North End Matters:
Using the People Assessing Their Health Process (PATH) to Explore the Social Determinants of Health in the African Nova Scotian Community in the North End

A Pilot Study Report

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For more information:
North End Matters: A Multi-Phase Project Facebook Page
EXECUTIVE SUMMARY

Summary of Project Description

The pilot study outlined in this report examined the health experiences of African Nova Scotian residents in the North End of Halifax in the context of the socio-economic transformation this area of the city has been undergoing over the past several years. The study comes at a time when many African Nova Scotian North End residents are among those most negatively impacted by the social and economic challenges brought on by gentrification.

Recognizing that some individuals conceptualize illness and poor health as resulting mainly from “bad genes” or internal biological malfunctioning, the study used the People Assessing their Health (PATH) discussion group process to engage a small group of African Nova Scotian North End residents in a discussion on the social determinants of health, i.e. the social, economic, and political factors and processes that impact health and well-being. The PATH process increases people’s understanding of the social determinants of health, as well as their appreciation for the factors that are priorities for creating and maintaining healthy communities. Through community engagement in planning and decision-making, PATH focuses on community capacity building, empowerment and advocacy. One of the main outcomes of the PATH process is a Community-Driven Health Impact Assessment Tool (CHIAT), which can be used to conduct a community health impact assessment (CHIA), which is a concrete strategy that enables citizens to evaluate how a proposed policy, program, service or project will affect the health and well-being of their community.

Research Objectives

The pilot study had the following two objectives:

- To examine, for the first time, the effectiveness of using the People Assessing their Health (PATH) process to engage the African Nova Scotian community in North End, Halifax in articulating the social determinants of health and
- To obtain participants’ vision of a healthy North End community.
Summary of Study Findings

The findings fall within four main themes (as listed below):

**An Evaluation of the PATH Discussion Group Process**

- Participants expressed that the PATH discussion group process left them feeling renewed, hopeful, equal, respected and valued.
- Participants also mentioned that the process offered them an opportunity to express their feelings in a safe, non-threatening environment where they felt welcomed, validated and free to be themselves.
- The process also made participants feel more connected to the community because it gave them an opportunity to come together with other community members who live in different areas of the North End, particularly individuals they had never met before.

**Effectiveness of the PATH Discussion Group Process in Helping Participants Understand & Articulate the Social Determinants of Health**

- The PATH discussion group reinforced and broadened participants’ perspectives about the relationship between various social determinants, the healthcare system and health outcomes for individuals and the community.
- The discussion group process enabled participants to appreciate how these determinants of health relate to their everyday lived experiences.
- Participants indicated that one of the most important factors in making and keeping people healthy in the North End is acceptance of diverse African Nova Scotian subpopulations in the North End, regardless of cultural heritage, nationality and geographic location.

**Community Empowerment, Mobilizing & Advocacy**

- Participants indicated that they were more motivated to take action on some of the health issues facing African Nova Scotians in the North End, including becoming more involved in committees or community groups to address issues affecting their community.
- Participants expressed that the PATH process could be an important catalyst for developing leadership in the African Nova Scotian community in the North End.
- The PATH process helped participants experience a shift in thinking that extended beyond the social determinants of health to a broader conceptualization of their role in creating “community” on three levels: as participants during the PATH discussion group; as African Nova Scotians in the North End; and as community advocates.

**Participants’ Vision of a Healthy North End Community**

Participants discussed various requirements for a healthy North End community:

- Empathy and compassion by the dominant group on “our issues”.
- Living in harmony in a way that is inclusive and respectful of racial, cultural, religious, sexual and gender differences.
- Equal employment opportunities, including employment of people within the community.
Ingrid holds a Ph.D. from the Sociology & Equity Studies in Education Department at the University of Toronto, a MA in Intercultural Education: Race, Ethnicity & Culture from the Institute of Education at the University of London (England) and a BA in Psychology from McGill University. She also completed a postdoctoral fellowship at the Center for Women’s Health in the Faculty of Medicine at the University of Toronto. Ingrid’s research and teaching focus on the sociology of race and ethnicity, the sociology of health and mental health, medical sociology, the social determinants of health and mental health, and health inequalities. Her scholarship focuses specifically on the impact of inequality and discrimination on the health and mental health of African Nova Scotian, African Canadian, Mi’kmaw, and immigrant communities in Canada. Ingrid teaches “Social & Cultural Determinants of Health”, “Women & Ageing”, “Community Health Assessment & Planning” and “Community Development & Advocacy” at the undergraduate and graduate levels. She has been funded by several grants as a principal investigator, including Canadian Institutes for Health Research (CIHR), Social Sciences & Humanities Research Council (SSHRC), Nova Scotia Health Research Foundation (NSHRF), and the Atlantic Metropolis Centre. Ingrid’s recent research projects focus on environmental racism in African Nova Scotian and Mi’kmaw communities and the social determinants of health in the African Nova Scotian community in the North End of Halifax. Her findings have been published in peer reviewed publications and edited book collections on Black political thought, women’s health, public health, community psychology, cardiovascular nursing, occupational therapy, and women’s studies. Her methodological expertise is in critical anti-oppression approaches, including Black feminist, anti-colonial, antiracism, African-centred, and Indigenous knowledge theories. Ingrid was the Director of Research for the “Racialization of Poverty” Research-Praxis Unit at Scadding Court Community Center in Toronto. Ingrid currently serves on several community and university advisory committees, including Health Association of African Canadians, Poverty Intervention Tool Network, Immigrant Settlement & Integration Services, Diversity Committee (School of Nursing, Dalhousie University), African Nova Scotian Health Sciences Initiative (Dalhousie University) and Imhotep Legacy Academy (Dalhousie University).
Sheri holds a Ph.D. from the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto and a MN and BScN from the School of Nursing at Dalhousie University. She also completed a postdoctoral fellowship at the Interdisciplinary School of Health Sciences at the University of Ottawa. Sheri has worked as a registered nurse (RN) in Nova Scotia for most of her 20-year nursing career. Her professional roles include: critical care nurse, community health nurse, acute care nurse practitioner, nursing educator and researcher. Sheri has focused her research predominantly in the areas of women's and community health, health services, career mobility, nursing work environments, professional socialization and interprofessional collaboration. Her research interests also include exploring issues of diversity and inclusion within healthcare and health professional education. Her research expertise includes innovative knowledge dissemination strategies, funded through the NSHRF and CIHR. She has used social media along with video vignettes and dramatic theatre to disseminate her research findings and has employed innovative arts-based media in the development of a nursing recruitment campaign entitled “Be a Nurse”. She recently completed a CHSRF-funded post-doctoral fellowship in health services and policy research within the Interdisciplinary School of Health Sciences at the University of Ottawa. Sheri’s research is predominantly qualitative in nature, using both interpretive (narrative) and post-structural methodologies. Sheri is an Affiliate Scientist in the Women’s Health Program at the IWK Health Centre, a Collaborator with the Pan-Canadian Health Human Research Network (CHHRN), a Co-Investigator with the WHO Collaborating Centre for Health Workforce Planning, and a Research Associate with the Atlantic Health Promotion Research Centre. Sheri is also actively involved in several community organizations, including those specific to diversity. She has served for the last 8 years on the executive of the Board of Directors for the Halifax YWCA; currently in role as Past President. She is the recipient of several alumni and leadership awards in recognition of her community service. She currently serves as co-investigator on several nationally-funded research studies and she has published and presented her work nationally and internationally.
FACULTY/RESEARCH TEAM

Felicia holds a Ph.D. in Home Economics Education from Penn State University, two Masters degrees in Vocational Home Economics Education and Family Life and Environment from Louisiana State University, a Diploma Certificate in Home Economics Education from the University of Ghana and a Certificate in Home Economics Education from Seaford College of Education in Brighton, England. She teaches The Roots of Peace & Conflict, Mediation & Conflict Management, Building Resilient Families, and Program Planning, Implementation & Evaluation at both graduate and undergraduate levels. She is the Coordinator of the Peace & Conflict Minor Program at Mount Saint Vincent University. She has conducted research in time use of husbands in household work, critical thinking, women and development and curriculum planning, and learning styles of students, menopause and midlife health of African Canadians. Her research results were widely presented locally, nationally and internationally. She won a research award from the Canadian Association for Research in Home Economics after presenting a paper on “The Myth of the Strong Black Woman.” Currently, her research experience focuses on African immigrant in Nova Scotia retirement experiences, health and well-being. Felicia is an advocate for peace, human rights and justice, dedicated to the wellbeing and advancement of women and their families. As a member of the immigrant community, she responds to the needs and issues that women and their families encounter in the areas of health, education, employment, integration and cross cultural understanding. As a strong community leader, she has served on several community advisory committees and boards, including Multicultural Women’s Association of Nova Scotia, Council on African Canadian Education, and James Robinson Chair in Black Canadian Studies. She is a founding member of the United African Canadian Women’s Association, the African Children’s Cultural Enrichment Program, the Immigrant Women’s Mentorship program, and the African Diaspora Association of the Maritime, all of which address the needs of immigrants. She is a recipient of the Halifax Mainland North Championship Award and the Queens Diamond Jubilee Award and has been given recognition at the Nova Scotia House of Assembly for her outstanding contribution to the Halifax community.
PROJECT DESCRIPTION

The pilot study presented in this report examined the health experiences of African Nova Scotian residents in the North End of Halifax in the context of the socio-economic transformation this area of the city has been undergoing over the past several years.

