

Résumé

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## Déterminants de la santé des femmes noires dans les communautés rurales et éloignées

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Les instigatrices du projet *On the Margins* se sont attachées à étudier l'état de santé, la prestation des soins et la fréquentation des services de santé au sein de la population des femmes afro-canadiennes vivant dans les régions rurales et éloignées de la Nouvelle-Écosse. On a fait appel à un modèle de recherche-action participative et procédé à la triangulation des méthodes de collecte de données — entrevues, groupes de discussion et questionnaires. Le codage et l'analyse des données ont été effectués au moyen du logiciel de gestion *Atlas ti*. Six thèmes s'en dégagent : les rôles multiples des femmes noires; les perceptions en matière de santé; les expériences relatives au système de santé; les facteurs qui influent sur la santé; les stratégies de gestion de la santé; et les solutions envisagées. Les auteures se concentrent sur l'un de ces thèmes, soit les facteurs qui influent sur la santé, et proposent une analyse de trois sous-thèmes connexes : race et racisme; pauvreté et chômage; et accès aux soins de santé.

Mots clés : femmes noires, déterminants de la santé, racisme, communautés rurales

# Determinants of Black Women's Health in Rural and Remote Communities

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The On the Margins project investigated health status, health-care delivery, and use of health services among African-Canadian women residing in rural and remote regions of the province of Nova Scotia. A participatory action research approach provided a framework for the study. Triangulation of data-collection methods — interviews, focus groups, and questionnaires — formed the basis of data generation. A total of 237 in-depth one-on-one interviews were conducted and coded verbatim. *Atlas-ti* data-management software was used to facilitate coding and analysis. Six themes emerged from the data: Black women's multiple roles, perceptions of health, experiences with the health-care system, factors affecting health, strategies for managing health, and envisioning solutions. The authors focus on 1 of these themes, factors affecting Black women's health, and discuss 3 subthemes: race and racism, poverty and unemployment, and access to health care.

Keywords: Black women, health determinants, racism, rural communities

## Background

Discrepancies in health are intimately associated with differences in social, economic, cultural, and political circumstances (Aday, 1993; Backlund, Sorlie, & Johnson, 1996; Bloom, 2001; Brown, 1995; Chen & Fou, 2002; Rogers, 1997). Economic inequities, in particular, have been implicated in poor health. Individuals of lower socio-economic status are at a much greater risk of illness and are much less likely to have timely access to health and social services than individuals of higher socio-economic status (Hay, 1994; Lynch, 1996; Lynch, Kaplan, & Shema, 1997; Pappas, Queen, Hadden, & Fisher, 1993; Poland, Coburn, Robertson, & Eakin, 1998). Yet while researchers have amply demonstrated the effects of such determinants on the health of people in Black communities, the vast majority of health research on Black women, men, and children originates in the United States, and only a small number of needs assessments and student theses focus on the health of African Canadians living in the province of Nova Scotia (Atwell & Atwell Human Resource Consultants, 2002; Enang, 1999; Enang, Edmonds, Amaratunga, & Atwell,

2001; Lawrence, 2000; Sharif, Dar, & Amaratunga, 2000; Thomas Bernard, 2001).

Current evidence suggests that the barriers to appropriate care and the health deficits faced by Black women in Canada are similar to those faced by African-American women, yet more definitive evidence on the circumstances and experiences of African Canadians is required (Enang, 2002). In addition, American and Canadian research on people of African descent tends to focus on urban conditions and experiences (Calvert, 1997; Dana, 2002; Enang, 1999; Enang et al., 2001; Geronimus, 1992; Graham, Raines, Andrews, & Mensah, 2001; Schulz et al., 2000). The challenges of accessing appropriate health services may be greater or simply different in rural and remote communities, and solutions recommended for African Americans living in the inner city may have limited value for African Canadians living along the south and west shores of Nova Scotia (Atwell & Atwell Human Resource Consultants, 2002).

