THE BLACK WOMEN'S HEALTH PROJECT

THE DETERMINANTS OF HEALTH OF AFRICAN NOVA SCOTIAN WOMEN AND THEIR CURRENT HEALTH STATUS

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Nina Thomas
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EXECUTIVE SUMMARY

It has become common to view health as consisting of many aspects of one's life and the medical community has now acknowledged this holistic view. These determinants that serve as predictors for one's physical, mental and emotional well-being are universal, however they can be unique to certain groups of individuals. We have asked African Nova Scotian women to discuss the most important determinants that they feel affect their health and the health of their families. Although there were many discussed, the critical determinants were found to be racism, culture and lifestyle, employment and economics, environment, gender, and health service and information quality (general and cultural). All of these determinants are typically intertwined and initiate either directly or indirectly the status of good or poor health. There are certain factors that are not specific to physical ailments, however it can be agreed upon that all of these factors influence mental and emotional well-being, creating a chain reaction by disrupting the mind-body system. From history until now these determinants have most likely remained the same, nevertheless this project aims to change policy, implement programs, and make African Nova Scotian women aware of their own health and to have power over it.

RECOMMENDATIONS

Finding #1: The availability of health services specific to the Black community is lacking and those that are available are inaccessible to people in rural or remote areas.
Recommendation #1: Implementation of anonymous services within the community for women's health, counselling services for women and youth, dealing with issues such as depression, suicide, abuse, crime etc., addiction services for alcohol, drugs, gambling etc., prenatal counselling and family counselling covering a wide range of emotional/mental problems within the home. Lend out the services of larger scale facilities to small clinics located in small communities once or twice per month, or increase transit service to these areas.

Finding #2: There is some unawareness of the racial divergences regarding health conditions, some of which are genetically predisposed, and treatments with either medication or other techniques.
Recommendation #2: Research must be carried out to identify the variations in the symptoms of Black women when afflicted with certain illnesses, as well as identifying the prevalence of certain illnesses in the Black community. Information gathered must then be taught in medical schools and the information distributed to hospitals, clinics, and doctor's offices. A seminar every so often may be useful to ensure the medical community is well educated on the new research.

Finding #3: The current atmosphere and comfort level of going to see a White doctor who may not understand the culture of Black women can create stress, contribute to a lack of communication leading to misdiagnosis and can contribute to systemic racism.
Recommendation #3: Change policy and create incentives to allow for more Black community members in academia to be represented in medical or nursing schools, and to

practice in smaller Black communities. Create a strategy for more Black doctors and nurses from the larger metropolitan area to come into the smaller communities on occasion where community members will be more likely to see about their ailments in a comfortable, familiar setting.

Finding #4: Information on "Black illnesses" is unavailable and not easily attainable to laypersons in the community. Education on the importance of these illnesses is lacking.
Recommendation #4: Preparation of pamphlets, posters or other media that contain information on "Black diseases". These media should be highly demonstrative and easily understandable to accommodate for the variation of literacy. These media should also be distributed in doctor's office's, clinics, hospitals as well as recreation centres, schools and churches. Create a women's resource handbook networking local and provincial amenities in health and other concerns.

Finding #5: Employment and economic circumstances can hinder the ability to acquire and maintain appropriate health care for oneself and one's family.
Recommendation #5: Employ partnerships between organizations, clinics, recreation centres and businesses to create Black Employment Centres in or near each community. Apply medication insurance for those without protection.

Finding #6: Racism impedes on proper health care given to African Nova Scotian women. This obstacle creates a stressful environment and can prevent Black women from going to see a doctor or other health professional.
Recommendation #6: A non-segregated African Nova Scotian centre or clinic, in or near the Black communities should be implemented, narrowing its focus on the needs of the Black community, health related and otherwise.

Finding #7: Environmental degradation in urban and some sub-urban areas can directly affect health and provide a non-nurturing, aesthetically unpleasing environment affecting emotional well-being.
Recommendation #7: Voice environmental concerns to government officials to provide a monitored clean-up mission and for government to provide funding for these projects. Start beatification projects in urban communities to provide a safe and healthy environment for children to play in and to develop community activities.

Finding #8: Women in the Black community fall into unhealthy lifestyle habits associated with culture learned from upbringing.
Recommendation #8: Provide an information session once a or twice a month in the community where health professionals can discuss healthy eating practices and plans for incorporating exercise in one's daily schedule. These sessions should be demonstrative and should include a clear explanation of cause and effect for certain behaviours.

INTRODUCTION

The Black Women's Health Program began in 1996 as an initiative of the North End Community Health Centre. Entitled, *Our Time for Our Health*, the program was meant to promote health in the Black communities of the Halifax Regional Municipality, specifically as it relates to the Black woman, with an emphasis on all the determinants of health. Black women came together in an open forum to express their concerns about the lack of health data and the lack of information provided by their primary health-care providers on the illnesses affecting them.

Historically, women of African descent have been the primary care givers in their immediate families, their families of origin and white families in Nova Scotia. Since their arrival in the 1600's many female family members including mothers, grandmothers, sisters and aunts were afflicted with illnesses unknown and their deaths were witnessed over a period of 400 years. Today it is common knowledge that the illnesses affecting these women were a multitude of diseases including cancer, diabetes, hypertension, heart disease, diabetes sarcoidosis, aneurysms, tuberculosis and other common illnesses found within the Black community. Although mental illness was not often taken into account, today it is considered a crucial measure of well-being. On this note it is important to state that many key determinants are factored into an individual's physical and mental health. While medical research will take a reductionistic approach for diagnosis and treatment, it is important to incorporate social, economic, cultural and environmental barriers that hinder access to, and impede receiving appropriate health care. In this study all of these factors are explored as well as many others that are important in the lives of Black Nova Scotian women. It is these determinants that can be taken into consideration when changes are to be made within the health-care system.