The North End is a neighbourhood located in the urban core of Halifax, Nova Scotia and is bounded on the east and north of the Halifax Harbour and the Bedford Basin, although the boundary originally ended at North Street. During the nineteenth century some of Halifax’s elite social classes were located on Brunswick Street in the north end of the city. Recognizing that identity is a socially constructed notion, it is important to state at the outset that the term “African Nova Scotian” was used in this study to include any individual who identified her/himself as a person of African descent regardless of birthplace, nationality, or cultural heritage/parent’s country of birth. A decision was also made by the research team to recruit any individual who self-identified as a “North End” resident. Initiatives to define the “North End” remain a highly contested issue, particularly for some members of the African Nova Scotian community for whom identity (particularly based on race and culture) is inextricably linked to that neighbourhood. Legislative decisions that have sought to define and concretize the boundaries of the North End have long held little weight for African Nova Scotian North End residents, who have yet to reach a consensus about the area’s geographic parameters. Consequently, this study recognizes that “place” (i.e. the North End) is a socially constructed concept that is often imagined, created and negotiated in diverse ways by residents, communities, business, planners, religious institutions and media, all of whom may have different and competing interests and agendas.

The North End has undergone more significant changes than any other area since Halifax was founded in 1749. The neighbourhood flourished after the economic boom that came on the heels of the Second World War. The main strip, Gottingen Street, became the pulse and thriving heart of the North End, bustling with shops, a bank, a theatre, a grocery store, dining establishments and other activities. However, the post-war decline saw many families migrate to the suburbs with businesses following them. The Gottingen Street area population declined by almost half between 1961 and 1971 and continued to decline until the late 1990s. In 1966 many of the African Nova Scotian residents that were expropriated out of Africville moved into Uniacke Square in the North End, a public housing complex. From 1960 to 2000, the number of retail and commercial services fell from 138 to 38 and were...

Gentrification can be defined as a dynamic process that seeks to restore a less affluent or working class neighbourhood through migration of and reinvestment by middle and upper-class individuals, including local government, business groups and community activists.
replaced by vacant buildings, empty lots and social services (Beaumont, 2013).

Today, the social and economic changes the North End has been experiencing can be attributed partly to the gentrification of the area. Gentrification can be defined as a dynamic process that seeks to restore a less affluent or working class neighbourhood through migration of and reinvestment by middle and upper-class individuals, including local government, business groups and community activists. Often old industrial buildings are converted to residences and shops. New businesses, which can afford increased commercial rent, cater to a more affluent base of consumers—further increasing the appeal to higher income migrants and decreasing accessibility to low-income and poor individuals. Aided by the North End Business Association, several businesses have moved into the Gottingen Street area over the past several years, including restaurants, retailers, an organic food store and a TV station. Some individuals perceive this as particularly beneficial to the area because it spruces up a deteriorating area and increases property values. However, low-income residents who have lived their entire lives in the area often resent these changes because they rarely see any of that money. The shift toward wealthier residents and/or businesses results in increasing property values and the displacement of residents who are no longer able to afford to live in the area (Beaumont, 2013; Roth, 2013; Silver, 2008). Therefore, while gentrification brings with it many benefits, including economic development, increased investment in business, the conversion of industrial buildings to residences and shops, and lower crime rates, it can also lead to decreased accessibility to low-income and poor individuals who become “priced out” of the area, unable to pay higher rents and property taxes. The response by the community to gentrification is often political action that either seeks to support and promote gentrification or oppose economic eviction and displacement.

While several studies focus on the social, economic, and political implications of gentrification in the North End, they have largely failed to consider the implications of gentrification for the health and well-being of residents, particularly those who are most marginalized. Similarly, while health researchers in Nova Scotia are increasingly embracing approaches that acknowledge the effects of social, economic and political factors and processes on health and well-being, they have yet to fully conceptualize gentrification as a health issue. Gentrification as a phenomenon offers researchers ample opportunity to use a social determinants of health approach to examine and critique how an analysis of the social context of inequality is important for understanding why unemployment, low-income, poverty, race, housing, food insecurity, discrimination, exclusion and other social factors or determinants are such important predictors of health status. A social determinants of health approach is premised on the notion that these and other determinants put individuals at risk for a number of health and mental health
problems. It also moves beyond analyses of individual health risks to acknowledge how the health of a community may be impacted by these determinants. A **healthy community approach** is premised on full and equitable access to resources and opportunities (economy; peace; food; water; shelter; income; safety; health care services; work and recreation; opportunities for learning and skill development), equity and social justice, self-determination and self-empowerment, supportive networks and communities, and collaborative community initiatives. It also involves diverse sectors of the community sharing their knowledge, expertise and perspectives in order to create a healthy community (Ontario Healthy Communities Coalition, 2010).