Another shortcoming of health research with respect to marginalized populations is the fact that many studies are conducted *on* rather than *with* communities (Acker, Barry, & Esseveld, 1991; Maguire, 1987; Mays & Pope, 2000; Nielsen, 1990). In the absence of genuine partnerships between communities and academic researchers, the questions posed by investigators, the instruments designed to answer those questions, and the conclusions reached may not be meaningful for the people being studied (Dickson & Green, 2001; Douglas, 1998; Richard & Jagielski, 1999; Sullivan, Kone, Senturia, & Chrisman, 2001). These factors not only serve to devalue the experiences and expertise of African Canadians but can lead to misunderstanding or misidentification of the problems facing Black people and to inappropriate solutions. Local Black researchers point out that health-care providers often do not understand the needs of Black women, while academic researchers tend to impose biomedical definitions of health and care, ignoring the ways in which Black women view and manage their own health and that of their families (Crawley, 1998; Edmonds, 2001; Fraser & Reddick, 1997). African Canadians constitute one of the largest visible minorities in the country and have lived throughout Nova Scotia for centuries. Yet they remain socially, economically, and politically disadvantaged and are underrepresented in health-care delivery, in health research, and in the design and implementation of health policy. As a result, there is a critical gap in research-based knowledge with respect to the health issues of Black Nova Scotians.

### **Objectives and Procedure**

The On the Margins project was designed to investigate health status, health-care delivery, and health-services utilization among African

Canadians residing in rural and remote regions of Nova Scotia from the perspectives of both community members and academic researchers. Its specific research objectives were to raise awareness of the issues that affect the health status of African Canadians living in southwest Nova Scotia, to establish collaborative research partnerships with Black communities, and to build the community capacity needed to eliminate barriers to health and appropriate health care.

The project combined qualitative and quantitative research methods, as well as a participatory action research (PAR) approach, to explore the intersecting inequities that compromise the health and health care of African women in Nova Scotia, their families, and their communities. Because each methodology has specific strengths, produces specific kinds of information, and creates specific relationships among investigators, use of a mixed methodology not only produced much needed insight into the health of African-Canadian women and their families but also allowed for triangulation of research methodologies and research perspectives, which enhanced the rigour of the research process and the significance and validity of the findings (Kirk & Miller, 1986; Mays & Pope, 2000).

The PAR approach combined community action and capacity-building. Three Community Facilitators were hired for the duration of the study. Each possessed a high degree of motivation and had close ties with the community, and each was trained in the PAR paradigm, Black people's health issues, focus group facilitation, and interview techniques, ready to gather information about the needs and experiences of Black women, families, and communities. The Community Facilitators were also trained in information technology skills and furnished with computer equipment and Internet access so that they could gather and disseminate health information to members of the Black community.

A prototype semi-structured interview was developed by the research team, but the Community Facilitators were instrumental in refining this guide and other research instruments. The prototype interview contained a qualitative portion as well as a quantitative questionnaire to be completed by the participant at the time of the interview. Ethical approval to conduct live research was obtained from the Social Sciences and Humanities Human Research Ethics Board at Dalhousie University prior to the start of the project, with continuation of approval granted following subsequent yearly reviews.

The Community Facilitators conducted 12 focus groups with women in various Black communities for the purpose of refining the research instruments. They then carried out 237 in-depth one-on-one interviews with Black women throughout the southwestern region of the province. Snowball sampling was used to recruit participants as the

Community Facilitators built on their contacts with members of their communities. Purposive sampling was used to ensure that a multiplicity of perspectives and experiences was captured in the interviews and group consultations, while snowball sampling served to identify exceptional or atypical perspectives (Kidd & Parshall, 2000; Mays & Pope, 2000; Patton, 1999). The interviews were audiotaped; they varied in length from 35 minutes to more than 2 hours.