The Black Women's Health Project has set out to form awareness of the concerns facing Black women, in addition to publishing the first statistics of their current health status. Through the facilitation of focus groups held across the province, our research team was able to bring forth the basic issues that Black women feel affect their health and the health of their families. In summing up these issues, a series of recommendations are delineated. These are offered as a prescription to common challenges faced by the majority of these women. In cooperation with the Atlantic Centre of Excellence for Women's Health the proposed strategy is to:

- Increase knowledge of, and to document some of the issues affecting the health of Black Nova Scotian women,
- To develop a plan to change policies that presently prevent documentation of Black health statistics in Canada, and
- To encourage development strategies to assist Black women in meeting their health needs.

Ultimately, the intention of the project is to build health awareness in the Black community through research and consultation with female community members.

RESEARCH QUESTION

This project has set out to ask what African Nova Scotian women feel are the major determinants of their health.

METHODOLOGY

The research carried out was of type Level 1. There has been no other study that has collected current data on the status of Black women's health, therefore the use of a questionnaire and discussion among participants were used to draw decisive information. A format using both quantitative and qualitative information was employed in order to obtain the most in-depth and insightful observation upon analysis. Quantitative investigation relied on a survey delving into many issues relating to physical health and emotional well-being. While qualitative information was provided through focus group sessions held with the same women who completed the survey.

The questionnaire originally provided in the study consisted of three sections: *Health Status*, *Health Determinants* and *General Questions*. While the *Health Status* section remained the same, there were changes made to the original questionnaire. Upon executing two focus group sessions, feedback was obtained from women who considered the format of *Health Determinants* to be too long, and they were unable to fully answer questions in which a written response was required. It was felt that changes must be made to accommodate for cases of illiteracy, visual problems and mental/physical disabilities. The formatting was modified to a simple check and/or circle layout, in which various answers were provided, and when necessary an "Other" option was offered. *General Questions*, which contained more personal and private information, was originally executed through telephone interviews. It was decided that this section could be incorporated into the other two sections, thus eliminating individual telephone interviews. In addition, the less relevant or redundant questions were discarded as it was felt that discussion would naturally progress to deal with many other concerns. The research team believed that discussion questions required more structure and that some of the topics dealt with in *Health Determinants* could do with more probing to add more dimensionality to issues such as race and culture and general health. The new questionnaire thus contained the original *Health Status* section along with general questions and various health determinants, which will be listed below and discussed later in conjunction with the data.

The health determinants explored in this study included environment, social and economic factors, community resources and community role, personal health practices, health services and general health determinants as expressed by the participants. For the purposes of this study, race/culture and gender were also included as major social determinants. General health determinants and race and culture were discussed aloud with participants.

Our research team proceeded to organize focus groups in twelve predominantly Black communities across Nova Scotia. These communities included 6 around the province (New Glasgow, Whitney Pier, Sunnyville (including Monastery), Yarmouth, Shelburne, Truro), and 6 in the Halifax Regional Municipality (Hammonds Plains, Spryfield, East Preston, North Preston, Dartmouth and North End Halifax). Contacts

were made to community leaders and members in each region to establish a sample of Black women aged 16 and up from in and around the specified region. A "snowball" or informal method of sampling was used to obtain participants. For some distant regions, a proxy, using various organizations and persons in contact with the community, was used to distribute flyers and pamphlets. As well, individual women were called and asked to participate by the research team. Upon completion of the focus groups a total of 88 women were surveyed and had participated in the discussion. Women were asked to sign a consent form detailing their participation in the focus group and ensuring their confidentiality. The form asked each woman if they would agree to participating in the focus group and to the taping of the discussion*. Subsequently, the survey was filled out, and a discussion followed.

Sample

The sample in this study consisted of various women of which a predetermined health status was not a criterion. It was ensured that the common denominators in each of these women were race and gender†. The majority of the women participating in the study were between the ages of 30 and 69 (73.9%) and were either married (50.0%) or single (19.3%). 61.4% of participants had children or dependants, while 22.7 % were single parents and 43.2% were not. Of all participants, 20.4 % stated they were the sole provider of their children or dependants, while 21.6 % indicated they were the principle wage earners and 19.3 % indicated their spouse as the principle wage earner. Educational factors were also assessed, and our sample contained a bimodal distribution with 54.2% receiving a grade 9 to grade 12 education and 44.3% receiving some type of post-secondary education (mostly community college and/or an undergraduate level degree). Income level, which included all sources, was found to be slightly in the range of $10,000 to $19,999 (20.4%) however with a lack of response equating 18.2%, it is difficult to assess the predominant economic status of this sample. Current employment came to 56.8%, while most of the remaining women were retired (19.3%) or pursued full-time homemaking (15.9%). Stability of employment was also evaluated, and of those employed, 66.0% held permanent full-time positions, and a fairly equal spread (spanning 2-49 years) was found in terms of length of employment.

Shown below is a breakdown of the sample of women according to personal, educational and employment status.

* The original format of the consent form asked whether participants would agree to the focus group as well as the individual interview (*General Questions*). This was an additional reason for incorporating this section to the survey, so as to eliminate the choice of not partaking in the interview, thus restricting the attainability of this data.

† The research project was designed to discriminate based on race and sex due to its subject (Black women). The research is carried out to benefit the members of this group thus fulfilling Article 6.1 of the *Code of Ethical Conduct for Research Involving Humans*.

Table 1. Breakdown of information from surveyed sample[†].

Age	20 – 29	6.8%
	30 – 39	17.1%
	40 – 49	25.0%
	50 – 59	12.5%
	60 – 69	19.3%
	70 –79	6.8%
	No Response	12.5%
Marital Status	Single	19.3 %
	Now Married	50.0%
	Separated	3.4%
	Divorced	10.2%
	Widow	8.0%
	Common Law	3.4%
	No Response	5.7%
Children/Dependants	1-2	30.7%
	3-4	18.2%
	5-8	6.8%
	Unknown Number	5.7%
	N/A	15.9%
	No Children/Dependants	22.7%
Single Parent	2-10 months	2.3%
	3-10 years	9.1%
	11 + years	6.7%
	Length not specified	4.6%
	No	43.2%
	N/A / No Response	34.1%

[†] All figures are shown as percentage.

