothers addicted to “crack” cocaine concludes that these women face additional barriers to accessing intervention services and supports which affect their ability to overcome their addictions (Thomas Bernard 2001).

3.3. 5 Sexual Behavior

There is evidence that socio-economic factors influence sexual health outcomes, especially among adolescents. Research has shown that several factors related to inadequate income distribution are directly associated with poor sexual health outcomes such as teenage pregnancy, low education level, and an increased reliance on social assistance (Neinstein, Rabinovitz and Schneir 1996; Langille 2000).

Some studies have reported that many Canadian adolescents experience sexual intercourse at an early age (Langille 2000). In Nova Scotia, a recent study shows that 37% of Grade 10 and 67% of Grade 12 students have engaged in sexual intercourse, and a significant portion engage in risky behaviors (e.g., not using condoms and contraception) (Langille 2000). Some U.S. research has shown racial differences in sexual behavior. For example, Kann et al. (1996) found that 51% of Black adolescents, compared to 39% of White adolescents, reported being sexually active. These high rates of adolescent sexual activity are problematic when one considers the health conditions which may occur as a result of inappropriate sexual behavior, e.g., chlamydia among young women (Langille 2000). Sexually transmitted infections (STIs) are common among adolescents and can lead to pelvic inflammatory disease, infertility, and ectopic pregnancies (Langille 2000). Sexual activity also puts an individual at risk for other STIs such as gonorrhea and HIV/AIDS.

3.4 Health Status

Most of the data cited in this section are derived from research studies conducted in the United States. Very few Canadian studies explore health issues in the context of race, gender and ethnicity. This makes it difficult to identify measures of health and well-being within a specific population such as Black people. Based on available literature and research, it is clear that certain health conditions affect Black women disproportionately. These conditions include diabetes mellitus, cardiovascular diseases (e.g., hypertension and stroke), cancer, HIV/AIDS, lupus, sickle cell disorder, and sarcoidosis. The factors influencing and incidence rates of each of these diseases for Black women is examined below.

Gender

Black women have unmet needs that result in increasing anger, isolation and stress.

Workshop Participant

3.4.1 Diabetes Mellitus

Diabetes mellitus, a chronic disorder involving abnormal glucose metabolism is a major health problem and cause of death among Black women. Black women are at more than double the risk of developing adult-onset diabetes than White women. Furthermore, Black men and women are more likely than White men and women to develop the serious complications associated with diabetes, i.e.,

blindness, amputation and kidney failure (NIH 1992). Brancati et al. (2000) found that one in four Black women develop diabetes compared with one in ten White women. In this study which compared the risk of incidence of diabetes in African Americans and White adults (aged of 45 and 64) from 1986 to 1989 with a nine years follow-up, Black women were 2.4 times more likely to develop diabetes than White women. Among Black men, 23% developed diabetes, compared with 16% of White men, placing Black men at more than 1.5 times the risk of developing diabetes (Brancati et al. 2000).

3.4.2 Cardiovascular Diseases

Although various health conditions affect the Black population disproportionately, cardiovascular diseases (CVD) (those health conditions which affect the heart and blood vessels) are the leading cause of death in this population. A significant number of men and women of all ethnic backgrounds suffer from some form of cardiovascular disease, e.g., hypertension (high blood pressure), coronary heart disease, and congestive heart failure. Of these conditions, high blood pressure is often identified as the major cause of death. As many as 30% of all deaths of Black men and 20% of deaths of Black women with hypertension are attributable to high blood pressure (AHA 2001). The prevalence of high blood pressure among Blacks in the United States is among the highest in the world. Compared with Whites, Blacks have earlier onset of hypertension and a 4.5 times greater rate of complications such as end-stage renal disease (AHA 2001).

Studies investigating high blood pressure in Black people living throughout the Western world clearly show the interaction between genes and the environment accounts for the high incidence of this condition in Black populations. For example, an international study that recruited participants from Nigeria, Jamaica and Chicago (U.S.) found a significant disparity in the incidence of high blood pressure in Black people at these locations (Rotimi, Cooper and Ward 1997; Cooper, Rotimi and Ward 1999). The study found that 7% percent of the Nigerians, 26% of the Jamaicans, and the 33% of the African Americans in the study were diagnosed with high blood pressure.

In 1998, 40.6% of all deaths were a result of CVDs and a significant number of these deaths were premature, i.e., before age 75 (NCHS 1996). Black women have the highest death rate from CVDs, 1.7 times that of White women (NCHS 1996). According to the American Heart Association (1997 data), 20% of White and 30.9% of Black adults 18 years and over were diagnosed with high blood pressure. Despite these alarming disparities, it has been documented that Black women are less likely than White men to be referred for an appropriate course of treatment such as cardiac catheterization (Schulman, Berlin and Harles 1999).

3.4.3 Cerebrovascular Diseases

Stroke, a complex syndrome caused by impaired blood supply to the brain, is a major health problem that affects people of all ethnic origins. However, when compared with other women, Black women have strokes almost twice as frequently as all other women irrespective of age (NCHS 1996). In 1998, strokes accounted for about one in every 14.8 deaths in the United States, and a large proportion of these deaths occurred outside the hospital because of the sudden nature of the attack and its severity (AHA 2001). Stroke is rated as the third leading cause of death, next to heart disease and cancer. The death rates for stroke in the United States in 1998 were 22% for White women compared with 37.2 for Black women, and 24.5% for White males compared with 46.8% for Black males (AHA 2001). These figures are further influenced by age. Although stroke is more common in men than women, more women die of stroke than men.

3.4.4 Cancer

Various forms of cancers affect women of all ethnic origins. Cancers affecting the breasts and lungs account for a high percentage of deaths from cancer. Although there is evidence that fewer Black women than White women are diagnosed with cancer, the survival rate is higher for White women because Black women are more often diagnosed at advanced stages of the disease (Miller et al. 1996). According to one U.S. study, Black women have a lower incidence of breast cancer overall, however, their death rate from this condition is higher than that of other populations (NWHN 1996). Incidence and deaths rates of other forms of cancer (e.g., cervical) vary among groups of women. Screening services for all cancers are often under utilized within the Black community. According to Douglas (1995), poor Black women are screened for breast cancer less frequently than more affluent women. Black women are less likely to utilize breast cancer screening facilities, relying more on community structures to manage health (Sharif et al. 2000).

Personal Health Practices and Coping Skills

Women do not have breast screening done because of their perception of how the technician will treat them ... Lack of cultural sensitivity [of health professionals] often results in different treatment due to perceived class ... There needs to be more information available regarding what happens during different medical procedures.

Workshop Participants

3.4.5 HIV/AIDS

The impact of HIV/AIDS in Black communities around the world is devastating. Researchers in the United States have identified Black people as one of the fastest growing segments of the HIV-infected U.S. population. Although African Americans comprise only 12% of the U.S. population, they make up to 37% of the total number of AIDS cases (CDC 2000). It is estimated that approximately one in 50 men and one in 160 women of African descent in the United States is infected with HIV. In 1999, more African Americans were reported with AIDS than any other racial/ethnic group, a rate eight times greater than that for Whites (CDC 2000). Approximately 63 percent of all women in the United States with AIDS are of African descent, and almost 65% of all pediatric AIDS cases are African American children (CDC 2000).

Although this data is based on studies conducted in the United States, the information may be helpful in providing direction for future Canadian research. In Canada, AIDS organizations have reported an increase in the number of HIV cases among Blacks, especially women (Douglas 1995). Studies among high risk groups suggest that issues such as the continued health disparity between socio-economic levels, challenges associated with controlling substance abuse and the interaction between substance abuse and the epidemic of HIV, and other sexually transmitted infections may account for the continued spread of this epidemic in marginalized communities (CDC 2000).

3.4.6 Lupus

Systemic lupus erythematosus (SLE), more commonly known as lupus, is characterized by an overactive immune system which attacks healthy tissues causing inflammation in parts of the body, e.g., joints, skin, kidneys, lungs, heart and brain. Lupus is most common among women between the ages of 15 and 45, with the peak incidence between ages 30 and 40. It is primarily a disease of women, occurring five to ten times more often among females than males; nine out of ten people affected by lupus are women (NIAMS 1999). Although the condition affects people of all races and ethnic backgrounds, it is three times more common in Black people than Whites (NIAMS 1999).

According to Douglas (1995), one in 1,000 White women and one in 250 Black women in Canada have the disease.

3.4.7 Sickle Cell Disorder

Sickle cell disorders refers to a collection of recessive genetic diseases characterized by variation in hemoglobin. It is a major public health concern in many parts of the world and one of the most prevalent genetic disorders in the United States, affecting one in 12 African Americans (NHLBI 1996). Both British and United States studies show that sickle cell disease affects people of African descent disproportionately (NHLBI 1996). In Canada, it has been estimated that over two million people are carriers of the sickle cell trait, and about 50,000 have sickle cell disease (Douglas 1995). There are a growing number of children who are affected by the disease, and it is believed that 80% of couples are at risk of not being diagnosed (Douglas 1995).

Although there is evidence that sickle cell disease affects a large number of people of African descent and Nova Scotia has the largest indigenous Black community in Canada, there are no appropriate services available in this province to meet the Black community's needs in identifying and treating this disease (Fraser and Reddick 1997). There is no published research documenting the incidence of sickle cell disease among people of African descent living in Nova Scotia. Routine screening of Black newborns in Nova Scotia remains an unrealized dream for many Black women and their families. Although sickle cell disease is not curable, early diagnosis will ensure appropriate management strategies thereby reducing mortality from the disease.

3.4.8 Sarcoidosis

Sarcoidosis is a multi-system disease that may affect any part of the body, most commonly the lymph nodes. Quite often it begins in the lungs but its cause is unknown. Sarcoidosis is usually not crippling. It often goes away by itself, with most cases healing in 24 to 36 months. Even when sarcoidosis lasts longer, most patients can go about their lives as usual. Sarcoidosis occurs in all people, however it is more prevalent among women between the ages of 20 to 40 (Douglas 1995). The disease is up to ten times more common in African Americans than Caucasians in the United States (NHLBI 2001). Ten percent of African Americans who have been diagnosed with the disease have other relatives with the disease.

4.0 Recommendations

Key messages articulated throughout the literature review and workshop have lead to recommendations in four areas: policy, education, research, and community capacity building.

4.1 Policy

Data Collection: As a first step, provincial and federal data “gaps” on the health of Black Nova Scotians must be identified. A province-wide survey to evaluate the needs, to assess the levels of services available, and to catalogue existing services and expertise in Black communities is required. A federally-funded research program on Black health issues should be put in place. These processes will begin to bridge the gap between Black Nova Scotian health needs and those of mainstream society.

Data Aggregation: Statistics Canada, other federal departments and agencies, and provincial data and statistical collection agencies should harmonize and integrate existing data on race, ethnicity and gender.

Collaboration: Provincial and federal health departments should foster a collaborative interdepartmental approach to allow for better utilization of resources and to give stability to infrastructure and financial resources to maintain initiatives focused on the health status of the Black community. A national consultation of Canadians of African descent with a view to generating a national policy research structure would be a first step. Further, establishment of a provincial-federal advisory committee on health issues and community development, modeled on the Nova Scotia Advisory Council on the Status of Women, would provide African Nova Scotians with a voice in the policy making process.