Data analysis involved the development of codes and the use of thematic analysis to categorize codes into themes. *Atlas-ti* data-management software was used to facilitate this process. The entire research team met regularly to analyze the data. In keeping with the principles of the PAR approach, which involves the creation of genuine partnerships with community members in order to generate research *with* rather than *about* communities, the team ensured that the Community Facilitators were actively engaged in every aspect of the research process, including data coding and analysis.

Rigour in the research process was ensured in a number of ways. Firstly, multiple sources of data (triangulation) were used, including interviews and focus groups, to obtain a comprehensive account of the women's experiences. Secondly, the participation of the Community Facilitators in the data-analysis meetings served as a means for them to review the researchers' interpretations of the stories, confirmed their analyses, and extended the data analysis. In addition, eight focus groups were held with community members who participated in the individual interviews in order to validate our interpretation of their experiences and to extend the data analysis. Guba and Lincoln (1989) describe such member "checks" as the best technique for establishing credibility. Thirdly, we admitted that, as researchers, we represented the instrument of data generation and that our research skills and experience could affect the credibility of the study (Patton, 2002). In response, we addressed credibility from this perspective through "peer debriefing." Peer debriefing was evident during the data-analysis meetings at which various researchers analyzed codes and themes and provided feedback to the research associate who led the data analysis. This process ensured consistency in the collective interpretation of the data. In addition, credibility and reliability of the study were ensured through an audit trail, which documented the details of the research process and the techniques and processes of data generation and analysis.

## Findings

The participants identified numerous issues affecting the health of their families and communities. The researchers identified several themes in

the data, including the multiple roles of Black women, perceptions of health, experiences with the health-care system, factors affecting Black women's health, strategies for managing health, and envisioning solutions. One of these themes — factors affecting Black women's health — is the main focus of this article. In exploring this theme, we are able to fulfil one of the main objectives of the study, namely to become more aware of issues that affect the health status of Black Nova Scotian women and their families. Key factors in or determinants of Black women's health that emerged during data analysis were racism, poverty, unemployment, access to health services, and caregiving roles. It is important to note that these factors are not mutually exclusive. Determinants such as access to employment and access to health services affect many rural populations, yet for these women racism was a key factor, intertwined with all of the other issues. For the purpose of this discussion, racism serves as the lens through which we examine all other determinants. None of these determinants exist separately in the lived experience, and we separate them only for the purpose of ensuring clarity for the reader. These key determinants of Black women's health are presented below under the headings of Race and Racism, Poverty and Unemployment, and Access to Health Care.

### ***Race and Racism***

In order to proceed with the main focus of this article, it is imperative that we attempt to clarify the concepts of race and racism and their link with health, given that race is the main factor distinguishing Black women from their white counterparts and racism is the factor that makes race salient. Race was originally viewed as a biological construct defined by one's physical characteristics such as skin colour, hair texture, and facial features (Thompson & Neville, 1999). In the recent past, natural scientists acknowledged the limitations of such a notion, while social scientists have moved towards defining race as a social construct (Thompson & Neville). Although the concept of race applies to phenotypical distinctiveness of human beings and one cannot deny the variations in physical characteristics of people around the world, the use of these human biological characteristics for racial significance is a social and historical process. Williams (1999) states:

There is no more genetic variation within our existing racial groups than between them. Moreover, genetics is not static but changes over time as human populations interact with their natural and social environment... Our racial groups importantly capture differences in power, status, and resources. (p. 175)

Winant (2000) defines race as “a concept that signifies and symbolizes sociopolitical conflicts and interests in reference to different types of human bodies” (p. 172). Historically, racial categorization has its roots in racism, and the construct of racism may enhance our understanding of racial differences in health. Williams defines racism as “an ideology of inferiority that is used to justify unequal treatment (discrimination) of members of groups defined as inferior, by both individuals and societal institutions” (p. 176). He asserts that this ideology of inferiority can lead to negative attitudes towards and beliefs about racial minorities (prejudice), but he argues that racism lies primarily within organized institutional structures and not in individual attitudes or behaviours.