Highest Level of Education	6-8	7.9%
	9-12	54.2%
	University (BA/BSc, Diploma, Professional Degree)	19.3%
	University (MA/MSc; PhD)	3.4%
	Other Post –Secondary (Community College, Polytechnical school, etc)	25.0%
	No Response	10.2%
***Income*[‡]**	Less than $10,000	13.6%
	$10,001 to $19,999	20.5%
	$20,000 to $29,999	16.0%
	$30,000 to $39,999	11.4%
	$40,000 to $49,999	5.7%
	Over $50,000	14.8%
	No Response	18.2%
Work Status	Employed	56.8%
	Student	1.1%
	Full-time homemaker	15.9%
	Retired	19.3%
	No Response	6.8%
Length of Employment*[§]	1 year or less	10.0%
	2-8 years	26.0%
	10-20 years	36.0%
	21-49 years	28.0%

[‡] Refers to approximate net household income, from all sources, before taxes in 2000.
[§] Refers to length of employment with current employer.
* Includes only respondents who specified themselves as currently employed at the time of the survey.

Type of Employment*	Permanent Full-time	66.0%
	Permanent Part-time	12.0%
	Temporary Full-time	12.0%
	Temporary Part-time	8.0%
Residence Location	Rural	44.3 %
	Urban	37.5%
	Sub-Urban	9.1 %
	No Response	9.1 %

DATA SUMMARY

Shown below is a tabular summary of quantitative data, under health status, collected from the 88 participants who were surveyed. The section was divided into two categories including physical ailments and emotional/mental well-being.

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Table 2. Health status results of surveyed sample[†].

Have you ever been bothered by:	Often	Sometimes	Never	N/A / No Response
Heart beating fast?	6.8	59.1	29.6	4.6
An upset stomach?	15.9	56.8	22.7	4.6
Hands or feet sweating so that they feel damp and clammy?	5.7	14.8	76.1	3.4
Shortness of breath when not exerting yourself?	4.6	27.3	62.5	5.7
Spells of dizziness?	6.8	53.4	36.4	2.3
Feeling of weakness all over?	4.6	28.4	62.5	4.6
Do you feel healthy enough to carry out the things you would like to do	52.3	30.7	10.2	6.8
Bothered by different ailments in different parts of the body	10.2	56.8	22.7	10.2
Loss of appetite	8.0	34.1	52.3	5.7
Trouble getting to sleep and staying asleep	17.1	51.1	29.6	2.3
Has health affected the amount of work you do?	12.5	36.4	46.6	4.6
Have you ever felt you were going to have a nervous breakdown?	6.8	34.1	55.7	3.4
Bothered by nightmares	5.7	39.8	50.0	4.6
Feel tired in the morning	18.2	59.1	19.3	3.4
Lose weight when important things are bothering you	10.2	33.0	53.4	3.4

During the last two weeks, did health problems cause you to do any of the following:	Yes	No	N/A
See a doctor for diagnosis?	28.4	65.9	5.7
Remain in a hospital overnight?	3.4	92.1	4.6
Stay in bed at home?	13.6	79.6	6.8

[†] All figures are shown as percentage.

Take medicine prescribed by a doctor?	44.3	52.3	3.4
Take non-prescription medicine?	36.4	55.7	8.0
Be absent from work or school?	17.1	69.3	13.6
Do you regularly feel that you are under stress?	40.9	42.5	17.1

During the past few weeks, how often have you felt...	**Often**	**Sometimes**	**Never**	**N/A / No Response**
On top of the world?	21.6	46.6	26.1	5.7
Very lonely or remote from other people?	10.2	40.9	42.1	6.8
Particularly excited or interested in something?	36.4	51.1	5.7	6.8
Depressed or very unhappy?	10.2	39.8	43.2	6.8
Pleased about having accomplished something?	45.5	44.3	5.7	4.6
Bored?	10.2	38.6	44.3	6.8
Proud because someone complimented you on something you had done?	36.4	54.6	4.6	4.6
So restless you couldn't sit long in a chair?	11.4	26.1	56.8	5.7
That things were going your way?	26.1	56.8	9.1	8.0
Upset because someone criticized you?	8.0	50.0	37.5	4.6

Activities you are unable to do because of health problems	
Housework	11.4
Work	5.7
Go to School	2.3
Other	5.7
N/A	75.0

Activities for which you need assistance or supervision	
Dressing	1.1
N/A	98.9

Below are the quantitative results of the health determinants survey.

Table 3. Health Determinants results of surveyed sample[†].

Hours of work/week	1-9	8.0
	10-29	9.1
	30 +	38.7
Time of work	Evening Weekend	4.6
	Normal work week	53.4
Limitations of Work	Responsibilities at home	6.8
	Own illness or disability	5.7
	Going to school	2.3
	Full time work under 30 hrs/week	4.6
	Other	4.6
Employed in area of training	Yes	48.9
	No	5.7
	Received no training	3.4
Time from home to work	Less than 15 minutes	33.0
	15-29 minutes	18.2
	30-44 minutes	5.7
	45-59 minutes	0
	An hour or more	1.1
Method of getting to work	Drive own vehicle	42.1
	Public transportation and/or walk and/or share ride with others and/or bicycle and/or drive	12.5
Level of income compared to coworkers[**]	Low	14.8
	Medium	37.5
	High	4.6
Position of Authority**	Low	6.8
	Medium	35.2
	High	13.6
Economically Stable	Yes	47.7
	No	35.2
Does economic instability affect your health?	Yes	21.6
	No	19.3
Good relationship with co-workers	Yes	53.4
	No	3.4

** This is a subjective ranking using the opinion of the participants.

Stressful/Demanding Job	Yes	36.4
	No	22.7
Expecting a Pension	Yes	44.3
	No	20.5
Types of Protection[††]	Life Insurance	23.8
	Disability Insurance	11.9
	Unemployment Insurance	15.9
	Employee Pension Plan	15.9
	Private Pension Plan	8.0
	House/Apartment or Liability Insurance	16.6
	All	8.0
Lose Income due to sickness/injury (within last year)	No	11.4
	Yes; Compensation received	3.4
	Yes; Compensation not received	4.6
Spend Money on medical not covered by insurance (within last year)	Yes (Range $12 to $1500)	39.8
	No	43.2
Ever spend money on medical not covered by insurance	Yes (Range $10 to $5000)	50.0
	No	39.8
Healthy Residence	Very	46.6
	Somewhat	35.2
	Not at all	6.8
Healthy Community	Very	12.5
	Somewhat	58.0
	Not at all	12.5
Safe Workplace	Very	27.3
	Somewhat	28.4
	Not at all	1.1
Injured at Work	Yes	18.2
	No	46.6
Leave of absence due to injury	Yes	19.3
	No	46.6
Healthy Workplace	Healthy	27.3

[††] Percentages shown are the proportion of individual answers out total number of answers given. Participants were allowed to give more than one response.