The pilot study presented in this report comes at a time when many African Nova Scotian North End residents are among those most negatively impacted by the social and economic challenges brought on by gentrification. Recognizing that some individuals conceptualize illness and poor health as resulting mainly from “bad genes” or internal biological malfunctioning, this study sought to engage residents in a discussion on health and well-being as an outcome of social, economic and political factors and processes. Using the **People Assessing their Health (PATH)** process that was developed by the PATH Network in northeastern Nova Scotia (Cameron, Ghosh & Eaton, 2011; Gillis, 1999; Mittlemark, 2001), the study (which commenced in the spring of 2013) engaged a small group of African Nova Scotian North End residents in a discussion on how they experience health and well-being in the context of some of the most pernicious social and economic transformations that have been occurring in the North End over the past several years. The PATH process increases people’s understanding of the social determinants of health, as well as their appreciation for the factors that are priorities for creating and maintaining healthy neighbourhoods and communities. Moreover, the PATH process can be a catalyst for the following: 1) community leadership; 2) community engagement in planning and decision-making; 3) community capacity-building; 4) community development; and 5) community advocacy. This study reflects the core principles of advocacy research. It provides data to support community members’ advocacy and mobilizing efforts in the following ways:

- Provides information to help community members make their case;
- Confirms beliefs and opinions about a particular issue;
- Positions community members as experts on the issue who are recognized as the authority, resulting in a stronger advocacy position;
- Gives community members credibility as serious advocates who have done the groundwork, which will make people more willing to listen to community concerns;
- Influences the formal and informal policies established by policymakers and others in power;
- Raises the profile of the issues in the community and in the general public;
- Garners public support around the issues; and
- Helps prevent harm to community members’ health and well-being.
Research Objectives & Questions

The pilot study had the following two objectives:

♦ To examine, for the first time, the effectiveness of using the People Assessing their Health (PATH) process to engage the African Nova Scotian community in North End, Halifax in articulating the social determinants of health and
♦ To obtain participants’ vision of a healthy North End community.

The study also sought to address two main research questions:

♦ How effective is the PATH process for engaging African Nova Scotians in North End, Halifax in articulating the social determinants of health? and
♦ What is African Nova Scotian participants’ vision of a healthy North End community?

The research team became aware of the PATH process after meeting with a Dalhousie medical student (who was later hired as the research coordinator on the project) in the summer of 2012. She had participated in the Community-Driven Health Impact Assessment Certificate Training Program at the COADY International Institute at St. Francis Xavier University in Antigonish a few years before and believed that PATH (the process that results in a Community-Driven Health Impact Assessment Tool) could potentially be an ideal process for the final phase of the multi-phase project that Dr. Waldron had been conducting over the past few years. That meeting was followed by a meeting with Colleen Cameron and Susan Eaton, two of the co-founders of the PATH process who have been teaching the Community-Driven Health Impact Assessment Certificate Training Program at the COADY International Institute for several years. The purpose of this meeting was to determine how the research team could design, develop and conduct a research study to assess the effectiveness of the PATH process. Subsequent meetings in 2012 and 2013 focused on community engagement, recruitment, and data collection. In April 2013, the research team was awarded a grant from Dalhousie’s School of Nursing Research & Development Fund to conduct the pilot study presented in this report. In addition, the PATH facilitator received a full scholarship from the COADY International Institute to attend the two-week Community-Driven Health Impact Assessment Certificate Training Program. This scholarship covered her tuition and accommodations. A grant from the Nova Scotia Health Research Foundation (NSHRF) was also awarded to the research team in the summer of 2013 to conduct a study with a larger sample after the pilot study concludes. The larger study commenced in May 2014 and will be completed in the spring of 2015.