Reflecting Diversity in Health Policy: The Nova Scotia Department of Health should develop multi-cultural health, anti-racism and equal opportunity policies for public health institutions. These “diversity” policies should be developed in collaboration with health organizations such as the District Health Authorities and Community Health Boards. Developing a strategy to increase cultural competence in the health system would effectively address the health needs of *all* Nova Scotians, including those of African descent. At the institutional level, mission statements, operating policies, and regulations should reflect the diversity of the population served, and strategic plans should address the health needs of minority groups. Institutions should partner with ethno-cultural communities to develop training programs that will ensure effective implementation of such policies through, for example, participation in evaluation programs.

Strategic Investments in Black Nova Scotians’ Health Care: The Nova Scotia Department of Health should develop a strategic health investment program that emphasizes the conditions that disproportionately affect the Black population, i.e., diabetes, sickle cell anemia, and prostate and breast cancers. The Department should create a unit with responsibility for diversity issues, with particular emphasis on those groups with limited health resources and demonstrated significantly poor health status, including the Black community.

Equitable Funding: The Nova Scotia Department of Health and Health Canada should provide equitable funding for health initiatives, research, programs, and services in Black communities.

Targeting Services: The Nova Scotia Department of Health should establish targeted screening programs, management and support services for conditions that disproportionately affect the Black population. These programs and services must address issues of location and transportation (e.g., provide outreach programs, satellite sites, and mobile screening clinics to *all* Black Nova Scotian communities). Information and public education materials must be provided in a culturally-appropriate language and format.

4.2 Education

Addressing Cultural Insensitivity and Racism: Incorporate cultural competency training as core aspect of health professions and medical schools. Health care professionals need to be educated on cultural issues that impact on health and on how to demonstrate cultural competency in their practice. In-service training and education on multicultural health issues should be available to both health care delivery staff and policy makers to increase their awareness of the issues and to maintain competency in addressing multicultural health issues.

Reflecting Diversity in the Health Professions: Increase the recruitment and retention of a culturally-diverse student population. Health care institutions and training schools need to use approaches such as mentors, transition year programs, and other innovative strategies to improve under-representation of African Nova Scotians in the health professions. Use Black health professionals as role models to encourage youth to consider the health professions as a career.

Interpretation Services: Health care delivery institutions need to ensure that trained interpreters are available to address language and communication problems.

4.3 Research

Research to Support the Health Professions: Conduct research on how to increase the recruitment and retention of marginalized groups in the health care delivery professions.

Multidisciplinary Research: The Nova Scotia Health Research Foundation (NSHRF) should support the formation of a multidisciplinary research team that will promote increased productivity and dissemination on Black health research in Nova Scotia.

Black Health Research: Statistics Canada, Health Canada, the Nova Scotia Department of Health, and NSHRF should build and disseminate evidence-based knowledge about Black health and social and economic inclusion and promote utilization of this research to guide health policy and data base development, as well as to inform clinical practice.

Race as a Determinant of Health: Support research on race as a determinant of health. Other initiatives that promote the conditions necessary for full equality in Canadian society are also required, e.g., provisions that promotes equality under the Charter of Rights and Freedoms in the Canada Health Act to explicitly support inclusion of Blacks in clinical research studies.

4.4 Community Capacity Building

Community-based Health Education: Facilitate health education workshops in African Nova Scotian communities using care providers that can relate to the Black Nova Scotian experience. Use community animators to mobilize people in the community to make appropriate use of health services, e.g., screening programs. Promote initiatives to build community capacity and support groups for health promotion, prevention and caregiving.

Research Support: Support Black communities in developing the necessary skills to define research priorities and provided them with adequate infrastructure to participate as full and equal partners in professional research initiatives. Community-based research programs will identify community needs and provide Blacks that normally would not be included in community projects with an increased feeling of community ownership.

Advocacy Support: Facilitate the establishment of an organization or network that will advocate for and help Black Nova Scotians to overcome some of the barriers to equitable health services.

Partnerships: Black Nova Scotians should pursue strategic partnerships and networking opportunities. Encourage collaboration between health care providers and Black community groups. Such partnerships should provide services based on an Afro-centric model.

Community Health Boards: Initiate community health board linkages. Advocate for the creation of a new Community Health Board within the Black community (i.e., the Prestons).

Collaboration with Local Organizations: Invite church, youth and other community-based service organizations to promote utilization of health care services and to assist in the development of effective strategies to address Black communities' health needs. Spirituality is significant in the African Nova Scotian community, and the church can be used as a direct source of education and support to the Black community through organizations such as the African United Baptist Association.

5.0 Research Dissemination

The sharing of this research information has taken various forms, starting with the formal workshop presentation at the Black Health Recreation Centre on 23-24 March 2001 (see Appendix B for the Workshop Proceedings). Team efforts to disseminate these research findings and to present its recommendations to policy audiences have moved this project from a research opportunity in Nova Scotia to provincial recognition, as well as national and international recognition. Presentations made to date and accepted presentations are listed below.

5.1 Refereed Presentations

Women's Health and Diversity: A National Conference, Montreal, 26-28 April 2001.

Pushing Beyond the Politics: Making Research Policy a Fact, School of Nursing Annual Research Conference, Dalhousie University, 3-4 May 2001.

Accepted for presentation at the "*Ethnizing the Nation*": *The Canadian Ethnic Studies Association Biennial Conference*, Halifax, 2-4 November 2001.

5.2 Public Presentations

Grand Opening of East Preston Well Women's Clinic, 30 April 2001. This event was covered by a local newspaper, *The Daily News*, and carried by Global, CBC and Shaw television thus promoting awareness of this study findings throughout the Atlantic region.

Health Canada Monthly Policy Forum, Ottawa, 25 May 2001. This national audience of over 60 senior Health Canada policy advisors was also broadcast via tele-conference to regional Health Canada audiences.

Breakfast on the Hill Session, Ottawa, 29 May 2001. An audience of 35 Members of Parliament, Senators and representatives from the Status of Women Canada gave positive feedback on this presentation, as well as that to the Health Canada Monthly Policy Forum.

United African Baptist Association Layman's Conference, Dartmouth, Nova Scotia, 2-3 June 2001. Over 200 participants attended the conference.

African United Baptist Association Women's Institute Annual Retreat, Tatamagouche Centre, Nova Scotia, 9 June 2001. Approximately 100 women participated in this event.

The analysis of this research was presented at the international symposium *Racism and the Black Response*, 5-12 August 2001, Halifax.

The research findings were disseminated at the United Nation's *World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance*, 31 August - 7 September 2001, South Africa.

In addition to the above presentations, edited copies and fact sheets of this report will be distributed to the funding agency (Health Canada), the Nova Scotia Department of Health, the Nova Scotia Health Research Foundation, Nova Scotia Health Authorities and Health Centres, Status of Women, the United African Canadian Women Association, WADE, African Canadian Services Division, workshop participants and other organizations that supported this research. Meetings have been scheduled with both Health Canada and the Nova Scotia Department of Health to

communicate these research findings and recommendations to policy audiences. With the support of the MCEWH, the report will be posted on the MCEWH website (<http://www.medicine.dal.ca/mcewh>) and links will be created with other national health groups, e.g., Canadian Women's Health Network (CWHN). Plans are underway to present this research at other conferences, to publish the research analysis in peer-reviewed journals such as the *Canadian Journal of Public Health* and *The Canadian Nurse*. All of these activities to promote utilization of this research have stimulated interest in undertaking further Black women's health research with several groups including the National Network on the Environment for Women's Health, York University, and the Status of Women Canada. The Health Association of African Canadians will continue to make this research accessible to researchers and others interested in Black health issues (Appendix D lists the founding members of the HAAC).

6.0 Conclusion

As demonstrated in the research findings from other jurisdictions discussed in this report, race, culture, gender and ethnicity are important determinants of health which are often interrelated. However, in Canada and particularly Nova Scotia, these factors are not routinely considered in either health policy or health research. It is important that steps be taken to incorporate diversity at all levels of government and society. We must ensure that

- racism is addressed as a determinant of health, and that the interplay among the determinants is fully explored;
- programs are targeted and based on a sound knowledge and understanding of the health care services and health needs of Black communities;
- federal, provincial and municipal levels of government collaborate on economic and social initiatives that promote healthy outcomes for African Nova Scotians;
- existing provincial and federal research and data are expanded to include indicators of Black Nova Scotians' health;
- investments are made in strategies to inform policy makers and Black Nova Scotian communities about health care services and health needs; and
- research is conducted on "access" issues and factors that promote/inhibit adoption of unhealthy/healthy lifestyles for African Nova Scotians.

By working together on these and other initiatives identified in this report, we can improve the health of African Nova Scotian women and their families.

Appendix A

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Appendix B

Health for the Black Community Proceedings of a Workshop held 23-23 March 2001

Edited by

Pratima Devichand

Pamela Edmonds

and

Susan Edmonds

September 2001

This document expresses the views and opinions of the workshop participants and does not necessarily represent the official policy or opinions of the Maritime Centre of Excellence for Women's Health or of Health Canada. The Health Association of African Canadians welcomes your feedback regarding this report.

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The Health Association of African Canadians

In August 2001, the Black Women's Health Network was legally registered as the Health Association of African Canadians (HAAC). The HAAC is a group of individuals from the research community and the community at large interested in promoting the health of Black Nova Scotians.

As the field of health research in Canada evolves, efforts are required to ensure that existing knowledge gaps are identified and that new research includes those voices that have been missing from mainstream research.

Health Research Relevant to Black Nova Scotians

There is a need to improve to the health, well-being and social inclusion of Blacks living in Nova Scotia.

In January 2001, the Population and Public Health Branch of Health Canada Atlantic awarded a grant to the Maritime Centre of Excellence in Women's Health (MCEWH) and the Health Association of African Canadians (HAAC) for a project entitled, A Synthesis of Health Research Relevant to Black Nova Scotians.

Taking the form of a literature review and a two-day workshop held on March 23 and 24, 2001, the Project involved researchers in the area of Black health and members of the Black community. The project team included Susan Edmonds, Carol Amaratunga, Josephine Enang and Yvonne Atwell.

Background

In an effort to address the numerous and complex health concerns of Blacks living in Nova Scotia, more information is needed to support evidence-based decision making, citizen engagement, increased community capacity, early health intervention, partnership building, and better health outcomes among Black Nova Scotians.

The MCEWH recognizes that the perceptions and voices of Black Nova Scotians are required to help government develop policies that ensure social inclusion of the most vulnerable and at risk populations in our society. MCEWH has offered outreach and facilitation services to the Black research community in an effort to foster links, networks, and partnerships across the Atlantic region. This inclusive approach aims to inform

public policy and raise critical consciousness about the need to move beyond discussions about poverty to focus on the underlying factors, which exclude populations such as Black Nova Scotians from mainstream society, civil governance and health service delivery.

The social inclusion research of the MCEWH has been supported by leaders from the Black Nova Scotian community. Together they have shifted thinking from a concentration on child poverty towards an analysis of the social and economic exclusion of women, children and families. It is hoped this workshop will contribute to the social inclusion "puzzle" in Atlantic Canada and that the findings will be integrated into ongoing research and policy initiatives.

There is a need to place health in a historical and racial context to understand the present situation of Blacks living in Nova Scotia.