	Somewhat	28.4
	Unhealthy	1.1
Leave of absence due to health problems	Yes	12.5
	No	51.1
Rate of current health	Very healthy	28.4
	Somewhat healthy	54.6
	Not healthy	9.1
Current health concerns	Yes	55.7
	No	35.2
History of these health concerns in the family	Yes	53.4
	No	13.6
Main Cause of death[††]	Stroke	10.5
	Heart disease	19.8
	Cancer	34.9
	Diabetes	7.0
	Heart Attack	7.0
	Old age	9.3
	Other	11.6
Diagnosis of long-term health problems[††]	Skin Allergies	4.6
	Hay Fever or Other Allergies	7.2
	High Blood Pressure	17.5
	Serious Back Problems	4.6
	Asthma	5.7
	Cancer	5.7
	Arthritis/Rheumatism	13.9
	Diabetes	7.2
	Stomach Ulcers	4.6
	Heart Disease	7.2
	Anemia	6.7
	Other	14.9
Health compared to males in the family	More healthy	26.1
	About the same	44.3
	Less healthy	20.5
Do men and women face the same health issues?	Yes	36.4
	No	58.0
Does one gender face more barriers to good health?	Yes	60.2
	No	27.3

If yes, which gender?	Men	11.4
	Women	48.9

Which factors affect the health status of women, men or both?

Health Factors	Women	Men	Both
Gender	21.6	3.4	37.8
Income	10.2	10.2	59.1
Education	10.2	9.1	59.1
Employment	13.6	9.1	54.6
Social support system	22.7	8.0	46.6
Social environments	19.3	2.3	52.3

Regular Doctor	Yes	86.4
	No	5.7
Last time you visited your doctor	Within last 2 weeks	28.5
	Within last month	20.5
	Last 3 months	21.6
	Last 6 months	13.6
	Last year	8.0
	Longer than a year	3.4
Do you feel able to meet personal health needs?	Yes	60.2
	No	31.8
Do you have enough :		
Time	Yes	53.4
	No	36.4
Money	Yes	42.1
	No	43.2
Knowledge about health issues	Yes	39.8
	No	47.7
If you have children/dependants who contributes more to their healthy development?	You	42.1
	Husband/partner	9.1
	You and Partner/relative	10.2
Do the proper circumstances exist all the time?	Yes	34.1
	No	27.3
Contacting your doctor	Easy	38.6
	Somewhat easy	35.2

	Somewhat difficult	13.6
	Difficult	5.7
Dental check up in last 12 months	Yes	60.2
	No	31.8
Currently on Medication	Yes	56.8
	No	36.4
Used more frequently	Prescription Drugs	56.8
	Over the counter medications	20.5
	Home Remedies	11.4
	Other	2.3
Have you ever had surgery?	Yes	80.7
	No	37.5
Asked for information about health during last 12 months?	Yes	53.6
	No	37.5
Where did you obtain the information? ††	Family Doctor	34.0
	Druggist	16.3
	Community Health Clinic	8.5
	Hospital Clinic or Emergency Department	8.5
	Friend or Relative	14.9
	Internet	6.4
	Other	11.3
Which of these services are found in your community? ††	Family Doctor	10.1
	Druggist	8.1
	Community Health Clinic	9.1
	Hospital Clinic or Emergency Department	4.2
	School or teacher	10.4
	Children's youth Clubs/Centres	7.1
	Daycare	12.0
	Church	13.0
	Library	5.8
	Nurse Practitioner	3.2
	Adult Education Centres/Programs	6.8
	Other	2.5

	All	5.8
	None	1.6
Are your health needs being met?	Yes	43.2
	Somewhat	42.1
	No	10.2
Are the health needs of your family being met?	Yes	39.8
	Somewhat	37.5
	No	11.4
Has your community been involved in any health initiatives?	Yes	34.1
	No	44.3
Would you participate in a community health initiative?	Yes	87.5
	No	6.8
Would you support a community health initiative	Yes	93.2
	No	2.3
Are you currently contributing to the health of your community?	Yes	52.3
	No	39.8

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Qualitative Analysis

The following review is an analysis of determinants of health put forward by the African Nova Scotian women who participated in this research. The analysis is based on the statements made during the focus group discussion transcriptions, notes prepared by the research team, written responses from the original questionnaire and from a quantitative evaluation of health concerns. Conclusions and overviews are extrapolated from the sentiments of the women and do not include those of the research team.

In dissecting each conversation, a number of health determinants were identified. Apart from genetics, the 6 major issues were found to be culture/lifestyle, racism, economics, gender, environment and health service/information quality (general and cultural). Each of these determinants will be explored further from the viewpoints of the Black Nova Scotian women surveyed in the study.