How does racism affect health? Racism and other forms of social inequality can affect health in many ways, by impacting on economic, environmental, psychosocial, and iatrogenic conditions (Krieger, 2003). For example, racism can limit the socio-economic progress of minority groups. Racial inequalities are created and reinforced via limited access by minority groups to educational and employment opportunities through processes such as segregation (Collins & Williams, 1999). Racial difference in socio-economic status is well documented in the literature, and health researchers examining the association between race and health routinely adjust for this variable (Williams, 1999). Thus, socio-economic status is considered not only a cofounder of racial differences in health but “part of the causal pathways by which race affects health” (Williams, 1999, p. 177).

Participants in this study spoke about their experiences of racism as well as the extent to which they perceived racism as a health issue affecting their families and communities. Most of the women indicated that racism was a significant problem for Black communities and went on to describe their experiences of everyday racism — the racist comments and attitudes they had endured throughout their lives, as children in school, as adults in the workplace, within their families, and in their dealings with health and social services and community organizations. It was clear to the researchers that the participants found it painful to share their stories.

Many of the women made it clear that racism caused significant stress, which in turn contributed to other issues and conditions such as low self-esteem:

*Anybody will tell you that they battle with their self-esteem every day. But I think, particularly as a Black woman, when you get ready for the day and you step outside the door, you never know what you're going to face. And as you walk the streets with your head high, people have certain*

*preconceived ideas about who you are. And some of them are good and some of them aren't. And I guess I struggle with that every day.*

The women also made a connection between racism and physical and emotional health:

*Women and children, they're the ones [who are] shafted, I find. Women are up against a lot of obstacles...and all these obstacles that they are up against have to do with their mental and physical aspects. And as far as Black people go, I find that it is very stressful if you want to become or do something in this lifetime. ...this stress, it can cause heart problems, it can cause high blood pressure, it can cause a lot of things. And migraine headaches.*

Participants explored the connection between racism and health in the context of their experiences with health-care providers. Some women felt that they were treated differently by health professionals because they were Black: in outpatient clinics they had to wait longer than white women, who sometimes were seen right away; their doctors did not believe them, stereotyped them, did not present information in an understandable way, did not spend an adequate amount of time with them, and would not touch them:

*When a woman walks into an office and she is complaining about pain, a doctor tends not to take her seriously, or to assume that she is hysterical or there is something mentally wrong, rather than saying this is a physical problem. That is, women in general and Black women especially.*

A number of women shared specific personal experiences of discrimination and mistreatment. In a particularly poignant moment, one woman recalled giving birth to her first child at the age of 19:

*I was having [child's name] at the hospital... My regular doctor couldn't come so they sent another doctor. I wasn't really worried because the nurse had everything down pat. Anyway, the cord was tied around [the baby's] neck. ...So in pops the doctor, who I never seen before. I just had the baby and he decides he's going to dig inside of me. Now, that is as blunt as I can put it. The nurse looked at me and she said, "If that was me I wouldn't let him do that." He was looking for what they call, I guess, a bleeder or something. I didn't know, but I got from the nurse that that wasn't the procedure. And then he asked me what I named the baby. I said, "I haven't figured it out yet. It may be [name]." He said, "Well, as long as you don't blame it on me." And I tried to figure it out. I think he figured that I was a single mom and didn't know whose child this was.*

When the women believed that they had not received or would not receive proper medical care because of their race, they became reluctant to seek advice from health professionals, arguing that there was little point in doing so:

*Why go to the hospital if I'm just going to be discriminated against? There's really no sense. ...If you're stressed out because you have something, why go to the hospital and be more stressed because people are going to be judging you? You might as well just stay home.*

### **Poverty and Unemployment**

Race as described in the above section is an antecedent and a determinant of socio-economic status, and racial differences in socio-economic status are to some degree a reflection of discriminatory policies and practices premised on the inferiority of certain racial groups (Williams, 1999). In support of this notion, Krieger (2003) asserts that "health is harmed not only by heinous crimes against humanity, such as slavery, lynching and genocide, but also by the grinding economic and social realities of what Essed (1991) has aptly termed, 'everyday racism'" (p. 195). Furthermore, Krieger (1987) argues that the poorer health of the Black population is the result of white privilege established through many forms of racial discrimination, rather than innate inferiority. These many forms of racial discrimination include unemployment and under-employment.