The Black Women's Health Project: Introduction

The specific goals of the Black Women's Health Project are:

- ~ To increase awareness about health issues of Blacks living in Nova Scotia through a comprehensive synthesis of research reports, secondary data, and findings from participant involvement;
- ~ To translate research findings into clear policy language for decision makers and the public at large;
- ~ To build capacity and networking in the Black community to address the challenges of promoting greater social and economic inclusion of Black women and families using a population health approach;
- ~ To convene a policy-based workshop to share the findings, conclusions and recommendations with policy makers, researchers, and community leaders; and
- ~ To convey the study findings to a wide audience including municipal, provincial and federal governments, district health authorities, community health boards, and community organizations.



This two-day workshop is a component of this larger project. During the facilitated workshop, community leaders and workshop participants were invited to share information about Black health issues, to identify health research priorities for Blacks living in Nova Scotia, and to review preliminary recommendations from the Black Women's Health Project. The workshop was held in East Preston, a large Black community just outside Metro Halifax.

The purpose of the workshop was to promote a sense of community, and to discuss the impact of determinants of health as they pertain to Blacks living in Nova Scotia using a population health approach. The participatory approach was used to heighten the awareness of the determinants of health and to foster an understanding of population health and its relevance to improving the health outcomes of Blacks living in Nova Scotia. The expected outcome was to build capacity and to facilitate empowerment among the workshop participants. It was also expected that this process would increase membership and active participation in the Health Association of African Canadians. From the evaluation responses, it is clear a dialogue was started that aims at taking action for policy change. Participants recognized and acknowledged the impact of gender, race, housing, environment, and economic status on their health and that of their families. Synthesis information from the workshop and the research findings of Josephine Enang will be used to inform future collaboration between government and the Black community. This information will provide a knowledge base for future evidence-based government economic and social policy development as it affects Black Nova Scotians.

The vision of this initiative is to enhance the health and well-being of Black Nova Scotian women and their families.

Day One

Determinants of Health and the Black Community

There is a need to place health in a historical context and translate the community voice into clear policy.

Susan Edmonds (Chair, Health Association of African Canadians) welcomed participants to the workshop and outlined the agenda for the next two days. She introduced Kathy Coffin (Regional Director, Population Public Health, Health Canada Atlantic), Carol Amaratunga (Executive Director, Maritime Centre of Excellence for Women's Health), Dolly Williams (Congress of Black Women), and Krista Connell (Director, Nova Scotia Health Research Foundation). Each speaker welcomed participants and underscored the value of the Health Association of African Canadians (formerly the Black Women's Health Network) as an interdisciplinary collaboration where community based health research and activities are placed in social and historical contexts.

Due to unforeseen logistic issues, Dr. Georgia Dunston's (Chair, Department of Microbiology, Howard University College of Medicine) keynote address was rescheduled to later in the day. Susan Edmonds introduced Josephine Enang (Researcher for the Health Association of African Canadians) who presented preliminary findings of the Black Women's Health Project.

Keynote Address

The Determinants of Health: Links between the human genome project and public health

Dr. Georgia Dunston

*Chair of the Department
of Microbiology
Howard University
College of Medicine*



There is more variation within an ethnic group than between groups.

The focus of Dr. Dunston's research is the African Diaspora, centering on the United States and West Africa. She emphasizes the pressing need to include people of African descent in genetic research, both as researchers and participants.

In February 2000, the race between the public and private research sectors in the United States to map the human genome ended with the publication of the public project's results. The human genome lays out a cycle with health as its focal point. Dr. Dunston critiqued the Eurocentric health paradigm with its emphasis on disease, explaining that health is much more than the absence of disease. She argued that health must be placed within the human context.

The technological advances made during the race to map the human genome were unprecedented, with technology far outstripping researchers' expectations. This has resulted in the need to find new ways of integrating the vast amounts of information generated into new models.

The key model must be reality based:

We cannot uncouple what we believe to be true from what we create and experience as true; this is empowerment itself...

The biology of the cell is well-known. Less than ten percent of the whole genetic sequence is needed to make a human being, and less than three percent actually defines all racial variance. Therefore, a significant portion of the genome spells out what is not visible. All diseases have a biological base, with the environment contributing to a varying extent. It is important to understand the role biology and environment play in causing disease. With the completion of the human genome sequence, a new knowledge base for biology and biomedical science has been developed. Interest is now shifting to understanding the pathways within the cell that allow for growth and change.

Genes are identified through variations in DNA sequences at particular sites on the genome. There is more variation within an ethnic group than between groups. The process of studying genetic variation is very long, beginning with a map of the genes and an understanding of who has the gene.

Because of population based variations and profiles of DNA sequences, the reference resources available for human genome research are critical to the assessment of natural versus pathologic variation in the human genome and to the application of genome-based technologies in the diagnosis and treatment of disease. Statistics

African people have the highest level of [genetic] variation, being that African life has existed for the longest period.

show that 85% of human variation is within Whites or Blacks, not between them. The category of Black or White is superfluous and the differences that are observable provide no basis for partitioning groups. There are, however, differences that relate to particular genetic

lineages. As a result, it is important for all groups seeking to benefit from this research to be included. Inclusion of the community, and Black people in particular, in this research process goes far beyond a social imperative and is central to deciphering genetic variation.

Discussion

The challenge for the Black community is to understand how the health system works and to be knowledgeable about how policy and laws are made. Our challenge is to examine the universality of the issues and to make the global connection with people of African descent in the diaspora. The genome is democratizing science, taking it out of the ivory tower and letting it function at the community level. Understanding human history is key to understanding the African story. African people have the highest level of genetic variation, being that African life has existed for the longest period according to anthropological studies; it is an older population.

Black Women's Health: A Synthesis of Research Relevant to Black Nova Scotians

Josephine Enang
RM, RN, IBCLC, MN

This research is funded by the Population Health Fund, Atlantic Region, Health Canada, with in-kind contributions from the Maritime Centre of Excellence for Women's Health

The goal of the Black Women's Health Project is to prepare a report on the current level of knowledge about the health of Nova Scotians of African descent, particularly women. There is great diversity within the group known as "Black women" (i.e. women of African descent). The preliminary findings of this research are drawn information presented in local (i.e., Atlantic Canada) research reports, relevant Canadian and American literature examining conditions for which Black women are more at risk, and interviews with community and academic researchers.

Preliminary Findings

Access to Health Services

Physical Location of Services and Transportation

The logistics of childcare and transportation play a significant role in determining whether or not a woman is able to reach a health care facility. An additional barrier to accessing health services is not knowing which services are available in particular facilities.

Lack of Research

There is limited population-based research on Black people in Nova Scotia and inappropriate tests have been used to assess the health of this population. For example, the signs used in APGAR scores to assess the health of babies may be inappropriate. A baby that is "pink" is considered "normal", while healthy Black babies may not necessarily be "pink" due to variation in skin color.

Lack of Information and Education

The patient must know what questions to ask to obtain relevant health information. The more knowledgeable the person is, the better health care they will receive.

Routine Screening

Routine screening is not usually available for conditions that disproportionately affect Blacks (e.g., there is no sickle cell screening for newborns in Nova Scotia.)

Racism

Racism exists towards patients in the health care system. Disrespect from patients for health care providers of colour may result in the providers confidence being shaken.

Language Barriers

Health care service providers need to use trained interpreter services on the front lines.

Diversity

Diverse ethnic groups are underrepresented at all levels of the workforce. An ethnically diverse work environment is more accepting, making people feel welcome. As a result, treatment with a conscious understanding of cultural difference is more effective. The health care system should accommodate different approaches to health care.

Health Status of Blacks

Diabetes

Black people are 2.5 times at risk for diabetes as White people. In the United States, one in four Black women older than 55 have diabetes.

Cardio-Vascular Diseases

The death rate from cardio-vascular diseases among African immigrants is double that of other Canadians.

Stroke

The stroke rate for Black people is 40% higher than White people (US data).

Hypertension

The rate of hypertension among Blacks is twice that of Whites.

Cancer

Black people more likely to be diagnosed at an advanced stage of cancer.

Breast Cancer

Black women experience earlier onset and late diagnosis of breast cancer.

Low Birth Weight Infants

Birth weight varies considerably with ethnicity and race; in the United States, the highest incidence of low birth rate is found among the Black population.

Obesity

Sixty percent of Black women over age 45 are obese – twice the rate for White women. Obesity also varies by social class, with lower income individuals having a higher rate of obesity due to historical patterns of eating, high fat intake, and inadequate cooking utensils.

Mental Health

Mental health issues affecting Blacks include a high rate of diagnosis of schizophrenia, the negative mental health impacts of racism, and an increasing suicide rate.

HIV/AIDS

In both the United States and Canada, there is an increasing number of cases of HIV/AIDS among Black women.

Sickle Cell Anemia

Over two million Canadians carry the trait and more than 50,000 have the disease. One in 12 African Americans have sickle cell anemia.

Lupus (Systemic Lupus Erythematosus-SLE)

The prevalence of this disease for the general Canadian population is one in 2,000, however, the rate for Black women is one in 250.

Sarcoidosis

Sarcoidosis is 10-15 times more common among African Americans than the general population.

General Status

Low Level of Education

Fifteen percent of African Nova Scotians have obtained less than Grade 9 level of education. (The Nova Scotian average is ten percent.)

Poverty

The unemployment among Black Nova Scotians is 20 %; the Nova Scotian average is 7.7% (1996 Statistics Canada).

Environmental Hazards

Blacks more likely to experience dangerous working conditions than Whites.

Stress

Stress is the most common health problem among Black Nova Scotians.

Personal Health Practices

Preventive Health

Black women are less likely to utilize preventive health services such as screening programs, regular check-ups, etc.



Breastfeeding

The rate of breastfeeding differs by ethnicity, e.g., 45% White, and 15% Black women breastfeed in the United States.

Nutrition

The significance of making healthy food choices is not always recognized, however, healthy food choices may be limited by poverty.

Behavior and Life Style

Exercise

Black women are less likely to engage in regular exercise than their White counterparts.

Smoking

Although smoking varies by age group, a large number of Black women smoke (US data).

Alcohol Consumption

There is a higher rate of death due to alcohol consumption among Blacks (6 per 100,000) than among Whites (3 per 100,000) (US data).

Sex

A US study indicates 51% of Black and 39% of White adolescents are sexually active.

Low Self-Esteem

Young women may resort to using sex to seek approval from males.

Illicit Drug Use

Although more White women have tried drugs such as cocaine, more Black women engage in the regular use of such drugs (Blacks 52%, Whites 23%).

Recommendations

Ms. Enang concluded with some preliminary recommendations:

1. Develop an organization or mechanism that will facilitate the implementation and monitoring of the recommendations of this synthesis research.
2. Develop outreach programs in the Community, i.e., use community animators.
3. Advocate for equal opportunity employment policies in health institutions.

4. Establish screening, management and support services for those conditions that disproportionately affect the Black population, i.e., sickle cell anemia.
5. Incorporate cultural issues as core aspect of health professions and medical training curriculums.
6. Conduct research on how to increase the recruitment and retention of marginalized groups in the health professions.
7. Health institutions and training schools need to use approaches such as mentorship and transition year programs to improve under-representation of African Nova Scotians.
8. Develop health resources with major emphasis on the conditions that disproportionately affect the Black population including support groups.
9. Build and disseminate evidenced-base knowledge about Black health issues.
10. Provide equitable funding for health programs and services in the Black community
11. Pursue strategic partnerships and networking opportunities.
12. Initiate community capacity building.
13. Use the church to promote utilization of health services.