Culture and Lifestyle

From this study it was apparent that cultural differences in the Black community gave way to lifestyle choices and hence became a major determinant of health. There are several aspects of culture that play a role in the choices made by Black women. The first of these was upbringing and the skills and/or habits learned in childhood. The way in which parents handle situations relating to health concerns becomes imprinted in the minds of their children. Whether it be a positive or negative practice it is exercised by the child when they become an adult. It was mentioned that often the parent would dismiss symptoms of an illness and not visit a doctor. One woman stated, "*In my family we had 13 children and if you cut yourself we weren't taken to the doctor...this is what you learned.*" This type of environment could give way to a culture in which medical concerns are not seriously addressed or are taboo. Whether it is circumstances or simply a mindset passed down from generation to generation, this aspect very much shapes the current coping skills of these women. On the contrary an upbringing can breed proper self-care and positive role models can become a resource for good health practices:

> "*I had a good upbringing...coming from the people who I came [from] ... my family had strong women, but sometimes they were very discrete but very strong... Myself personally, I gained from people and other resources...that has increased my knowledge [and] I am very happy not only physically but within my spirit, my soul and my mind. That's where I developed and gained my knowledge.*"

It was also revealed that survival played a role in upbringing and thus a strength developed within. As such, coping with stress or illness is internally dealt with without the aid of medication or other persons. When women were asked about some of the ways in which they cope with disease, illness or stress we received an array of responses. The most common responses for personal self-remedy were mental or physical activity (hobbies, reading, playing music, exercise, housework, sex), home remedies, eating for comfort, secluding oneself (including sleeping, crying/catharsis, being withdrawn), keeping a positive attitude (using humour, dismissing painful feelings) and prayer. Religious and spiritual guidance was often mentioned as a resort for healing oneself physically and emotionally from an illness when medicine and health professionals have

not been entirely effective. This was yet another theme identified in upbringing. One woman states:

> *"I know when I was younger when I first went to a doctor, my goodness, you just didn't know what the doctor was, because a lot of the time our sickness was just prayed away...you didn't understand it but it's the primary key and it's always the last one you use."*

Although this may seem an extreme example of reliance on spirituality, it illustrates a key determinant for most of these women who feel it can acquire them positive mental and emotional well-being. Social support was yet another coping skill involving an external factor. In most cases it is exercised in seeking out family, friends, organizations (church, women's groups etc) and health professionals to deal with illness or stress. The popular opinion was that talking with others about problems and sharing emotions created a positive environment and fostered a sense of companionship.

> *"My support system is my family, my friends or a minister at church or someone whether it's [the] spiritual side of your life, it helps if you put your mind on something else, but for me that is my source of strength. If I didn't have that it would be very difficult for me."*

Since one can often feel alone in difficult circumstances, especially relating to health, this was a solution that came up repeatedly as an effective way to cope with stress, illness or disease and is a way to identify with others going through the same problems.

Social support as a method of coping brings us to another facet of culture, and was expressed frequently. Be it a result of background as mentioned previously or the need for privacy it would seem that certain health issues or health in general remains taboo and tends not to be discussed in families or among friends. This perhaps is a product of living in a small community as this sentiment was mostly expressed in rural residents. Indeed it is this outlook that inhibits a proliferation of knowledge and preserves myths and misinformation, especially in communities with little access to information and resources, a topic that will be discussed later. Being afflicted with a physical ailment such as breast cancer or even a mental illness such as depression seems to be inaccessible for discussion.

> *"In our community we were taught that health is a personal thing and we were told that we don't talk about it. Just like abuse, we don't talk about it in our community or at home - that is your business. That is a weakness. So for years you live with that."*

> *"My experience in the black community...depression is something that is constantly hidden. Now, nobody wants to identify or say that [they] are depressed. I don't know if it's [because of] lack of education or knowledge around depression...the Black population [is] afraid and ashamed to say that they're depressed. They won't take their medication because their medication...is a very common medication as to what [it is] used for."*

It is clear that a stigma is attached to mental illness, especially depression. The lack of an outlet to communicate the fears and concerns of an individual affected by this can lead to improper self-care. It is important to create awareness in these communities and, to some extent, desensitize the Black community to the frequency of depression, especially in

women, and other commonly diagnosed health issues. Women in the Black community had a tendency to let their condition worsen without seeking early medical intervention. This type of practice can lead to a higher degree of secondary preventative health care in the Black community and could be detrimental if these types of services were not readily available or accessible.

Amid the cultural dynamics lay another feature that was determined as an unhealthy lifestyle practice. It would seem that the diet of African Nova Scotian women is very much a by-product of environment, economics and background.

"By culture alone we eat differently. We eat a lot of fried, fatty foods (soul food)"

This statement represents sentiments that were articulated repeatedly in almost each community. Perhaps as a result of growing up in hardship, it was necessary for Black women to make do with what was available, having very little money to buy food. In generations to come this type of diet was passed down as a lifestyle that is celebrated as a part of Black heritage. Ultimately, the cooking and eating practices of Black women are affected and the habit of eating foods high in calories is almost inevitable. If one is able to break this habit succeeded to them, economic circumstances may not allow the purchase of healthy foods. In some cases, women stated that they did not have the means to follow a consistent diet of healthy foods or to comply with the Canadian Food Guidelines. On the contrary, this aspect had a positive affect on one woman who told us she could not afford store brand baby foods and thus had to make her own, which turned out to be healthier for her infant.

One woman from an urban area discussed an interesting component to the deterrence of healthy eating practices. She stated that she gave her children healthy foods to eat at school, such as a salad with water, however she was concerned that such a practice would be looked upon as "White" culture. An interpretation of this sentiment could be the disdain towards healthy eating habits and one could go so far as to suggest this as a denial of racial and/or cultural identity in one of its purest forms.

The best way to encapsulate culture as a determinant is with a quote from a woman in Shelburne:

"I see three generations sitting here. Emotionally, some of them had to go through a lot, some of them are single parents, they have support from their family, and they go through a lot of ridicule, but they have learned to cope. Physically they are strong. They learned how to cook food from nothing and learned how to sew and do a lot of housework for other people. The next generation, they are lucky..."

Racism

While some claim that it is a subtle and intangible experience and others tell stories of more blatant experiences, racism, admittedly, can and does affect Black Nova Scotian women in many areas of their life. The inability to get employment or to increase in the corporate ladder financially and in status can cripple the well-being and health of the Black woman and her family. Having to battle prejudice on a daily basis can cause quite a bit of stress and this battle is likely to be a constant struggle throughout life. In a more direct way, women have expressed that racism within the healthcare profession itself can overlook the necessities of Black women and consequently dismiss their health needs as a non-priority. The reason for this disregard was offered by several women who felt that doctors held a stereotypical view of the "strong" Black woman who is able to cope with illness themselves at all times. It is not realized that Black women, regardless of displaying characteristics of strength, need to be nurtured and taken care of. There were several stories from women who experienced blatant racism by doctors and other members of the health care profession. In most of the stories recounted, certain stereotypes of Black women were assumed.

