

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

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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 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.

A
Dialogue

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 Cooley
Internal Medicine
QEII Health Centre*

Dr. Cooley 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.