Plenary Session: Panel

Moderator

Caroline Fowler
Community Activist

This panel brought together health professionals with specific backgrounds of working with marginalized people and people of colour, in this case of African descent. Each panelist recounted their experiences as professionals, elaborating on the health impacts of differential treatment, exclusion from social policy making, lack of documentation around diseases specific to the Black population, and living with racism.

Presenters

Dr. David Hasse
Infectious Diseases
QEII Health Centre

Jeffrey Nguyen
Health Educator
Pat Thompson
Consultants

Dr. Agnes Calliste
Sociology
St. Francis Xavier
University

Linda Snyder
Coordinator
Inclusion Project
Maritime Centre for
Excellence for Women's
Health

Winnie Benton
Social Worker
NS Department of
Social Services

Rose Fraser
North End Community
Clinic

Winnie Benton presented findings from her research as a social worker on the effects of internalized racism. Rose Fraser, coordinator of the Black Women's Project, has surveyed Blacks living in Halifax's North End regarding their perceptions of health and needs. The Project has conducted successful health education programs for Black Women living in the North End community. Both of these presentations connected the social determinants of health, such as poverty, literacy, lack of access, race, and gender.

Dr. David Hasse brought his perspectives on HIV and sexually transmitted diseases and the need for adequate documentation and education of the Black population living in Nova Scotia, emphasizing the need for the Black community's involvement in this research. This information encompasses the sexual health, education, and lifestyle choices as a determinant of health.

Jeffrey Nguyen is a health educator with vast experience in introducing culturally sensitive health delivery service. He centred his comments on the need to validate how different cultural reactions to illness may deviate from the accepted norm.

Dr. Agnes Calliste, educator and researcher, brought to light the difficulties faced by peoples of African descent in the nursing profession. The outcomes of her research speak to the impact of the work environment as a determinant of health and the need for the schools of nursing to actively recruit Blacks into the profession.

Linda Snyder brought her perspective from working with the Just Society Project, speaking to the impacts of exclusion of marginalized people from the policy making and implementation processes. She highlighted the impacts of exclusion on health expectations and outcomes.

Winnie Benton

Winnie Benton presented research investigating how racism has historically been internalized in the Black community. She has approached her research from an Afrocentric perspective and developed resources specifically for African Nova Scotians on this

issue. Ms. Benton differentiated between racism and discrimination, citing racism as the power to oppress a race of people. Each person of African descent possesses an individual or private “self-system”, as well as a racial or collective self-system. This self-system has developed from childhood as a natural progression with both internal and external influences. Stereotypes affect how racism is internalized at an early age: society says negative things about Black people, they buy into those ideas, and they act these stereotypes out.

Rose Fraser

Rose Fraser presented information from the 1995 Health Needs Survey in the North End Community, Halifax, with particular emphasis on strategies for taking charge/control of one’s own health. The survey revealed that one of the main areas not being addressed was Black women’s health. The Black Women’s Health Program was established by a group of concerned Black women living in the North End of Halifax attending the North End Health Clinic. The Program presents information on disease and its prevention, the justice system, the women’s movement, and internalized racism. Through their activities, they found that Black women need to be in charge of their own health care, have a sense of what they need, and want to be authors of their own reality.

The Program has put forward numerous recommendations to provincial and federal departments of health and local health service delivery programs and institutions including the following:

- Establish an antiracism policy for the schools of health professions at Dalhousie University.
- Test all babies for sickle cell anemia at the IWK Health Centre in Halifax.
- Host a seminar for Black women at the provincial level on health issues pertinent to the Black community.
- Use a holistic health approach to address problems with police and racism in the Black community.

Linda Snyder

Linda Snyder presented findings from the Social Inclusion Project coordinated by the Maritime Centre of Excellence for Women’s Health (MCEWH). The Project grew out of a discussion group on child poverty in Atlantic Canada. Three reference groups (Nova Scotia/Prince Edward Island, Newfoundland and Labrador, and New Brunswick) comprised of government, community and academic researchers are gathering information on exclusion/inclusion in the four Atlantic provinces using a participatory research process. After investigating services and programs and implications for policy, the Project participants will explore how to change the way that people do things.

Ms. Snyder noted that racism is an underlying theme interwoven in our society. Discussion in this workshop on exclusion, inclusion, and the barriers to inclusion and the role of racism will be used by project participants.

Ms. Snyder presented the example of the World Bank's multidimensional approach to poverty. She urged participants to address poverty and to pay special attention to the factors that are routinely excluded in such discussions. She encouraged workshop participants to work towards breaking the cycle of exclusion through development of inclusive public policy.

Dr. David Hasse

Dr. David Hasse is particularly interested in improving access to health care, preventive health programs for Black women, and identifying Black women's health needs that are not being addressed. Dr. Hasse's comments focused on findings emerging from his research on sexually transmitted diseases, particularly in the areas of service provision, access to health services, treatment options, and clinical drug trials. He indicated there is not enough data or experience in the Black community, particularly for Black women, to identify their needs and to provide adequate services in this important area of health.

Although researchers recognize the need for sexual health services in the Black community, research regarding sexually transmitted diseases affecting this community is limited. Researchers have found that women bear the brunt of sexually transmitted diseases due to complications resulting from these infections, mainly as diseases for an unborn child. Further, the lack of Black health professionals in clinics has translated to a lack of Black people participating in research studies.

Dr. Agnes Calliste

Dr. Agnes Calliste has been researching the impacts of racism in nursing with an emphasis on why Black women are under-represented in nursing in Nova Scotia. Dr. Calliste identified several issues that prevent people of colour from progressing in the health professions including excessive monitoring and under-valuation of personnel which results in people living in poverty and the break-up of families.

Jeffrey Nguyen

Jeffrey Nguyen presented the realities of a lack of cultural sensitivity in health care institutions. He role played the example of an African lady coming into the emergency department pulling at her hair, tapping her stomach and moaning. The staff, who immediately reacted based on a Euro-centric health model, interpreted her as being mentally unstable, and admitted her into the psychiatric ward. The Western value system does not allow for significant expression of distress. The woman died three days later. Upon examination, it became apparent that she had a

malignant stomach tumor that was never detected as she had not been physically examined following her admission to the hospital.

Mr. Nguyen expressed how immigrant people are often stereotyped and how this affects their access to health care. For example, Black women are often not offered an epidural during childbirth as they are perceived as stoic and strong and able to withstand the pain without medical assistance. Health care workers need to be able to work from an approach different from the Euro-centric model so that they are able to correctly diagnose and treat people from different cultures. Mr. Nguyen connected racism with mental illness, suggesting that a person who is racist is mentally unhealthy.

Mr. Nguyen emphasized the need for health care professionals to utilize professional cultural health interpreter services in order to provide appropriate health care to all their patients, regardless of their ability to speak English, the color of their skin, or their country of origin.

Discussion

Workshop participants agreed that there was a gap in research at the local and regional levels, particularly with regard to Black women's health issues. Participants noted there are many infectious diseases that cause suffering and death in the Black community. Although HIV should be of concern, this disease has been overblown in terms of risk and transmission and other infections that cause as much suffering and are as prevalent are ignored. HIV, human papillomavirus (HPV) and the Hepatitis B viruses are a concern for women in homeless shelters and their transmission is an issue that they must deal with on a continual basis. There is a silence in the Black community around HIV, HPV and Hepatitis B that needs to be addressed urgently.

Day Two

Strategies for Improving the Health of Black Women and Their Families

Susan Edmonds, (Chair, BWHN) welcomed speakers and participants to the second day of the workshop. In her opening remarks, Wendy Lill (MP, Dartmouth East) emphasized that stress and unemployment were important determinants of Black women's health. Women are burdened with many stresses and do not seem to have their overall care needs met.

Reflection Exercise

The workshop program continued with Chrystal Taylor (in background in photo) leading a discussion that revolved around Black feminist theory. She noted the exclusion of Black women from the first generation feminist movement. It is now recognized that the fight for social equality in terms of women's rights is also a struggle that should address power inequalities related to racial injustice. These issues are interdependent.

Ms. Taylor facilitated a reflection exercise that was designed to elicit the key issues and research needs identified in Day One of the workshop. Participants, grouped by table, were given ten minutes to reflect on these issues. Each group then shared two key issues with the plenary group, focussing on implementation and research needs.

Reflections were based on the following themes:

The "Individual Black Woman"

Participants noted the medical system has been culturally insensitive to the needs of women of colour. Using the example of breast screening, participants observed that many Black women do not have this testing done because of their perception that health professionals will mistreat them. There is a need to provide more information to the community through education to encourage Black women to utilize health services that are available to them.

Black Women's Health

Black women participants remarked that they are under a lot of stress as a result of racism, which affects their self-esteem. Issues related to poverty and loneliness at home or at the workplace leads to feelings of powerlessness. Their unmet needs (i.e., services and programs to deal with these underlying social and economic issues) increases their sense of anger, isolation, and stress. Participants noted the need for Black women to network to increase communication and knowledge.

In short, participants observed the health system has to accommodate Black women's health issues. Participants suggested preventative care education on:

- psychiatric interpretation;
- behaviour and lifestyles; and
- education about diseases with higher prevalence in the Black community, e.g., sickle cell anemia.

Community

Participants referred to Black women's sense of isolation, stress, anger, and lack of self-esteem. The sense of isolation occurs from not being valued or validated within the dominant culture.

Accountability

Participants made several suggestions concerning accountability of decision makers and participation of the Black community in health policy formation:

- policy makers should be accountable to communities;
- policy makers often consulted them *after* the policies had been made;
- communities must clearly state their needs to policy makers;
- the Black community must ensure that one Black person at a table is not there merely as tokenism, they cannot represent the whole community themselves; and
- health data must be collected with reference to race to improve accountability of health policy makers in Nova Scotia.

Health Care Services and Professionals

Participants noted:

- bias in interpretation of symptoms and treatment with misdiagnosis being common;
- apprehension within the Black community about utilizing medical services;
- limited access to clinics by Black Nova Scotians due to lack of transportation and geographical location of the clinics;
- a need for medical professionals must validate an Afrocentric approach and use of traditional healing and herbs;
- a need to increase the representation of Black women in the health professions; and
- a need for programs to mentor youth and new health care professionals.

Partnerships

One main question participants asked was "How does one define a true partnership?" They noted that there was often a lack of incentive to partner, as well as a lack of information flowing between partners. Effective partnerships must address the following questions:

- What questions should we be asking?
- Who defines the terms of the partnership, i.e., the issue of control?
- Who is employed within potential partner agencies and services and how can this present or breakdown barriers to true partnerships?

Communication

Participants identified improved communication as the key to addressing many of the issues raised at the workshop. The women felt that there was a history of being silenced and isolated through illiteracy and intimidation. In health care, this silencing made a significant difference in the quality of care received by Black women. A lack of use of deaf interpreters and cultural health interpreters has resulted in some misdiagnoses due to misunderstandings between patients and health care providers.

Racism

Participants identified racism as the foundation of both visible and invisible barriers faced by Black women, including:

- lack of access to appropriate health care services;
- low levels of education and acceptance into certain professions;
- low economic status;
- lack of trust in and for institutions (medical and others) when one sees no Black person employed there (lawyer, nurse, etc.);
- institutional racism and differential treatment of Black people; and
- lack of trust by institutions in health professionals of colour, with their abilities often being questioned.