> *"I'll tell you a personal situation. Last Christmas I had to take my mother to the hospital. She had gotten very sick and she couldn't wake up, she was off balance, the whole bit. We took her to the out-patients [but] she couldn't stay awake, so this intern came into the emergency side and started to check her over, and she would wake up in between to try and answer some questions. He started asking her personal questions that wouldn't have helped her, about her income, and how could she afford this and that. I said 'Excuse me. Is this going to help her condition?' But for me that was racism. He felt my mother had no income."*

> *"Well I had a friend [and] she had something wrong with her hands, so he took out a little table assuming she didn't know anything and he was explaining, 'This is the dermis and the epidermis...' treating her like she was 3 years old. Little did he know [that] she went to Carlton University...Then what happened was he had to leave her for a few minutes and he came back [and] he said, 'This woman is always washing her hands,' and my friend said, 'She has OCD,' and he said, 'Oh! How do you know?' "*

> *"I have two White friends that have taken their children to the same exact doctor [as me]. They love this doctor and I say, 'No. I can't. I don't like this doctor...' They do love him and they're there all the time...they ask questions and I say what is the problem? Maybe he just doesn't like my personality"*

> *"The doctor tried to convince me and my mother that I was pregnant. I said, 'It must be immaculate conception.' I was in emergency screaming in pain. My mom was White, I don't know if that made a difference but he tried to convince my mother that I was pregnant, I <u>had</u> to be pregnant. I kept saying,*

'I hadn't had sex. I can't be pregnant.' He ignored me looked at my mother and said, "I think your daughter's lying. I think she's pregnant.'"

"I called a doctor and I was in severe pain, I needed a house call and what was the first thing out of the doctor's mouth? 'I do not carry narcotics in my bag,' I wasn't asking you for narcotics I was asking you for assistance. Actually that was the time my gall bladder had exploded and I needed emergency surgery."

From these examples of prejudice it is easy to identify common misconceptions and stereotypes of Black women. Assumptions of poverty, unintelligence, disagreeable personality, drug use and sexual promiscuity are able to skew the judgments of health professionals thus abandoning the rights of Black women to appropriate, objective healthcare. This type of bias tends to follow a regime of merely prescribing medications without explaining the problem to patients (as in the case below) or simply not investigating the problem at all and presuming the cause of the illness based on race alone, leading to diagnosis of stereotypical Black illnesses when it is possible that it may be something else. Many women told us of these types of instances and had experienced them with their children. These approaches hinder proper treatment and contribute to meagre health services.

"My experience as a black woman, I [would] tell [my doctor] all the problems and everything. They'd go through the examination and everything and other than, 'Hi. How are you?' [they'd] get me a vital statistic and would actually give examinations and write out a prescription. I walked out of the office and someone asked, 'So, what's wrong?' and I would say, 'I don't know, he didn't tell me. He just gave me these pills. I have no idea.' This went on for a year...I had to ask what was wrong with me before they would tell me...They're just writing prescriptions again and not asking me or asking, 'Are you allergic to anything?'... I only got sicker and I'd go back and say I'm worse and then they would say, 'Try this,' and never, 'What's wrong?' I think part of it was my fault, by this time I should have known better. I think I was in Ontario before I found out that I was lactose intolerant [and] drinking lot's of milk and lot's of dairy products all my life...but they never told me that. So I was taking pills and drinking milk and eating iced cream, I mean, I was doubled up. I could spend hours in the bathroom, I couldn't move and it was just the case of too much dairy products. It was killing me, and after I went to Toronto the doctor asked me, 'Why are you drinking milk? Why are you eating this amount of dairy products when you know what it does to your body?' I never knew."

This case envelops many other factors which tie into the status of Black women's health, including the need for appropriate health care and information, and the education of not only the patients but of health care professionals as well. These factors will be described later.

Many women experience a lack of respect when being treated by a physician or when entering a healthcare facility, however this respect is afforded to their White counterparts. Behaviour regarded as unacceptable can involve the doctor not wanting to touch the patient, or lack of eye contact or comments made.

> *"I don't know if this is discrimination or not but [when] my doctor's not giving me eye contact he makes me feel uncomfortable. The first time I had my pap smear test I decided to go to the Well Women's clinic at the IWK and I said to my husband, 'I will never go to that doctor again and let him put that thing in me. I will start going to the Well Women's clinic where I feel more comfortable...' Well that's what I chalked it up to be – he made me feel uncomfortable by not giving me eye contact."*

> *"In an emergency room sometimes you'll hear people talking in the back and they'll say, 'Oh Mrs. Johnson's doing this, and Mr. so and so is doing okay and the Black guy down there...' it's like he doesn't have a name. They do that a lot. It's those kinds of things, so from the minute you're entering the door you feel it. So it may not be the individual doctor who's racist against you but to be hearing those kinds of things like, 'The Black lady sitting over there,' but everybody else is Mrs. so and so."*

Observable racism of doctors is rare and most of the women agreed on this. Instead they felt it was subtler at times, as in the cases above, and even more so in the medical community. It was a common belief that systemic racism does subsist and some women having not experienced racism in their efforts to receive appropriate health care, admitted that they know it exists.

Health Service and Information Quality (General and Cultural)

In each of the examples of racism above, it is evident in each case that proper doctor-patient interaction was key and essential for diagnosis, treatment and communication. The women from these communities had a great deal to say concerning the relationship between themselves, their doctors and the health care system. Misdiagnosis was a common occurrence. A number of women recounted stories of poor diagnostics and treatments, which in turn caused stress to them and their families. As mentioned earlier, bias can contribute to improper diagnosis and treatment, however it is often unnoticeable and women can more easily identify receiving erroneous advice or treatment.

> *"I went to a doctor that told me I had shingles. I had little blotches and little bumps, a few on my legs, a few on my arms, a few on my back and she said I had shingles. She wrote me out a prescription for an over-the-counter medication that cost me $20.00. I went to my doctor and told him that I went to outpatients last night and told him that Dr. so and so told me I had shingles and he said, 'You don't have shingles,' and I said, 'I didn't think I did and that's why I'm here today.' Shingles doesn't appear in little tiny bumps on a lot of different areas of your body."*

"I had a friend who was dying with cancer and they said she had the flu. They kept giving her prescriptions for this and for that, they thought it was pneumonia [and] it was lung cancer."

