Health Association of African Canadians

Our Health is our Wealth

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Special Interest Articles:

Individual Highlights:

Co-chairs Corner - *Community Engagement in Research*

This has been a busy and exciting time for HAAC. Some of the health issues we have been involved with over the fall of 2013 are highlighted in this newsletter.

Through funding received from the IWK Community Grants and in partnership with the Association of Black Social Workers, a program to enhance women's health needs and concerns was developed. "Kitchen Table Talk" sessions were held in Halifax, East Preston, Windsor and Truro. African Nova Scotian women learned of the community supports available and community health professionals shared suggestions for healthy living.

This year, HAAC was approached by the Department of Health and Wellness to take the lead on the development of a mental health strategy to increase cultural competency among those who provide mental health care to African Nova Scotians. We are pleased to have Lana MacLean and Robert Wright as consultants on this project. We will develop a network of African Nova Scotian mental health providers and host an annual mental health forum to address the gaps in services.

Dr. Williams, an internationally recognized authority on social influences on health will be here in February. We continue to carry out health fairs and community health education sessions. We plan to host a circle (for men by men) soon, and our annual general meeting is being planned for April 2014. Happy New Year to all!

Donna Smith HAAC Co-chair

Engaging African NS Youth in Health Professions

Many African Nova Scotian youth are now more aware of the variety health professions. Over 150 African Nova Scotian youth in grades 9-12 attended one of two events organized this fall by Capital Health staff and two Community Health Boards (Halifax and Southeastern).

Black health professionals already working in Capital Health, IWK or other community organizations shared their passion and experience with the students and Bruce English, Director of People Services and Arlene MacAskill, Seniors Advisor of the IWK shared information about working in the health system.

A quick survey was taken at the end of both events and of the participants who completed the survey, 61% said yes; they will consider a career in health as a result of the events and 34% said maybe.

Funding and support came from many organizations including African Canadian Services Division (Dept. of Education), Africa Nova Scotian Affairs, Black Educators Association, Schools Plus, Health Association of African Canadians, Global Health (Dalhousie), Transition Year Program, IWK and Capital Health

Anna Jacobs

We would like to thank everyone who provided content for this edition of our newsletter. Phyllis Marsh-Jarvis and Louise Adongo

George Borden - Persons of African Descent, Diabetes and Dialysis

A patients Testimony…

"You are probably already aware that we of African descent are by far and away the most likely race to become diabetic."

"*I direct my remarks to persons of African descent, mainly the menfolk; but not to omit our sisters…"*

Most people are aware of the common symptoms relating to diabetes, i.e. lack of energy, blurred vision, dramatic weight lost, frequent urination, etc. However, very few are aware that prolonged and untreated diabetes can, and frequently does, lead to loss of kidney function and eventually to dialysis.

Dialysis! What's dialysis? If you don't know what dialysis is, and you can't spell it, then perhaps you should continue reading.

Dialysis is a medical treatment requiring that you be connected by needles or tubes to a free standing robotic-like machine designed to withdraw your blood, clean it and return it to you.

The standard process is three to five hours in duration, and must normally be performed three days a week. Doesn't sound so comfortable or convenient does it? Well, it isn't very comfortable or convenient to be lying or half-sitting in a fixed and passive position hooked up to a machine for that period of time. Such is the life of a dialysis patient. I'm a dialysis patient, so I know…

So why am I telling you this? Well, if you are of African descent, then you need to know what your chances are for becoming a "dialysis patient".

You are probably already aware that we of African descent are by far and away the most likely race to become diabetic. All the research and statistics tell us so. That having been said, it therefore follows that we of African descent are at very high risk of experiencing prolonged and maybe inadequately treated diabetes culminating in the loss of kidney function resulting in life-long dialysis treatment. Remember what I said about the ills and woes of dialysis?

Let me tell you, I was totally surprised when I was informed that my kidneys were failing so badly that I would have to start dialysis. That came as a shock because I didn't even know what dialysis was. In fact I couldn't even spell it. Oh yes, I knew I was a diabetic; but I didn't feel so unhealthy as to suffer kidney loss. I was wrong!

I was given three choices of dialysis treatment. One involved oversized needles in my arm (one in a vein, the other in an artery) which turned me off totally. Another involved a catheter permanently inserted in my abdomen, which would be connected to tubes by which urine is drained from the bladder. That made me most uncomfortable even to imagine. So, like "Goldie Locks", I chose treatment number three, to me the least invasive and the least frightening.

My choice involves permanently inserting a catheter into the main blood vessel in my front right shoulder at the torso and neck line, leading to my head. Two tube-like lines are connected to the catheter, through which blood passes from and to my body. It is painless but extremely boring most of the time. The catheter is covered at all times to prevent infections. Now and again some incident may occur within my body or within the machine. Fortunately, there are competent nurses present to readjust and correct the process.