Education

The women noted that early education of health risks and preventive health practices, as well as mentors and role models in the health professions was important in improving Black Nova Scotians health. In terms of career counseling, it did not seem as though Black youth are being encouraged to take sciences, with overall career counseling not available. This confidence would be facilitated by exposing children, starting in kindergarten, to positive role models in the health care fields, such as Black doctors. In order to facilitate this, there needs to be active recruitment and retention of doctors, nurses and other health professionals, and youth must be encouraged to choose these professions as careers.

Plenary Session: Identifying Strategies

This session gave professionals from various cultural backgrounds an opportunity to voice their experiences around health determinants as perceived in the African Nova Scotian community. In the concurrent sessions which followed, workshop participants shared, questioned and

advised on their experiences and expectations as they pertain to health and changes in policy and health programs and delivery necessary to improve health outcomes of African Nova Scotian communities and the community at large.

Common Humanity ... That Which Binds

*Dr. Norman Cook
NGO Division
Canadian International
Development Agency*

Dr. Cook began his comments with the remark that as a community African Canadians need to think globally and act locally. African Canadians have a rich history with high mobility starting at the beginning of the 21st century and most recently over the past three decades, with 60% of African Canadians presently in Canada were born outside this country. Although these communities are poorer than the average Canadian, the people are also very resourceful and have survived many hardships.

“Think globally, act locally.”

Health

Dr. Cook identified basic health care as a universal human right. Because of recent immigration patterns, Canadians of African descent have family and friends in African countries. With increased travel, our concern around health issues are not just for Canadians of African descent, but for global citizens.

National boundaries are becoming more fluid and future generations will have to be conscious of global events. Canadians have grown up fairly healthy under the Medicare system. Medicare entitles all Canadians to health care services which obliges us to understand and share the knowledge of the social policy framework in which we live. We cannot afford to give up this heritage of health care; a two-tier health care system would not be an advantage to all Canadians. Most of us do not have the resources to ensure that we would receive optimal health care in such a system.



Diversity

African Canadian families are changing and the lack of “purity” in any race is evident in our homes; 27% of African Canadian people live in homes with one White parent. The understanding of who we are does not extend from the color of our skins. It is our responsibility to share knowledge and understanding with others, to connect experiences, and to act in ways that support us all. A new challenge facing community development is to reflect the cultural diversity of immigrants of African descent in our communities. We have to work inclusively to appreciate our diversity. We cannot assume anything about a person’s mindset and identity, e.g., many people are not descendents of slaves and this is not part of their identity.

Poverty

In order to explore future health issues, we must address poverty. Twice as many African Canadians are poor compared to the national average. Further, African Canadians are twice as

poor as the poorest White Canadian. The poorest people in the country are single mothers, and there are three times the national average of African Canadian single mothers. The health of African Canadian women is integral to their communities as they are the caregivers in the family. Seniors are also often in economically precarious positions as many immigrated late in life and were not able to become stable. Poverty also extends to youth; the Black youth unemployment rate is double the national average and has been as high as six times the national average.

Research

There is an upcoming downturn in the economy and we have to be able to ride it. We must build a database so that we have research capacity at the national and local levels to see where Black communities stand in areas such as health, income, education, occupations, and employment levels. At present we lack control over what we should know to protect our people and to ensure their well-being. We also need control over the resources to build this research capacity.

Participation and Communication

Research is a small aspect of a larger picture that includes engagement of our citizens, the people who really need this information. We have to raise consciousness and involve more young people in the research dissemination process. The information gathered in reports

has to be communicated to the people in ways that they can relate to and understand. We have to use methods of communication that the young people are already open to such as culture, e.g., rap music and street theater, industries where African Canadians are doing very well.

We have to participate and be prepared to get into the fight at all levels as public health policy is at all levels. We must recognize that global policy making is shifting into the hands of the private sector where profit is the most important thing, not the well-being of the people. Elected officials must be accountable to the people in order to maintain input into policy.

Conclusion

The transfer of policy making to the national, provincial and municipal levels means we must have a voice on boards at all levels. Many of us are politically and technically qualified to participate in this process; we must ensure that our voices are heard. Such participation is the key to building capacity and participation. We have to think strategically, determine where people are at and link appropriately. In addition, we have to be inclusive and engage the diversity present in our communities. At the same time, we have to be patient with each other. We must realize that part of what is problematic with lack of self-esteem and racism is that sometimes we do not perform at the standards that we set for each other.

“The North Star”: A Genetic Research Centre in Nova Scotia

Dr. Georgia Dunston

Dr. Dunston began her presentation by reiterating the importance of understanding that the diversity of genetic variation within people of African descent means their participation in the human genome project is essential. The tremendous genetic variation of Blacks in Africa has been enhanced with migration to North America and subsequent mixing with people of European descent. This gives the project both a national and international focus.

The goal of the human genome project is to bring together multicultural perspectives and resources to understand the implications of genetic variation for health promotion and disease prevention. An increased understanding of how much the environment contributes to health will develop as the role of genetic variation is teased out through migration studies. Black communities can take greater ownership of this process through active participation. With

researchers being accountable to the community, Dr. Dunston sees the community as an equal partner and stakeholder in the project. The success of the research would be measured through the impact on the health of the community.

Dr. Dunston also sees a role in understanding the appropriate application and use of genetic medicine. After we gain an appreciation of where we are at, we can decide which direction to go in, and what the appropriate questions are.

In the future, Dr. Dunston would like to develop a project of genetic research based in Nova Scotia in partnership with organizations such as the Health Association of African Canadians. The inherent genetic variation and the disease prevalence in Nova Scotia would provide the basis for the project's research.

Issues and Challenges in the Management of Hypertension

*Dr. Ben Coockey
Internal Medicine
QEII Health Centre*

Dr. Coockey presented information regarding hypertension in the Black population. He began with an overview of the burden of disease and death due to hypertension. The incidence of hypertension is much higher in the Black population compared with the Canadian average. He noted that if a premature death is due to heart failure, that individual most likely had inherited risk factors for this

disease.

The main indicator of hypertension is blood pressure higher than 140/90, with normal being 120/80. One of the problems is that people are told that their blood pressure is borderline with no action being taken to decrease it. This results in an enlarged and weakened heart that can easily go into arrest, causing a heart attack.

There are many other risk factors for hypertension such as diabetes and cigarette smoking. The large percentage of people may not even know that they have hypertension or are not being treated when they should be; hypertension is treated and controlled for 16% of sufferers. Dr. Cookey finished his

presentation with advice on the types of questions to ask a family doctor so that you can stay in control of your health. He also suggested preventive treatment such as being compliant with prescribed treatment, watching diet and exercising regularly.

Concurrent Sessions

Facilitators:

Winnie Benton
Carolyn Fowler
Joanne Henderson-White
Kike Ehigiator
George Gray
Bernadette Anyanwu
Crystal Taylor
Robinah Kakembo

The workshop participants were divided into groups to discuss key issues and to develop strategies for addressing these issues. The summary of the group discussions is presented under four themes: policy, education, research and community capacity building.

Policy

- ~ The provincial and federal departments of health and community and district health boards must include African Nova Scotians in all discussion and decisions concerning health strategy development to ensure issues and barriers faced by African Nova Scotian communities are addressed.
- ~ The Nova Scotia Department of Health should consider establishing an advisory council/board on minority health.
- ~ The Nova Scotia Department of Health should provide long-term funding for the Well Woman's Clinic in East Preston and provide resources and staff from the IWK Health Centre in partnership with the community. To ensure quality services, such clinics require community representation and should be staffed with personnel recruited from the community wherever possible.
- ~ The IWK Health Centre must make sickle cell testing mandatory for all newborns of African descent.
- ~ The federal and provincial departments of health and provincial epidemiological reporting framework should reflect the incidence and prevalence of diseases such as diabetes, prostate cancer, breast cancer, hypertension, and asthma in the Black Nova Scotian population.
- ~ Federal and provincial health authorities must be made aware of the need for policy changes related to collecting and assessing race-related statistics on HIV/AIDS, violence abuse towards women, and addictions as they impact on the health of African Nova Scotians.

- ~ Partnerships with other Black organizations, the Health Association of African Canadians, non-governmental organizations, the Nova Scotia Department of Health, Health Canada, and church leaders must be developed to address barriers facing African Nova Scotians living outside of the Halifax Regional Municipality in accessing health care, treatment and support (e.g., travelling clinics, telemedicine at Community Animation Program (CAP) sites, and childcare and transportation issues).
- ~ Policy makers at all levels need to be made aware of the importance of racism as a determinant of health.

Education

- ~ Schools, health professionals and health centres should provide training and resources to physicians and support staff regarding cultural genetic differences.
- ~ Health professions schools must actively recruit within the Black community.
- ~ Health professionals should establish mentoring programs for young people of color.
- ~ Educational institutions and the community need to involve youth in the sciences and medical technologies.
- ~ Health professionals must validate an Afrocentric approach, and use of traditional healing practices.

Research

- ~ Researchers at universities and the IWK Health Centre must partner with the African Nova Scotian community to promote, conduct and disseminate research relevant to the African Nova Scotian community. Workshop participants emphasized the need for data collection regarding the effects of gender, race and economic status on health outcomes. Researchers must identify resources and establish a database of health information on the health of Black Nova Scotians.
- ~ Data and research that validates the experiences and perceptions of the Black community will encourage ownership of health issues specific to African Nova Scotians.
- ~ Research needs to be done allowing Black people to address their day-to-day experiences with racism. Research questions should extend beyond race and culture to engage the mainstream community.
- ~ A communication strategy using plain language tools and culturally appropriate content is required. Communication strategies should

be directed to establishing co-operation, respect and patience with one another.

- ~ Canadian research councils, university researchers and Health Canada need to support African Nova Scotian communities in developing expertise in identifying and conducting their own social, quantitative and qualitative research, and in learning to provide peer reviews of research studies.

Community Capacity Building

- ~ Federal and provincial health agencies and non-governmental organizations must work with Black educators, health professionals, and Black church societies to make health promotion and treatment programs more accessible to African Nova Scotians. The Black community must clearly understand the impacts of the determinants of health, especially social and economic policies, as well as the research process on their health outcomes.
- ~ Partnerships should be fostered with the media (e.g., University of King's College School of Journalism and Mount Saint University's public relations program) to increase the sensitivity of media to racism, sexism and ableism, and their effects on health outcomes.
- ~ Workshop participants agreed on the need for Black women to have a network to disseminate health information, to facilitate preventive health education, to set research agendas, and to discuss the expectations of the Black community regarding health service delivery. The network would serve as a vehicle for advocacy and lobbying regarding change in social policy as it pertains to community economic development. The network was seen as a sounding board for voicing concerns regarding differential treatment received, or perceived to be received, by the Black community around health issues. It could initiate an intergenerational/cultural dialogue, empower the Black community by identifying resources and solutions in the community itself, and develop a collective voice to express health concerns of African Nova Scotians.
- ~ Within the Black community, individuals need to take responsibility to increasing their knowledge of their basic rights and develop strategies that work for their own personal situations (e.g., bring along a list of questions to medical appointments, or bring a translator/companion for emotional support).
- ~ Develop a list of "do's and don'ts" for your community that can be used by health professionals.