In addition to misdiagnosis, some of the women said their doctor was writing prescription after prescription for their illness, with limited enquiry of their symptoms - a problem that may stem from, not only the doctor, but the education of the patient with regards to their own general health and the health issues specific to African Nova Scotian women. Currently there is a lack of information concerning certain illnesses that specific to Black women in Canada. In each community the question was asked, *Do you feel you have enough information on Black health issues?* Overwhelmingly, the answer was "No", as there was none readily available. It would seem that any information made available in regards to women's health is based on studies done predominantly on White women. Such a disregard for the genetic predisposition of Black women to certain illnesses such as breast cancer, asthma, diabetes, heart disease and a host of other illnesses impedes their opportunity to learn about these specific health issues and make an educated self-diagnosis for themselves and their children. It also prevents the ability to ask educated questions if they feel a misdiagnosis has occurred. This came up as an issue, since the lack of education related to health often left Black women feeling intimidated by their doctors – an authority that was not to be questioned. If the women are armed with the information to ask informed and relevant questions about the illness, the symptoms and the medication doctors may be more likely to go out of their way to find the information for them.

Although many of the women said their doctor did not have adequate information regarding various Black health issues, they felt that their doctor would try and find it for them providing the information was readily available.

"You won't go to your average medical centre and pick up hardly any pamphlets on black people's health concerns."

While most women received health information from their family doctor, other common sources were the pharmacy/druggist, community health centre, hospital clinic/emergency department and friends or relatives. The Internet was also indicated as a place to get information specific to Black women.

"Information regarding diseases that affect people of my culture is not readily available. Thank God for the Internet."

Each community had some awareness of certain health concerns that affected people of African descent, and among those mentioned were sickle cell anemia, diabetes, high blood pressure, breast cancer and lactose intolerance. It was stated a few times that while society has become more tolerant and multiculturalism has flourished, it has established a mentality of unity and equality in terms of social respects, which has spilled over into corporal territory. Doctors may fall into this view in terms of health concerns, regardless of their medical education and treat Black women and other ethnic groups in the same manner as their White counterparts.

"We do not have the same type of illnesses. Like how you treat diabetes in a White woman and/or another person of culture may not be treated the same

way...especially cancer, even high blood pressure...Some medications we take make us sicker before they make us better because we are women of colour."

Unfamiliarity with Black health issues in the doctor's office can lead to misdiagnosis and improper treatment as mentioned above. Although these differences are not well identified or may not even exist, it was felt that more research was needed to investigate any divergence in the way Black women are affected by certain illnesses compared to White women, and proper treatment to correspond with these differences must be followed.

In terms of the general and/or health services available in each community, women felt that there was a lack of specific services that could cater to their needs as well as the needs of their community. Women's clinics, counselling services, addiction services, crime prevention or community initiatives were some of the services that were mentioned as a way to decrease the pressures of daily life and increase family lifestyle practices.

Cultural education of health professionals is imperative and should begin early. Information on the subject of Black health must become available in the health profession to ensure that doctors are aware of the differences in treatment and diagnosis:

"I go to my doctor and my doctor doesn't say you are more prevalent to this, that and the other because you're Black. You're doctor doesn't say that. Now this is the person that is expected to tell me [about] my child, and you should be able to tell them about sickle cell anemia and some of the allergies. I mean, a lot of our children have allergies and some are allergic to milk and they don't tell you those things. They don't know"

The need for racial and cultural awareness was mentioned time after time. The opportunity to learn and to educate must be given and must be implemented from elementary school to medical school to prepare doctors and other health professionals for encountering persons of different backgrounds.

"In medical schools they teach you how to identify paleness in White people and it does not apply to us. There is a way, but they don't do it by skin colour for jaundice or gangrene or discoloration, so naturally they would miss it...We are going to be misdiagnosed."

In one case, a woman recounted an experience with her doctor, in which her doctor could not tell if there was swelling in her leg due to her skin tone. Most likely, there are many women of colour who, because of skin colour, have experienced this same scenario. Whether it is a blemish or a discolouration, doctors must be better trained when it comes to they're diagnostic skills and even more so when dealing with a range of diverse ethnicities.

It was frequently stated that White doctors simply could not identify with the needs and expectations of African Nova Scotian women, and their ignorance to practiced culture, described earlier, may be an obstruction to providing optimal care. The obvious problem was that there were little to no Black doctors practicing, especially in and around the smaller communities. Going to a Black doctor, especially if it was a woman, was an idea that provided comfort and safety. It was also felt that a Black doctor would be more likely than a White doctor to familiarize him/herself with specific Black health issues, would be more sympathetic and additionally, the difficulty of racism would cease to exist.

"I don't feel there are enough black women physiatrists. Why would I want to go to a White physiatrist, which is still a good physiatrist, to talk about how I feel? What [does] she have to offer? She doesn't know. I feel the concerns are different and if you're having metal health problems no matter how big or small, I think it would be more important to have a black person to talk to who might have had the same problems. There aren't enough. I don't think there are any in this city."

Regardless of race or gender, it was clear that the women had criticisms about the comportment of their doctors with patients in general. They felt that doctors were lazy, not personable and were unwilling to admit not having the knowledge to properly treat their illness. They stated that a poor medical practice was no excuse for this.