In the present study, 62% of the sample ( $n = 237$ ) indicated that their average annual personal income was under \$15,000 and 28% indicated that their average annual *household* income was under \$15,000. In addition, 75% of the sample reported having financial problems. We began our data collection with some suspicion that poverty was a major concern within Black communities, but the incorporation of qualitative methodology allowed us to examine firsthand accounts of how lack of access to economic resources affects the health and the lives of African-Canadian women living in rural areas.

When asked whether there were aspects of their lives that made it more difficult for them to be healthy, many women spoke about poverty. While some women were reluctant to discuss their actual income, others spoke at length about how their financial concerns affected their overall well-being:

*My biggest concern is not being able to...afford to eat healthy. ...last payday, when I paid my rent and paid \$50 on my phone bill, \$50 on my light bill, I had \$20 left. So I don't eat healthy. So I'll get french fries or hotdogs or something. And if I do treat myself...once in a while just to get*

*out to stop looking at the four walls, I can't really do it. I pay for it for weeks and weeks. I can't even have a social life.*

Poverty had a striking impact on the health of these Black women. Worrying constantly about how to pay their bills and provide for themselves and their families caused significant amounts of stress, which, aside from being a concern in itself, can lead to numerous health problems, including heart attack and chronic headache (Frey, 1999). As indicated in the examples below, poverty also affects the health of Black women in very specific ways. In discussing their financial concerns, many women explained that it was difficult or even impossible for them to afford healthy foods such as fruits and vegetables, especially in the wintertime when these foods are more expensive:

*To eat healthy, to do things that are good for your body, to keep you healthy, it takes money. And if I followed the Canada Food Guide and ate the way that I'm supposed to eat, I'd better go get a couple more jobs, because this one ain't cutting it. I just look at fruit on TV, because that's just ridiculous. And this winter it's going to be worse. I can't afford to buy those extras. If I've got meat and potato on my plate, I can't be looking at dessert and appetizers and all the rest that go along with it, and this and that. No, I can't.*

Although many of the participants were knowledgeable about healthy behaviours, they simply did not have the means to incorporate such behaviours into their daily lives.

Poverty also acts as a determinant of health by restricting access to health services and treatment. More than half of the 237 participants, 57%, reported that they did not have enough money for medication. Several of the women related instances of failing to seek medical attention for a health concern only because they could not afford to travel to the nearest health centre. One woman with vision problems said that she wore \$1 eyeglasses purchased from the drugstore because she could not pay for prescription glasses. Many women indicated that they could not afford dental care:

Interviewer: *Do you go to the dentist?*

Participant: *You can't afford that, woman! [giggle] I can't afford no dentist!*

Interviewer: *So you don't go?*

Participant: *No, unless it's absolutely necessary.*

...

Interviewer: *If you had the money to go, you would go?*

Participant: *Well, you know you'd go. You could be like everybody else and have your teeth cleaned.*

Very few of the women had access to medical insurance, and many of those who did have coverage were not reimbursed for all of their medical expenses.