Conclusion

Many barriers exist with respect to advancing health outcomes for Blacks in Nova Scotia, the least of which is that those in power do not clearly understand the concerns of marginalized people, the impact of

exclusion from policy making, and the service and fiscal needs of the Black community. The conclusions from this workshop should not be viewed as comprehensive, but rather as an extended invitation to work together to amend the complexities of these barriers. Simply locating a program or service in a community will not guarantee community participation. True participatory community development must be nurtured from the bottom up. Many Blacks feel cynical, alienated and that they have no meaningful contribution to make to change social and health outcomes. A shift is possible (see the example of what a small group of women can do in organizing this workshop). It begins with embracing the knowledge, skills, experiences, energy, and potential for change that already exists in our communities and organizations, and building capacities across sectors to move toward together for a better community. Co-operation is the use of power with others to decide together how resources will be shared and for what purpose. This workshop was a step forward in this process.

Biographical Sketches

Georgia M. Dunston is Professor and Chair of the Department of Microbiology, Howard University College of Medicine, where she has been on the faculty since 1972. She holds a PhD in Human Genetics from the University of Michigan and conducted postdoctoral work in Tumor Immunology at the National Institutes of Health, in the Laboratory of Immunodiagnosis, National Cancer Institute. In 1985 her interests in the biomedical significance of genomic polymorphisms in African-Americans led her to establish the Human Immunogenetics Laboratory at Howard University. Dr. Dunston has published and spoken widely on genetic variation in human major histocompatibility antigens and other genetic markers in African Americans. Dr. Dunston has served on the National Advisory Council for the National Institute of Environmental Health Sciences; the Genetic Basis of

Disease Review Committee for the National Institute of General Medical Sciences, and as member of the National Academy of Sciences Review Committee on the Human Genome Diversity Project. Her research interest in the biomedical implications of human genome variation is the vanguard of current efforts at Howard University to build national and international research collaborations focusing on the genetics of diseases common in African Americans and other people of the African Diaspora. This research has also served as the core and foundation for creation of the National Human Genome Center at Howard University, formed in 1998 with Dr. Dunston as Acting Director. The goal of the latter is to bring multicultural perspectives and resources to an understanding of human genome variation and its applications as well as implications for health promotion and disease prevention.

Dr. Norman Cook is Director, NGO Division, Special Initiatives, Canadian International Development Agency. His team has both policy and operational responsibilities for maintains responsibility for Canadian non-governmental organizations working in Africa, Asia, the Americas and the Middle East engaged in initiatives for sustainable peace building, human rights and democratic development. Dr. Cook has held a series of positions of increasing responsibility with CIDA. Dr. Cook's experience in cross-cultural matters has made him a valued member of the Canadian team supporting the Middle-East Peace Process. He has received awards from the Palestinian Community for Special Support for Palestinian Rights, from the Canadian Institute for Conflict Resolution for work on peace building and, most recently, the 'Unity Award' from the Baha'i

Josephine Enang obtained her diplomas in Midwifery and Nursing in Nigeria. She moved to Halifax, Nova Scotia in 1991 where she completed her Master of Nursing degree from Dalhousie University. She has worked with the IWK Health Centre, Halifax, Nova Scotia for the past eight years as perinatal nurse, lactation consultant, professional development consultant and breastfeeding clinical educator. She also worked as a Clinical Instructor for Dalhousie University School of Nursing and a Nurse Educator for the

Faith Group in Ottawa. Recently Dr. Cook initiated a process to work with governments in developing countries to advance their relations with their respective civil society organizations. Prior to joining CIDA, Dr. Cook was a Professor of Sociology at Concordia and McGill Universities in Montreal. He was also posted for four years to Cuba with a Canadian NGO. Social justice and equity underlie his vocational commitment and also form part of his personal life. He has been a committed volunteer throughout his career. He founded the first Visible Minority Employees Committee in the federal public service. Most recently, as National Chair of the Steering Committee for Communities of African Descent in Canada, Norman Cook initiated a National Roundtable Process for Dialogue amongst the various communities of African origin in Canada.

Parent Channel. She is currently a Researcher for the Health Association of African Canadians hosted by the Maritime Centre of Excellence for Women's Health, Halifax. Her research interests include health inequalities, racism, culture and health, and all aspects of perinatal and women's health issues. Ms. Enang is the founding Chair of the Multicultural Health Committee at the Maternal and Newborn Health Program in the IWK Health Centre.

Participants

Carol Amaratunga
Maritime Centre of Excellence for Women's
Health
c/o IWK Health Centre
PO Box 3070
Halifax, NS B3J 3G9

Ricky Anderson
"Go Ricky" Motivational Speaker
5674 Merkle Street
Halifax, NS B3K 2H9

Benny Anyanwu
239 Oceanview Drive
Bedford, NS B4A 4G9

Yvonne Atwell
Maritime Centre of Excellence for Women's
Health
c/o IWK Health Centre
PO Box 3070
Halifax, NS B3H 3G9

Rhonda Atwell-Ambakederemo
Community YMCA
401 Upper Partridge Road
East Preston, NS B2Z 1H4

Andrea Aucoin
Health Canada
Population and Public Health Branch
Suite 1816, 1505 Barrington Street
Halifax, NS B3J 3Y6

Winnie Benton
71 Silver Maple Drive
Timberlea, NS B3T 1G8

Carla Bernard
33B Locks Road
Dartmouth, NS B2X 2J6

Janet Brooks
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

June Brooks
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

Adrienne Brown
6 Perron Drive, Apartment 13
Dartmouth, NS B2W 4R3

Suzanne Brown
BLT Teen Health Centre
35 Beech Tree Run
Beechville, NS B3T 2E5

Geraldine Browning
8358, Highway #221 West Centreville
Kings County, NS B0P 1J0

Cheryl Butler
Black Community Workgroup of Halifax
2352 Gottingen Street
Halifax, NS B3K 3B2

Zelda Calley
East Preston Day Care Centre
W-5 Mall, 1900 Highway #7, Suite 501
East Preston, NS B2Z 1E9

Anges Calliste
St Francis Xavier University
Antigonish, Nova Scotia B2G 2W5

Linda Carvery
Nova Scotia Status of Women
2110 Creighton Street
Halifax, NS B3K 3R4

Rose Clayton
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

Susan Clayton
North End Community Health Centre
2165 Gottingen Street
Halifax, NS B3K 3B5

Kathy Coffin
Health Canada
1802-1505 Barrington Street
Halifax, NS B3J 3Y6

Anne Cogdon
Capital District Health Authority
294 Pleasant Street
Dartmouth, NS B2Y 3S3

Catherine Cole
Medical Society of Nova Scotia
5 Spectacle Lake Drive
Dartmouth, NS B3B 1X7

Edith Colley
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

Susan Coulter
Public Health Services
Box 211
Middleton, NS B0S 1P0

Krista Connell
Nova Scotia Health Research Foundation
PO Box 488
Halifax, NS B3J 2R8

Beverly Crawley
Advisory for Black Women's Health
Program
9 Kennedy Drive #308
Dartmouth, NS B2X 1N5

Iona Crawley
Dalhousie University, School of Nursing
5869 University Avenue
Halifax, NS B3H 3J5

Doreen Crick
Pro-Pins Mail Order
PO Box 25136
Halifax, NS B3M 4H4

Margaret Davis
21 Paul Street
Dartmouth, NS B2W 6A1

Sharon Davis Murdock
Health Association of African Canadians
1690 Hollis Street
Halifax, NS B3J 2R8

Gilbert Daye
Canadian Heritage
1869 Upper Water Street
Halifax, NS B3J 1S9

Pratima Devichand
12 Pinewood Terrace
Halifax, NS B3M 2A8

Margie Diggs
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

Debbie Douglas
East Preston Parent Resource Centre
W-5 Mall, 1900 Highway #7, Suite 501
East Preston, NS B2Z 1E9

Dorthory Edem
Nova Scotia Hospital
300 Pleasant Street, P.O. Box 1004
Dartmouth, NS B2Y 3Z9

Susan Edmonds
Health Association of African Canadians
9 Glencoe Drive
Dartmouth, NS B2X 1J2

Pamela Edmonds
15 Kennedy Drive #613
Dartmouth, NS B2X 1N7

Felicia R. Eghan
United African Canadian Women
Association
82 Tangmere Crescent
Halifax, NS B3M 1K1

Kike Ehigiator
Metropolitan Immigrant Settlement
Association
2131 Gottingen Street, Suite 200
Halifax, NS B3K 5Z7

Josephine Enang
Dalhousie University, School of Nursing
1236 Henry Street
Halifax, NS B3H 1Z5

Doris Evans
11 Cherry Brook Road
Dartmouth, NS B2Z 1A8

Kate Fancy
DAWN Canada
9 Lawrence Street #204
Dartmouth, NS B2Y 3H8

Carolyn Fowler
61 Nelsons Landing Blvd., Apt. 610
Bedford, NS B4A 3X3

Bernadette Fraser
Bloomfield Centre
2786 Agricola Street #201
Halifax, NS B2K 4E1

Rose Fraser
Health Association of African Canadians
2165 Gottingen Street
Halifax, NS B3K 3B5

Jacqueline Gahagan
Dalhousie University
School of Health and Human Performance
6230 South Street
Halifax, NS B3H 3J5

Deborah Grant
Canadian Breast Cancer Foundation
Suite 417 5251 Duke Street
Halifax, NS B3J 1P3

George Gray
10 Pondcherry Crescent
Dartmouth, NS B2W 5C5

Kelly Grover
Planned Parenthood Metro Clinic
6009 Quinpool Road, Ste 201
Halifax, NS B3K 5J7

Angela Harper
Queen Elizabeth II Health Sciences Centre
5955 Veterans' Memorial Lane
Halifax, NS B3H 2E1

Frances Harper
Health Association of African Canadians
8 Clifford Drive
Dartmouth, NS B3W 1T8

James Harper
86 Clifford Drive
Dartmouth, NS

David Hasse
Queen Elizabeth II Health Sciences Centre
5955 Veterans' Memorial Lane
Halifax, NS B3H 2E1

Jo-Anne Henderson-White
Metropolitan Immigrant Settlement
Association
2131 Gottingen Street
Halifax, NS B3K 5Z7

Judith Hockney
Women's Health Program
IWK Grace Health Centre
Halifax, NS B3J 3G9

Bonnie Hostrawser
Canadian Cancer Society
#1 - 5826 South Street
Halifax, NS B3H 1R6

Iyesatu Jalloh
1 Farthington Place, Apartment 407
Dartmouth, NS B3A 2K3

Mesi Jo
AW Evans Foundation
2290 #7 Highway
Dartmouth, NS B2Z 1G1

Funmi Joseph
Black Business Initiative
2101 Gottingen Street
Halifax, NS B3K 3B2

Robinah Kakembo
Nova Scotia Department of Education,
African Canadian
Services Division
PO Box 578,
2021 Brunswick Street, Suite 402
Halifax, NS B3J 2S9

Barbara Keddy
NSG & Women's Studies, Dalhousie
University
1236 Henry Street
Halifax, NS B3H 3J5

Abdullal Kerumira
Biomedical Diagnostics
94 Wentworth Road
Windsor, NS B0N 1T0

Wambui Kipusi
Nova Scotia Department of Housing and
Municipal Affairs
PO Box 216
Halifax, NS B3J 2M4

Darlene Lawrence
Digby County Family Resource Centre
PO Box 163
Digby, NS B0V 1A0

Wendy Lill
MP - Dartmouth
67 Portland Street
Dartmouth, NS B2Y 1H1

Sandra Loppie
North End Community Health Centre
2165 Gottingen Street
Halifax, NS B3K 3B5

Charlotte Loppie
Dalhousie University
2560 Oxford Street
Halifax, NS B3H 4R2

Velma McPhee
384 Granville Street
New Glasgow, NS B2H 4Z2

Margie Macdonald
Population and Public Health Branch of
Health Canada
1505 Barrington Street, Suite 1816
Halifax, NS B3J 3Y6