Environment

The right environment in every sense can shape lifestyle practices, provide adequate and accessible health services or directly contribute one's health condition. Obligations to family and the strains of family life can greatly impact women and cause an undue amount of stress. Having to raise a family and also deal with the stresses of work can compound on a daily basis and lead to serious health problems. Becoming exposed to this type of environment is usually an onus of women and being the primary caregivers the issue of social role comes into effect, this shall be discussed shortly. Social environment can significantly influence emotional and mental well being having either a negative or positive effect on coping strategy and health. Negativity within the home can breed a negative state of mind thus weighing heavily on a woman. Physical abuse, violent neighbourhoods, antagonistic co-workers, or even taking care of many children without the aid of a partner, can be a trigger for emotional stress giving way to depression, high blood pressure (which was a common health concern) or even heart attacks. In such cases, it may be difficult for a woman to escape her circumstances and may need a better way to cope or, for more extreme cases, some type of intervention. Pollutants can often affect the health of a residence, as well as the neighbourhood in which one lives can affect the safety of a residence. It has been mentioned that crime, drugs and other unhealthy behaviours can play a part in the lives of young people and as a result influence the lifestyle of the people living in that community. One woman from the Halifax area stated that society can often pressure young Black women to follow into roles that are set by the community. This statement confirms that social influence can propagate and lead to unhealthy choices from economics to employment to coping skills. One's environment can also provide opportunities such as employment or education, or it can create a positive multicultural environment where factors of discrimination or lack of cultural knowledge do not come into play, as expressed by one woman, *"The doctors are a lot better in Toronto...it's a multicultural city."*

Environment is, most importantly, inclusive of living conditions and the quality of the natural environment. While this condition was frequently agreed upon as a main determinant of health, most of the communities were not affected by serious environmental problems.

"We don't have chemical plants, we don't have any tar ponds...It is basically clean business and they're not stuffing toxic waste in your back yard I don't' think we have that many issues..."

"I live in the country so we have nice fresh air every morning."

While some women stated that there were no major concerns regarding environmental issues, most of the communities did not bring up any natural environmental problems at all. However, there was no community more affected by their natural environment like Whitney Pier in Sydney. As a result of the tar ponds, the coke ovens and the local steel plant, pollution has caused the residents unfit living conditions. Toxic water, air and land has given these women a great deal to agonize over.

"Living on contaminated property with the unsafe chemicals found in basements and outdoors. This is the result of years of steel making and nearby tar ponds."

It is unimaginable to identify with the stress created in such an environment and disappointingly it is a determinant for which changing one's circumstance is entirely dependant on those who have the political and financial power to do so.

External environment is a basis of the living conditions in the home or even the workplace. One's living condition may also be a result of financial troubles and one can end up living is a residence consisting of dangerous chemical fumes, shoddy carpentry or electrical work or an unstable foundation – these are settings from which stress is created or serious physical health may be in jeopardy.

Economics and Employment

One of the most important determinants to good health was the effort to provide financially for oneself and for one's family. Receiving and maintaining employment seemed to be a struggle for some and was mainly due to racial barriers or simply limited options in the job market.

> *"Over all it's a struggle to find and to have a good job and be sure of making a decent wage with what your trained for. [It's] very hard here, there's lots of other jobs – lower scale paying jobs, but it doesn't always help when you have a family or just trying to start out. There's not really a good broad range of employment in this area."*

> *"I work part-time and I work 3 days a week and my pay scale for the education I have, my pay scale is not up there and I don't have any help for dental or medical...I can't afford it."*

Often, as in these cases, it is hard to find reasonable employment even when it is matched with an acceptable educational background. Apart from this reason racism can play a part in receiving employment. For some it is an observed trend to not see a large number of minorities working in the larger community. There seems be inequality when trying to acquire high status, high authority positions with some stability in some communities.

> *"Around here a lot of our people work in the fish plants and it's just seasonal work."*

Economics seemed to be a common association for all factors relating to health causing stress, depression and directly affecting the ability to purchase medications.

> *"If you had asthma, and you can control it and you can't afford to buy the steroid which you need to control the asthma [because] it costs $80. If you can't get it, it's going to make your asthma worse."*

For the most part, the ability to buy medication was of paramount concern. Most of the women felt it was very expensive to take care of an illness with the prices of some medications especially when holding a job with little to no health benefits.

> *"I can't afford for my kids to eat and go to the dentist, I mean, my kids haven't been to a dentist, I bet you, in a good ten years. It's like you're paying $80 to $100 just for a check-up and a cleaning and if you want them to have good teeth and be healthy then it's every 6 months."*

There was some disapproval as it was felt that the medical community was centred on money and relying on the return of patients (such as dental visits) who needed more care or medication. As a result, this type of financial burden can lead patients to neglect their own health and their family's health and essential doctor's visits may be set aside as unnecessary.

Gender/Social Role

There is no doubt that the social role of African Nova Scotian woman has a significant bearing on her health. As it has been stated, the role allotted to women carries great responsibility at home and, if a woman chooses to work, in the office. Pressures to raise children and contribute financially to their well-being and education can often create a negative, tension filled environment. With more that half of the women in this study holding employment, a delicate balance of family and work is often difficult to establish.

> *"Women don't take the time to look after themselves, to condition our own health. We don't have that kind of resource for our physical health, we don't exercise or eat properly."*

When confronted with numerous challenges and obstacles on a daily basis, it is no wonder that African Nova Scotian women tend to put aside their own personal health concerns and put the needs of their family first. Women find it selfish to put their health needs first and, in a sense, they see it as abandoning their responsibilities as a wife and/or mother.

> *"What I find with Black women is that they have a tendency to forget their own individuality, and I went through that stage from the first ten years of my marriage and I had forgotten that I had a life too...My focus was just around this husband and keeping this house clean ..."*

Health does not seem to be a priority as it was often stated that Black women tend not to see a doctor until a symptom becomes intolerable and eventually makes them sicker.

Apart from the pressures of raising a family, women tend to respond positively to social support. Having a social network as a coping skill greatly reduces the stress of Black women and reinforces good lifestyle habits if her social support is knowledgeable and can pass on that knowledge.

CONCLUSION

It has been said that given the large contributing population of African-Nova Scotian women to the larger community, there should be more efforts to investigate their health issues. African Nova Scotian woman feel that research into Black women's health and the determinants discussed in this paper are necessary. Based on the discussions, women from these communities feel they are lacking information about general Black health concerns compared to other groups. There must be an effort to provide information about specific Black health concerns, supply information about services that are presently available, and delivering services that are not. Services should be offered within these communities that would provide a more secure and comfortable environment for these women without feeling discriminated against. The Black community is lacking in specific health and social services that would greatly benefit not only women but also every member of the community. An improvement in overcoming barriers to good health will consequently build a stronger Black community nearly devoid of other looming social concerns.