While for some women poor housing was a sensitive aspect of poverty, others openly identified poor housing as a major concern in rural Black communities. Some participants spoke of being unable to afford the repairs necessary to keep their homes up to standard. Others faced limited housing choices because of financial constraints:

*Housing is an issue. Many people are living in...rundown apartments, homes that have been amalgamated into 20 apartments. They should be condemned...and they're still rented and the Black people take it because they can afford it. You know, the doors are thin...holes in the walls are terrible, the floor hasn't been changed. It's [a] health concern. It's unsanitary. But it's cheap — they can afford it.*

Unemployment is another indicator of health status. Due to the remote location of some of the communities concerned, and the lack of access to resources, very little employment is available. While some community members have regular full-time or part-time jobs, many others are employed only seasonally in fish plants or on lobster boats. Unemployment rates are high, and the stress of trying to find work weighed heavily on some of the women:

*I know that I'm never going to get ahead and I'm never going to find a job in this town no matter how hard I try. Because what's the point to go work at [a fast-food restaurant], you know what I mean? I'll only be making what I'm making right now, and that's nothing. And then on top of that, I'm going to have to pay for my own babysitter because welfare doesn't want to help me pay for a sitter.*

In talking with some of these women about their lack of employment, the intersection of race and poverty became apparent. Some women shared their experiences of being unable to find work because of their skin colour:

*I went to try at some of the motels there, because I had cooking experience and they advertised for a cook, but I was told not to bother going because they wouldn't hire me because I was Black. When I went in to see the lady, just the look on her face told me I wasn't going to be hired.*

For other women, the threat of racism made it very difficult to seek employment:

*Sometimes not having a job, that stresses me out, because I feel like I'm able to work and I'm smart and I should be — I don't want to be on welfare, but it's not easy to get a job around here. Being a Black person and, like, I'm not saying every place is racist, but in this town and if you're Black and, like, if there's a Black person and a white person they'll give the job to the white person and it doesn't matter how many qualities or skills that you could offer, it doesn't matter.*

Women drew upon different explanations to account for their difficulty in finding employment, citing access and racism as significant issues.

### ***Access to Health Care***

Issues relating to access to appropriate health services are prominent in the On the Margins data. Black women living in rural and remote areas face a number of barriers to health-care access, all of which affect their health status. Some of these barriers concern the accessibility of the services themselves, and are common to most rural communities. For example, a number of participants spoke about physician shortages and long line-ups in outpatient clinics. Many women reported that they did not have a family doctor they could see on a regular basis. In one community a general practitioner who had served the area for years had passed away approximately 1 year prior to data collection. As a result, many families were left without a doctor and still had not found a new family physician at the time of the interviews. When health issues did arise, the women were forced to go to the outpatient clinic of a rural hospital and wait for hours to be seen. These barriers prevented many rural Black women from having routine checkups. Some women even resigned themselves to going without medical care when they required it:

*My doctor died, so I don't have any doctor. The only doctors that are around here are the ones that aren't taking any on, [or they're] out in the country. I don't have any transportation so I'm not getting there. So we don't go to outpatients, of course, because there's, like, a 6-hour wait, sitting in there. I'm sick right now and I can't go see a doctor or anything...my ears have been plugged for 2 weeks and I can't get to see a doctor.*

As this example demonstrates, lack of transportation was also a barrier to health-care access. Many of the communities do not have public transportation, and women who did not own a vehicle and could not afford taxis had great difficulty getting to and from appointments. Participants also spoke about the inadequacy of rural hospitals. These hospitals offer only limited services, forcing community members to travel several hours to the city for specialized testing and even for childbirth.

Lack of information is another barrier to health-care access. When the Community Facilitators spoke with women about services available in their areas, many women were not aware of these resources. For women without access to the Internet, information on available services and on specific health conditions is difficult to access. In addition, there is a general dearth of information on health issues that affect Black people specifically:

*I don't think the white doctors know enough about the Black women's anatomy to be in judgement of us, of what our bodies are about. ...I've always felt that way. I've always felt that the doctors out there — and they've all been white in my books — and I've never seen any of them give me the knowledge of a Black woman's anatomy, or how a Black woman's body functions. We have diseases in our system, in our Black history, that white people don't have. So that obviously gives us a different chemistry level right there. ...that's one thing I don't think anybody has enough information on.*

Some women believed that they would not receive culturally relevant information even if they did have access to health services.