Maureen MacDonald
MLA Halifax-Needham Bloomfield Centre
2786 Agricola Street #201
Halifax, NS B2K 4E1

Lana MacLean
Drug Dependency Services
1673 Bedford Row
Halifax, NS B3J 1T1

Donna Meagher-Stewart
Dalhousie, School of Nursing
1459 Oxford Street
Halifax, NS B3H 4R2

Kathleen Mitchell
Human Resources Canada
Box 2400 DEPS
Dartmouth, NS B2H 4A5

Marla Mitchell
Human Resources Canada
Box 2400 DEPS
Dartmouth, NS B2W 4A5

Denise Moore
Health Association of African Canadians
PO Box 745
Halifax, NS B3J 2T3

Jemell Moriah
Cornwallis Street Baptist Church
5457 Cornwallis Street
Halifax, NS B3K 1B1

Josephine Muxlow
Department of Justice, Correctional Services
3rd Floor 1690 Hollis Street
Halifax, NS B3J 2J9

Jeffery Nyugen
Thompson Associates
1701 Purdy Tower II
Halifax, NS

Doreen Paris
Auba-Women Institute and Pictou County
Women's Centre
PO Box 964
New Glasgow, NS B2H 5K7

Slyvia Paris
PO Box 34001
Halifax, NS B3J 3S1

Wanda Patterson
25A Church Hill Drive
Dartmouth, NS B2X 1M8

Laura Paynter
33 Locks Road
Dartmouth, NS B2X 2J6

Tina Paynter
33 Locks Road
Dartmouth, NS B2X 2J6

Sheila Pelly
Lincolntonville Community Development
RR #1 Monastery (Lincolntonville)
Guysborough County, NS B0H 1N0

Bernadette Reid
Watershed Association Development
Enterprises
PO Box 2832 East
Dartmouth, NS B2W 4R4

Loretta Reily
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

Janice Rhodes
Nova Scotia Gynecological Cancer
Screening Program
PO Box 9000
Halifax, NS B3K 6A3

Cathy Sanford
Auba-Women Institute and Pictou County
Women's Centre
PO Box 964
New Glasgow, NS B2H 5K7

Lorna Simms
Energy Kinesiology
PO Box 23099, RPO SC
Dartmouth, NS B3A 4S9

Wendy Skinner
Canadian Cancer Society
#1 - 5826 South Street
Halifax, NS B3H 1R6

Francine Slawter
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

Donna Sealy
21 Garden Court Terrace
Dartmouth, NS B3A 3S6

Linda Snyder
Maritime Centre of Excellence for Women's
Health
PO Box 3070
Halifax, NS B3J 3G9

Margaret States
RCH Co-ordinator South West Regional
School Board
85 West Grove Place #8
Halifax, NS B3M 3L7

Leeanne Stevenson
Digby County Family Resource Centre
PO Box 163
Digby, NS B0V 1A0

Crystal Taylor
Federal Department of Human Resources
Bedford Row
Halifax, NS

Tracey Thomas
Black Business Initiative
1575 Brunswick Street
Halifax, NS B3J 2G1

Margaret Thomas
212 Jarvis Bay Terrace
Halifax, NS B3K 3J3

Betty Thomas
Sister to Sister
2131 Gottingen Street, Apt. 543
Halifax, NS B3K 3B8

Wanda Thomas Bernard
Maritime School of Social Work
Dalhousie University
1236 Henry Street
Halifax, NS B3H 3J5

Pat Thompson
NS Council on Multicultural Health
Suite 200, 2786 Agricola Street
Halifax, NS B3K 4E1

Esmeralda Thornhill
Dalhousie Law School
6061 University Avenue
Halifax, NS B3H 3H9

Lisa Tobin
Planned Parenthood Metro Clinic
6009 Quinpool Road, Suite 201
Halifax, NS B3K 5J7

Gertrude Tynes
73 Collins Grove #9
Dartmouth, NS B2W 4G3

Dawn Upshaw
Three Mile Plains Community Groups
Panuke Road
3 Mile Plains, NS B0N 2T0

Adele Vukic
Dalhousie University, School of Nursing
5869 University Avenue
Halifax, NS B3H 3J5

Elaine White
49 Brompton Road
Dartmouth, NS B2W 4M5

Ada Williams
East Preston Seniors Club
24 Brooks Road
Dartmouth, NS B3A 3B4

Dolly Williams
Congress of Black Women of Canada
1935 Highway #7
East Preston, NS B2Z 1E9

Norma Williams
Halifax Regional School Board
90 Alderney Drive
Dartmouth, NS B2Y 4S8

Gail Wilson
Nova Scotia Power Corp.
PO Box 910
Halifax, NS B3J 2W5

Brenda Zareski
Sexual Assault Nurse Examiners
5670 Spring Garden Road
Halifax, NS B3J 1H6

Appendix C

Annotated Bibliography

Atwell, Y. 2001. *Finding the Way: Establishing a Dialogue with Rural African Canadian Communities in the Prestons*. A Community Development Project funded by Atlantic Regional Office of the Population and Public Health Branch of Health Canada, Halifax, Nova Scotia.

This research project focuses on establishing a dialogue between rural African Nova Scotian communities in the Prestons, Nova Scotia, and Health Canada and gathering information and responses that represent the voices of that community. The project is ongoing. The project report will be presented to Health Canada to facilitate informed policy affecting the Black community and will suggest strategies to maintain regular dialogue with that community.

Benton, W. M. 1997. *The Evolution of African Consciousness: The effects of R.A.C.I.S.M. on Afrikans in the diaspora*. Unpublished Master of Social Work thesis, Dalhousie University, Halifax, Nova Scotia.

This thesis examines the evolution of *Afrikan* consciousness from the acceptance of *Afrikan* identity through a progression of Africentric orientation to continued maintenance of awareness and analysis of individual and collective *Afrikan* identities. It explores the personal and ethno-cultural identity development required to reach a mature level of *Afrikan* consciousness as well as racism and its impacts on the *Afrikan* Nova Scotian experience. Based on the study findings, the author concludes “the majority of *Afrikan* Nova Scotians cope with racism through the development of an *Afrikan* consciousness, influenced by the knowledge of racism”.

Black Learners Advisory Committee (BLAC). 1994. *BLAC Report on Education Redressing Inequity - Empowering Black Learners*. Volumes 1 & 2. Halifax: Nova Scotia Department of Education.

The authors of this report used a variety of research methods including community consultations and a literature review to explore the issues of inequity in the Nova Scotian education system in an effort to empower Black learners. The researchers identified several strategies to promote an effective learning environment for the Black community (e.g., active involvement of the community and incorporation of materials and cultural resources reflecting the Black community in the school curriculum). The report concludes with several recommendations to enable the Department of Education improve the Black experience in the education system.

Boyd, J. 1998. *Racism: Whose Problem? Strategies for understanding and dealing with racism in our communities*. Halifax: Metro Coalition for a Non-Racist Society.

Produced and distributed by the Metro Coalition for a Non-Racist Society, this book provides a useful learning resource on racism from the perspective of both white and non-white people. It describes how racism affects most of what we do as individuals and as a society. The book seeks to motivate readers to put in practice what they have learned.

Colman, R. 2000. *Women's Health in Atlantic Canada: A statistical portrait*. Policy Discussion Series No. 8. Halifax: Maritime Centre of Excellence for Women's Health.

This report provides a statistical review of available data on women's health in Atlantic Canada using the determinants of health as a framework. The report shows the relationship between the various determinants of health, i.e., gender, education, social supports, etc. It provides some recommendations on practical policy initiatives that can move the system past crisis interventions toward promotion of population health. The report concludes with a discussion on data limitations and directions for future research.

Crawley, I. 1998. *Black Women's Health Research: Policy implications*. Halifax: Maritime Centre of Excellence for Women's Health (Unpublished report).

This is the report of a research project conducted by the Women's Health Program at the IWK Health Centre. The study explored some of the barriers influencing the utilization of women's health services in the Metro Halifax area. Specifically, it looked at rural Black communities such as North and East Prestons. Major findings include insufficient research on Black health, a lack of knowledge on services available, limited education of care providers about Black health, under-representation of Blacks in the health professions and a lack of outreach programs. The report concludes with some suggestions to bridge these gaps.

Daniels, S. 1997. *The Potential for Midwifery in Nova Scotia*. A review by the Reproductive Care Program (RCP) of Nova Scotia on behalf of the Nova Scotia Department of Health, Halifax, Nova Scotia.

This review utilizes several strategies, including a literature review and consultations with community groups, health professionals and organizations, to solicit diverse opinions about midwifery in Nova Scotia. The study identified deficiencies in maternity services including cultural insensitivity by health care professionals. The author concludes there is a need for vigorous efforts to improve particular areas of perinatal care and recommends that maternity health service providers be more respectful of women and their families and be more responsive to their expectations.

Douglas, S. 1995. *Taking Control of Our Health: An Exploratory Study of the Health of Black Women in Peel*. Report of a study funded by the Ontario Ministry of Health, Women's Health Bureau, May, Peel, Ontario.

This study examines the issue of accessibility to the health care system for Black women in Peel County, Ontario. Researchers used community consultations, individual interviews and a literature review to identify Black women's health issues and how the health care system has addresses these issues. The study concludes that the inequities that exist in education, employment and housing have had negative influence on the health of Black women. The researcher recommends developing strategies to address concerns of Black women, i.e., enhancing accessibility to health care and eliminating discrimination within the health care system, especially mental health services.

Downey, S. 1999. *Bridging the Gaps: A capacity building project to address the needs of breast health and breast cancer support and information within the Black Nova Scotia Community*. A project funded by Health Canada, Health Promotion and Programs Branch, Atlantic Region, Halifax, Nova Scotia.

This report presents the findings and recommendation of a project which explored the gaps and barriers influencing Black women ability to access breast health and cancer information. The project conducted focus group sessions throughout Halifax Regional Municipality to ascertain the issues and to raise awareness of the services available on breast health and breast cancer support. The study identified barriers to attaining relevant information including a lack of interest by health care professionals' to deal with Black people and the lack accessible health care services within Black Nova Scotian's communities. Recommendations included developing culturally sensitive health programs and resources for the Black community and providing community-based services to address this health information need.

Edmonds, S. and J.E. Enang. 2000. *Hearing Black Voices: Transition Program Needs Assessment for Community Colleges*. A reported to Human Resources Development Canada, Halifax, Nova Scotia.

This is a report of a needs assessment conducted within Halifax Regional Municipality to identify the educational needs of the Black Nova Scotian community with particular focus on the need for a transition year program (TYP) in the community college system. The research findings suggest that current policies and service delivery systems have systematically ignored the perspectives of the Black community. The researchers recommend that efforts be made to ensure active involvement of the Black community in the process of addressing the current educational needs of the Black community. The authors conclude that a transition year program would be a useful tool to facilitate recruitment of Black Nova Scotians into community colleges.

Enang, J.E. 1999. *The Childbirth Experiences of African Nova Scotian Women*. Unpublished Master of Nursing thesis, Dalhousie University, Halifax, Nova Scotia.