Because of my age and other medical issues, I am ineligible for a kidney transplant, so me and my machine will be a twosome to the end. As I hinted earlier, this is not a convenient or comfortable life-style and is totally void of personal independence. My travel life is extremely limited given that I must be near and hooked up to a dialyzer every other day. And, dialysis units are not like corner grocery stores, they are in fact few and far between.

I was, in the past, very active in all manner of events, festivals, sports, etc. But with so much of my time commanded by dialysis, I can only attend off-day happenings. Dialysis can also alter your meal time habits, at both ends of your treatment times. Equally distracting, is the stress, strain inconvenience placed on family members and caregivers required for transport to and from the dialysis unit. Again I direct my remarks to persons of African descent, mainly the menfolk; but not to omit our sisters, them as well. We are the product of our heritage which renders us most susceptible to diabetes, inadequate health care and eventual loss of kidney function...thus dialysis.

"We black Nova Scotians must be alert to the extremely high ratio of our men who fall prey to diabetes and subsequent kidney dysfunction resulting in renal dialysis treatment"

Consider this! In my little corner of the Dialysis Unit which I attend, there are six (6) of us (black males) each on a machine within an eight (8) hour period (2 shifts), three days a week. The maximum capacity for the unit is ten (10) per shift, while the average attendance is nine (9), so that is a max of twenty (20), and an average of 18, over eight (8) hours. So we folks of African descent comprises six (6) out of (18) patients, that is one third – 33%. Compare that with our population ratio of one thirtieth 3.3%. What's wrong with this picture? Truly, cause for thought.
We black Nova Scotians must be alert to the extremely high ratio of our men who fall prey to diabetes and subsequent kidney dysfunction resulting in renal dialysis treatment. If you wish not to end your days in that situation, watch your blood sugars, listen to your physician, take care of your health and avoid one of the most inconvenient and uncomfortable medical afflictions you can imagine. Now, I'm not saying that you can't live a relatively normal life on dialysis, but you will no longer hold control of your life, as you do now. Not something to look forward to. I tell you from firsthand experience. Don't make the same mistake I made by not attending to personal health business, when I could have and should have done so. My best wishes to you! *George A. Borden - Dialysis Patient*

Healthy Living – Kitchen Table Chats

The IWK Health Centre has been generous in supporting HAAC with a grant to provide culturally competent health education for African Nova Scotian (ANS) Women in four (2 rural, 2 urban) communities.

The four communities are; Annapolis Valley, Truro, Halifax North End, and East Preston. As part of our project, HAAC will offer a series (4) of health /wellness related topics to a minimum of 6 individuals within the community.

We have chosen to use the 'kitchen table discourse' as our form of communication to encourage an informal discussion. We have been extremely fortunate to have the support from members of each of these communities, who have volunteered to open their home to host these health- related sessions.

To date, HAAC has held two of the four health sessions within the North End of Halifax. The participation from local residents has been excellent. Participants have commented on the ease of participation and the level of comfort they have in expressing their thoughts and health related needs as a community.

Participants continue to identify gaps within the health system and have been useful in providing suggestions in narrowing the gaps. HAAC aims to continue to support communities and ANS women in receiving the best health services available to them.

"Health sessions within the North End of Halifax will be completed by the end of July. The next area to host these health education sessions is the Annapolis Valley region. To learn more about our project, feel free to contact Edith Bennett at edith.bennett@mail.mcgill.ca

SICKLE CELL DISEASE ASSOCIATION OF CANADA
ASSOCIATION D'ANEMIE FALCIFORME DU CANADA

Sickle Cell screening for children … An announcement of the inclusion of Sickle Cell Disease and 9 other conditions by the Nova Scotia Minister of Health was made at IWK in Halifax, Nova Scotia on April 22nd, 2013

The Social Determinants of Health

COMING SOON!
We will be starting a series profiling the social determinants of health on our website (www.haac.ca).

The social determinants of health influence the health of populations.
They include income and social status; social support networks; education; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; gender; and culture.

Source: http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/

HAAC – Focus on NS Health Service Research

Hep NS research report

Throughout February and March of this year, HepNS conducted a short community outreach project to get a sense of how hepatitis C was affecting, being talked about or being addressed in the African, Caribbean and Black communities in the HRM. The ideas and suggestions from the community consultations and workshops conducted through this project, encourages us to continue dialogues with like agencies, look for community partnerships in hepatitis prevention work and how to make our workshops more effective for all communities. The report is available on our HAAC website (www.haac.ca). If you have any questions about the report or the work of HepNS, please feel free to connect directly with HepNS Executive Director Colin Green at director@hepns.ca

HepNS

Cancer Care NS research report

Cancer Care Nova Scotia
Many hearts. Many minds. One goal.

Learning that you or someone close to you has cancer is life-changing, and because culture and life experience defines who we are, it is not surprising that our needs within the formal health system will vary accordingly.