A related barrier for Black women living in rural and remote communities is the lack of culturally sensitive and appropriate services. While the racist attitudes of health-care providers present an obvious barrier, the lack of diversity among health-care personnel also makes it difficult for some women to access suitable health-care providers:

*I would love to see Black doctors. I would love to see Black nurses. ...when I was in the hospital in [city] and I was going through my cancer treatment, there was one Black nurse and there were three white nurses, and they were all on [the doctor's] team. And the only one that I could really relate to, or actually have anything in common with, was the Black nurse.*

Some women reported a fear or mistrust of health professionals in general. Others spoke of feeling much more comfortable around Black professionals. They believed that Black doctors would be able to identify issues specific to Black people that white doctors might not know about, would be better able to understand how Black women feel, would know how to approach issues with Black people, and would be able to identify issues in the Black community.

## Discussion

The findings reveal that numerous factors affect the health status of Black women living in rural and remote Nova Scotian communities. These

factors include racism, unemployment and poverty, and lack of access to health care. The many faces of racism have a significant impact on women's health. They include the lack of information specific to the health needs of Black people, the lack of culturally sensitive health-care providers in rural and remote communities in the region, and the lack of culturally relevant outreach programs. Inappropriate and insensitive care may also arise from subtler assumptions embedded in the health-care system, particularly the tendency to embrace the white, middle-class, male experience as normative.

Racism causes additional stress in the lives of Black women, and years of accumulated stress due to racism heightens women's feelings of fatigue. When their dedication goes unrewarded with job promotion and recognition, it takes a toll on their health, as Black women must continually struggle for validation, recognition, and commendation. Working in an environment rife with overt and covert racism, and without support, Black women have little in terms of motivation. Several researchers have argued that the subjective experience of racial discrimination can have adverse effects on the health of Black people (Evans et al., 2005; Karlsen & Nazroo, 2002; Williams, 1999). Williams points to several American studies that have linked internalized racism to depression, distress, and chronic physical conditions. Socio-economic status is a powerful indicator of health, affecting overall wellness, access to health services, access to information, and even life expectancy (Hay, 1994; Lynch, 1996; Lynch et al., 1997; Pappas et al., 1993; Poland et al., 1998; Williams). Ethnocultural identity, along with socio-economic status, profoundly influences the quality of care available to Canadians (Courtney, 2000). Cultural stereotypes sometimes translate into overt discrimination. For instance, sex-trade workers, typically women, often find it difficult to access services or receive appropriate care when providers assume that immoral behaviour is at the root of their ill health (Jackson, 2002). Black people are similarly subjected to insensitive or inappropriate care, especially when their illnesses are interpreted as the consequence of a predisposition to violence or sexual promiscuity (Blake & Darling, 2000; Bolaria & Bolaria, 1994; Murrell, Smith, Gill, & Oxley, 1996; Robb, 1998; Thomas Bernard, 2001; Utsey, Ponterotto, Reynolds, & Cancelli, 2002; Van Ryn & Burke, 2000; Williams & Williams-Morris, 2000).

The impact of race, racism, and poverty has attracted increasing attention. As with class and gender, race and poverty have been strongly correlated with poor health (Barbee & Bauer, 1988; Blake & Darling, 2000; Bolaria & Bolaria, 1994; Brancati, Kao, Folsom, Watson, & Szklo, 2000; Dana, 2002; Doswell, 2000; Fisher, Cooper, Weber, & Liao, 1996; Graham et al., 2001; LeClere, Rogers, & Peters, 1997; Schulz et al., 2000; Utsey et al., 2000). For example, African Americans experience hyper-

tension at younger ages than white Americans, and are much more prone to dangerous complications such as end-stage renal disease (American Heart Association, 2001). Black people living in the United States are also twice as likely as white Americans to develop adult-onset diabetes and to face serious sequelae of the disease, including amputation and blindness (Brancati et al., 2000; National Institutes of Health [NIH], 1992). Although fewer Black than white women are diagnosed with breast cancer, Black women are more likely to be diagnosed at an advanced stage and to die from the disease (Miller et al., 1996). In the case of HIV, African-American women are approximately three times more likely to become infected than African-American men, and eight times more likely than white Americans (NIH).