This thesis explores the perinatal health care experiences of Black Nova Scotian women. The research seeks to generate knowledge about the impact of racism on these women's experiences. In turn, this information will be used by care providers to effectively address Black Nova Scotian women's needs. The study identified lack of health care access, cultural insensitivity and the presence of racism in the health care system. The author makes several recommendations concerning research, education, clinical practice and policy. The researcher used participatory action research methodology used and includes a social action component in her research.

Fraser, R. 1998. *The Black Women's Health Project. Phase V*. Report submitted to the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

This report presents an overview of the Black presence in Nova Scotia since the 1600 and the Black Women's Health Program which began at the North End Community Health Centre (NECHC) in 1996. The report identifies the need to develop a research data base on Black health as a first step in addressing Black

women's health needs. It also recommends ways in which the government may collaborate with the Black community to address their health needs.

Fraser, R. and T. Reddick. 1997. *North End Community Health Centre Black Women's Health Program Report: Building Black Women's Capacity on Health*. Halifax: Black Women's Health Program.

This needs assessment was conducted in the Black community using several focus group meetings as the main source of data collection. The researchers identified several gaps in the health care system's ability to effectively care for the Black community including the lack of statistical information on Black health and cultural insensitivity by care providers. The researchers suggest some areas where change is necessary, e.g., routine screening of Black newborns for sickle cell disorder and conducting province-wide health education sessions for Black women.

Howard, L.L. 1997. *Culturally Sensitive Breast Health Information Kit: A report on delivering Breast Health Information to Ethnic Communities*. Atlantic Breast Cancer Project, Prince Edward Island.

This report is based on eight focus groups conducted in the Atlantic region to examine breast health. The research identified some of the barriers to getting appropriate health information and the popular ways minority women use to obtain health information. The report suggests methods to use to disseminate information on breast health and breast cancer to hard-to-reach women.

Langille, D. 2000. *Sexual Health Services and Education for Adolescents: Options for Nova Scotia*. Policy Discussion Series Paper No. 8. Halifax: MCEWH.

This research on adolescent sexual health issues emphasizes those issues that relate to the sexual health of young women. Based on an analysis of the literature, the author demonstrates some of the gaps in health outcomes, especially with respect to adolescent pregnancy, as well as the shortcomings in health service delivery. The report concludes with suggestions for holistic changes that are needs based, youth-centred and outcome focussed. For example, the author suggests the need for a complete change in the delivery of sexual health education and services for this population.

Lawrence, D. 2000. *Digby County Family Resource Centre Needs Assessment. An annual report*. Digby, NS: Digby County Family Resource Centre.

This report presents the findings of a project conducted to facilitate the development of strategies to address the issues facing people in Digby County. Focus group sessions, questionnaires and individual interviews were used to collect data. The findings suggest that funding be sought by the Digby Family Resource Centre to run a program that trains community animators to facilitate educational opportunities in the community and to work collaboratively with youth to develop appropriate support programs. The author recommends forming strategic partnerships between Centre staff and community members and other organizations and identifies the need for a daycare centre in this region.

Maclean, L. 2001. *Sources of Healing Following Childhood Trauma*. Unpublished Master of Social Work thesis, Dalhousie University, Halifax, Nova Scotia.

This thesis explore the concept of healing following childhood trauma among Black women aged 24-52. A critique of the literature on Black women's health and contemporary healing informed the study. The research findings are grouped under several themes, e.g., social action and spirituality, family and community support, self help group – “sister-time”, voicing and naming the trauma, and personal. The author recommends creating a richer body of knowledge on Black research, including Afrocentricity and cultural stories in the educational curriculum, and facilitating focus groups to enhance healing among victims of trauma and Black professionals.

Mauricette, R. 1997. *Culture and Childbearing in the Context of Prenatal Education*. Unpublished Master of Arts thesis, Dalhousie University, Halifax, Nova Scotia.

This thesis examines the extent to which the perinatal health care needs of culturally diverse people are met within the prenatal program at the North End Community Health Centre in Halifax, Nova Scotia. The study found some inconsistencies in the beliefs and values of care providers and care recipients in the areas of the childbirth process and breastfeeding. The cultural background of the patient and care provider influenced the care provision. The author makes several recommendations based on these findings.

Registered Nurses Association of Nova Scotia. 1995. *Multicultural health education for nurses: A Community perspective*. Halifax: Registered Nurses Association of Nova Scotia.

This study explored the multicultural health needs of First Nations and ethnic minorities and sought to identify how nurses can provide culturally sensitive health services. The study used focus group meetings to collect data and qualitative method to analyze the data. Several challenges and gaps were identified both from the consumers' and providers' perspective including language problems, lack of cultural sensitivity, and discrimination within the health care system. Based on these findings recommendations, the authors make recommendations in the areas of policy, nursing education, and nursing practice and administration.

Sharif, N. R., A.A. Dar and C. Amaratunga. 2000. *Ethnicity, Income and Access to Health Care in the Atlantic Region: A synthesis of the literature*. Halifax: MCEWH.

This project scanned relevant academic and popular literature on the accessibility of health care services to different income and /or ethnic groups in Atlantic Canada. The report highlights the significant areas of health care accessibility from the perspective of marginalized groups in this region. The authors identify the limited research available on the role of ethnicity and low income status and their interaction with health status as a factor negatively influencing health care policy for this population. The authors recommend the building a critical mass of research-based literature in area of ethnicity and socio-economic status as they relate to health and health care access.

Skinner, E. 1998. *Meeting the Health Needs of a Culturally Diverse Nova Scotian Population*. A Master of Health Services Administration project prepared in conjunction with the Nova Scotia Department of Health and the School of Health Services Administration, Dalhousie University, Halifax, Nova Scotia.

This project examined the extent to which race and ethnicity are addressed in health research and health policy in Nova Scotia. The author concludes ethnicity is not routinely considered in health research and policy although there is enough evidence to support the fact that health inequities exist along ethnic lines in Nova Scotia. The author acknowledges the presence of culturally-related barriers to health care access and utilization. Based on her analysis of the literature and consultations with individuals and groups knowledgeable in the area, she developed conclusions and recommendations in five key areas including the need to establish a centre within the Nova Scotia Department of Health that would be responsible for diversity issues.

Task Force on Government Services to the Nova Scotian Black Community. 1996. Halifax: Task Force on Government Services to the Nova Scotian Black Community.

This Task Force reports on some of the gaps in services available to the Black Nova Scotian community. It identifies several problems facing this community, e.g., the lack of role models for young Black girls and boys. The Task Force makes several recommendations to facilitate availability of government services to the Black community and to enhance the utilization of these services.

Taylor, C.S. 1996. *Silenced Voices: Nova Scotia Black Women's Perspective on Feminism*. Unpublished Master of Arts thesis, Dalhousie University, Halifax, Nova Scotia.

This thesis explores the concepts of Black womanhood and feminist consciousness. The study presents in the women's voices, the many barriers and struggles encountered in their everyday lives including their race consciousness, self-definition and survival strategies. The research findings indicate that although Black women have been excluded from the feminist movement, they clearly demonstrate feminist values and beliefs.

Thomas Bernard, W. 2001. *Including Black Women in Health and Social Policy and Development: Winning over addictions and empowering Black mothers with addictions to overcome triple jeopardy*. Halifax: MCEWH.

The project examined addiction among Black mothers who had some involvement with child welfare. Using a participatory action research methodology, the author found that these women experienced multiple oppression interlocked on many levels. The study findings suggest that there is a lack of culturally responsive services and very limited resources available to Black women struggling with addictions. The author concludes there is urgent need to develop more preventive programs to address the needs of this population.

Thomas Bernard, W. 2000. *Beyond Inclusion: Diversity in women's health research*. A paper presented at MCEWH Policy Forum, Halifax, Nova Scotia.

In this paper the author discusses how the notions of inclusion, social exclusion, power and privilege, oppression and diversity relate to women's health research

and the implication for policy and practice. The author suggests that eliminating the barriers affecting diverse women's health is vital to addressing the issue of accessibility. The author concludes with the recommendation that future research on women's health must not view women as a homogeneous group, but acknowledge their diverse views, opinions and experiences as a core component of the research.

van Roosmalen, E., and C. Loppie. 1999. *Women's Voices: Women's perception of the determinants of health and well-being*. Halifax: MCEWH.

This participatory research project used a telephone survey to assess women's perception of their own health, what determines their health and the meaning of health in their everyday lives. The study involved women from various ethnic groups, including Aboriginal, Black, Acadian, rural and low income women, found there is a lack of awareness about the relationship between socio-cultural factors and health in marginalized populations. Participants also identified cultural insensitivity among health care professions towards ethnic minorities as an issue that require attention. The authors make recommendations to address policy and education issues in the health care system.

Watershed Association Development Enterprises Ltd. (WADE). 2000. *Preston Area Health Issues Roundtable Discussion*. Dartmouth: WADE.

This one day roundtable included members of Black communities, including the Prestons, Cherry Brook, Lake Echo and Lake Loon as well as representatives from various health care organizations (over 50 people). The discussion report identifies several significant health issues affecting these communities including illegal garbage dumping at various sites, poor quality drinking water, and lack of health education in the communities as well as lack of representation of the community in health forums such as the Community Health Board. The report makes several recommendations including the hiring of a community health advisory worker to co-ordinate work on the identified issues.

Watson, G. 1997. *Findings of the Summer Study on Race Relations*. Halifax: Faculty of Medicine, Dalhousie University.

This study examined the state of race relations within the Faculty of Medicine at Dalhousie University as of 1997. Focus group meetings were used as a forum for students to share their experiences about racial insensitivity. An analysis was performed on areas where racial insensitivity were notable within the school. The study findings show a presence of racial insensitivity in areas throughout the school, e.g., faculty-student interactions and patient-doctor relationships. The author concludes with several suggestions for incorporating ways of dealing with discrimination in training curriculum and developing a support program for victims of racial insensitivity.

Appendix D

Health Association of African Canadians

The following are the founding members of the Health Association of African Canadians (formerly the Black Women's Health Network). The membership of the HAAC continues to expand.

Ms. Susan Edmonds
Chair, Health Association of African
Canadians
9 Gencoe Drive
Dartmouth, Nova Scotia

Ms. Josephine Enang
IWK Health Centre
Halifax, Nova Scotia

Ms. Yvonne Atwell
Policy Advisor
Maritime Centre of Excellence for Women's
Health
P.O. Box 3070
Halifax, Nova Scotia B3J 3G9

Ms. Sharon Davis-Murdock
Senior Policy Analyst
Nova Scotia Department of Health
Health Services Branch
Halifax, Nova Scotia

Ms. Frances Harper
MABLE Nurse
IWK Health Centre
Halifax, Nova Scotia

Ms. Denise Moore
Coordinator of Regional Services
Nova Scotia Advisory Council on the Status
of Women
P. O. Box 745
Halifax, Nova Scotia

Ms. Iona Crawley
School of Nursing
Dalhousie University
Halifax, Nova Scotia

Ms. Dolly Williams
Congress of Black Women of Canada
1935 Highway # 7
East Preston, Nova Scotia

Ms. Rose Fraser
North End Community Health Centre
Halifax, Nova Scotia

Carol Amaratunga, Ph.D.
Executive Director
Maritime Centre of Excellence for Women's
Health
P.O. Box 3070
Halifax, Nova Scotia B3J 3G9

Jacqueline Gahagan, Ph.D.
Assistant Professor
School of Health and Human Performance
Dalhousie University,
Halifax Nova Scotia

Ms. Margaret Bruhier
Social Work
Dept. of Community Services
Halifax, Nova Scotia

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