In 2012, Cancer Care NS (CCNS) conducted a series of focus groups in five ANS communities (Yarmouth, Tracadie, Whitney Pier, North and East Preston and metro Halifax) to find out if the organization's efforts had resulted in an improved experience for African Nova Scotians.

Although the African Nova Scotian experience with the cancer system has greatly improved, the work is not yet complete, as some African Nova Scotians continue to:

- experience systemic racism, particularly within primary health care settings;
- encounter delays in accessing cancer specialist services;
- hold misconceptions regarding cancer and its treatment;
- face challenges in communicating with health professionals;
- struggle in making informed decisions about their care; and
- face barriers with respect to transportation, medication costs, other financial issues and geographic isolation.

CCNS appreciates the contribution of all who took time to share their experience through focus groups.

Their contribution provides CCNS and others with information that will help us re-focus our efforts as we continue our work to improve the African Nova Scotian experience with the province's cancer system.

Over the coming months, CCNS will also be meeting with a variety of stakeholders to explore how to address the broader health system and research issues raised in this report. For the full story and more information read the Cancer Care NS report at HAAC's website (www.haac.ca)

NS HIV/AIDS surveillance report

Our Health – What We Should Know About Sexually Transmitted Diseases (STDs) or Infections (STIs) *NS Specific Information - Adapted from the NS Surveillance Report on HIV/AIDS in Nova Scotia: 1983-2011(Population Health Assessment and*

Dear HAAC Friends,

The following information from the US Center for Disease Control was written targeting African Americans.

We have adapted it and added excerpts from the Nova Scotia Surveillance Report on HIV/AIDS in Nova Scotia: 1983-2011(Population Health Assessment and Surveillance). We wanted to share information that was relevant to African Descended People living in Nova Scotia.

HAAC continues our work in the spirit of thriving with good health of mind, body and spirit. We are working to encourage the development of culturally specific, African Canadian health information from right here at home while continuing to share health information that is important to you and your family.

Reports by Race/Ethnicity

Surveillance information on HIV in Canada and worldwide often includes information on race/ethnicity because systemic and structural inequalities that increase vulnerability to HIV infection (such as poverty and lack of access to health services) may be more prevalent in certain ethnic groups.

In the first years of the HIV epidemic in Nova Scotia, nearly all cases in Nova Scotia with reported race/ethnicity information were White.

Since that time, the number and proportion of White cases has declined. While the proportion of cases in non- White race/ethnicity groups has increased over time, the absolute number of these cases has remained relatively constant, with an average of 3 (range of 0 to 8) cases reported per year.

Between 2002 and 2011, 81.9% of reported HIV cases were White.

Black cases accounted for the next largest race/ethnicity group, at 10.6% of all cases. According to the Census visible minority and Aboriginal identity data, 2.0% of Nova Scotia residents self-identified as Black, 2.6% self-identified as Aboriginal, and 1.6% self-identified as Asian, Latin American or another visible minority. All of these populations appear to be slightly overrepresented in Nova Scotia HIV cases.

The likelihood of identification by race/ethnicity may differ between the Census and through HIV case follow up, making the comparison between these two data sources difficult to interpret. Demographics and exposure categories for HIV cases can provide some insight into trends in reported cases by race/ethnicity.

For Black cases, the age and geographic distributions were similar to the distributions for all HIV cases. However, 40.0% of the Black cases were female, which is higher than the overall percentage of female cases (17.5%).

Of the Black cases, 70.0% were born outside of Canada, and the exposure category for the majority of the cases (60.0%) was origin from an HIV-endemic country.

As previously noted, cases in this exposure category may have acquired their infections outside of Nova Scotia, and so it is likely that some of the Black HIV cases included in provincial surveillance data are not reflective of disease acquisition within the province.

Sharon Davis-Murdoch

The Health Association of African Canadians (HAAC) invites you to a community event discussing the impact of racism on physical and mental health to be held with Dr. David Williams of Harvard School of Public Health. This event is hosted in partnership with Cancer Care Nova Scotia, Capital District Health Authority and Dalhousie University.

Date: February 10, 2014,
Time: TBA (evening),
Location: NSCC Waterfront Campus, Dartmouth

We're on the Web!
See us at:
www.haac.ca

About HAAC …

The Health Association of African Canadians (HAAC) was formed in 2000 to address African Canadian health issues and the system inequities affecting health. Prompting the formation of HAAC was a project was sponsored by the Dalhousie School of Nursing and the Atlantic Center of Excellence for Women's Health.

The project focused on women's health but stakeholders quickly acknowledged that women's health could not be examined in isolation. Thus, HAAC was formed with the understanding that women's health was a subset of the health of the entire family.

Today, HAAC has a broad mandate and ready to implement a business plan with the goals, objectives and deliverables to meet its needs.