Unemployment and poverty cause stress, not only because of personal economic deprivation but also because of their impact on one's identity (Beiser, Johnson, & Turner, 1993). Unemployment increases the risk of depression because work has the function of providing not only an income but also a purpose to life, defining status and identity and enabling individuals to develop and maintain meaningful social relationships (Aycan & Berry, 1996; Pernice & Brooks, 1996; Pernice, Trlin, Henderson, & North, 2000). A number of studies have explored the link between unemployment and mental health and have found unemployment to be a predictor of mental disorders (Abbott, Wong, Williams, Au, & Young, 1999, 2000; Pernice & Brooks). There is also evidence of an inverse relationship between social class and premature death; people in lower socio-economic classes die earlier than people in higher socio-economic classes (Adler, Boyce, Chesney, Folkman, & Syme, 1993; Guralnik, Land, Blazer, Fillenbaum, & Branch, 1993; Isaacs & Schroeder, 2004).

Black women in the region of Nova Scotia chosen for the study face many of the same health and access challenges that confront anyone living in a rural or remote location, including lack of hospital services, lack of transportation, and a shortage of doctors and services. However, the ability of Black women to achieve and maintain health — their own and that of their loved ones — is further compromised by discrimination and a lack of culturally competent care. In addition, the combination of racism and poverty limits women's choices in housing, employment, and education — factors that in turn affect their health status. Most vulnerable of all are people who experience overlapping disadvantages, including poverty and ethnocultural discrimination. Women from visible minorities routinely experience this double jeopardy and its pernicious effect on their health (Thomas Bernard, 2001).

## **Conclusion**

Although Black people have lived in these rural and remote Nova Scotian communities for centuries, they remain socially, economically, and politically marginalized: many are unemployed or underemployed and live in poverty; most have limited access to appropriate social, economic, and health services; and they are under-represented in health-care delivery, in health research, and in the design and implementation of health policies. Like their urban counterparts, African Nova Scotians living in rural and remote regions encounter strong barriers to appropriate health care, but their situation is compounded by their geographic location. Even when they have the financial and social resources to access health services, they are confronted with the challenge of finding culturally competent providers, programs, and facilities a reasonable distance from their homes.

While people living in rural areas, irrespective of cultural background, have been identified as lacking access to appropriate health care, Black women face additional barriers, such as racism and lack of culturally competent care. Most of the participants in this study faced higher risk of marginalization because of their triple-jeopardy situation: being Black, being poor, and living in a rural community. Although a few studies have attempted to explicate the determinants of Black women's health status in Canada in general and Nova Scotia in particular, this is the first to examine the issue in the context of rural and remote communities, thus adding a unique perspective to the growing body of literature in this area.

Health disparities along racial lines have multiple root causes, including racism, poverty, and differential health-care access, which are interwoven in complex ways. The present findings illuminate some aspects of these complex issues, including the ways in which racism impacts on Black women's health. An understanding of these issues is vital to efforts aimed at addressing diversity and social inclusion in today's culturally diverse society. Although studies in other jurisdictions have identified the health impact of racism, poverty, and access to health care, the On the Margins project has uncovered the extent to which these complex issues are interwoven to create health problems in the Nova Scotia context. The project has explicated some of the intersecting inequities that affect and compromise the health and health care of Black women, families, and communities in the region. It is important that researchers maintain the goal of forming research partnerships with African-Canadian communities in order to fully explicate their health

issues and improve the health of this population. It is also important that any future research in this area be undertaken with the recognition that race interacts with numerous other variables and experiences to determine the health of Canadian Black women and their families.

The analysis presented above also explicates the potential areas of future research, including specific conditions (i.e., hypertension, diabetes, heart disease), in order to further identify differences and similarities in the health of African Americans and African Canadians.

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