Healthy public policy is understood to be public policy that creates a supportive environment to enable people to lead healthy lives. It improves the conditions in which people live and is characterized by an explicit concern for health equity. While several reports exist on the PATH process, the study outlined here is the first time that a research study has ever been conducted to evaluate the process. The study is unique for a number of other reasons. First, it was the first time that the PATH process had been conducted in Halifax. It was also the first time that the PATH process was conducted with an African Canadian community, let alone an African Nova Scotian one.
PATH was developed in northeastern Nova Scotia in the mid-1990s as a way to stimulate community participation in an emerging regional health system, increase awareness in the community of the social determinants of health and support the involvement of community members in the development of healthy public policy (HPP) (Cameron, Ghosh & Eaton, 2011; Gillis, 1999). Healthy public policy is understood to be public policy that creates a supportive environment to enable people to lead healthy lives. It improves the conditions in which people live and is characterized by an explicit concern for health equity. The PATH process increases people’s understanding of the determinants of health, as well as their appreciation for the factors that are priorities for creating and maintaining healthy communities. One of the most significant features of PATH is its focus on community capacity building and empowerment through community engagement in planning and decision-making.

PATH was sparked by the decentralization in health planning in Nova Scotia (Gillis, 1999; People Assessing Their Health (PATH) Network, 2002). PATH I was a project that took place between 1996 and 1997 to help people assess all aspects of their individual and community’s health. Trained facilitators conducted the PATH process in Guysborough County Eastern Shore, St. Ann’s Bay and Whitney Pier, resulting in each community creating its own toolkit entitled: “PATHways to Building Healthy Communities in Northeastern Nova Scotia”. The Regional Advisory Committee of PATH I moved on to form the PATH Network, which is a network of groups and individuals sharing ideas and resources to build healthy communities in northeastern Nova Scotia.

PATH II, which was initiated by the PATH Network, was a collaborative project that took place between December 2000 and March 2002. It involved partnerships with four other community organizations: Antigonish Women’s Resource Centre, Extension Department of St. Francis Xavier University, Public Health Services (Districts 7 and 8), and the Antigonish Town and County Community Health Board (ATCCHB). The main objectives of PATH II were to support the ATCCHB in raising awareness about community health and PATH. The project involved 57 focus group consultations with 550 residents between November 1999 and February 2000 and resulted in the creation of a Community Health Impact Assessment Tool (CHIAT) (discussed in more detail later) for the Antigonish Town and County Community Health Board. This CHIAT was subsequently tested with three community groups (Antigonish Town Council, a local breastfeeding advocacy group, and the Community Health Board).

Gillis (1999) outlines the following four key steps in the PATH process: 1) building the community process; 2) facilitating community discussions; 3) designing the CHIAT; and 4) supporting community use of the tool. Step one involves holding public meetings in the community to determine interest, forming a community-based committee and selecting a local person to facilitate PATH. The PATH facilitator must undergo training in group dynamics, small group facilitation, active listening, group decision-making, story-telling/structured dialogue and participatory data-analysis techniques. In step two, the PATH facilitator conducts the PATH discussion group process with community members who have an understanding of what it takes to make and keep them healthy. Information collected
during the PATH process is used to assemble the CHIAT. The steering committee and PATH facilitator meet to develop the CHIAT. This involves identifying themes in the information collected during the PATH process that represent the community’s interpretation of the determinants of health. In step three, a draft CHIAT is designed and tested in community workshops. These workshops also involve strategizing for continued use of the tool. Finally, step four of the PATH process involves disseminating the CHIAT to local leaders, decision-makers and organizations.

The PATH discussion group process begins by bringing together one or more small groups of people who will reflect on their experience and collectively answer the question: “What does it take to make and keep our community healthy?” With the help of a facilitator, people in the group(s) are invited to tell a story from their life experience that has to do with health, including (but not limited to) health services. The facilitator guides the group through a series of key questions to delve deeper into one of the stories in order to identify all of the factors that affect health and well-being (the determinants of health) and the ways in which these factors are inter-related. This process of exploration and reflection on these questions produces a group analysis of the issues and factors that make and keep a community healthy. The group then develops a “Vision of a Healthy Community”, using their own words and emphasizing their own priorities. The process focuses on opportunities, not problems, and reflects both the diversity and the uniqueness of the community. Based on this vision, the group designs its own CHIAT, which can then be used to conduct a Community Health Impact Assessment (CHIA). A CHIA is a collaborative community development and health promotion approach that can be used to assess projects, programs and policies and to engage the community and organizations in the development of HPP. It acknowledges that health and well-being are influenced by a wide range of factors both within and outside the health sector (social determinants of health).

The pilot study presented in this report followed the methodology of the PATH process outlined by Mittlemark (2001):

- Public meetings were held to gauge interest of individual community members;
- The facilitator was trained to conduct the PATH discussion group;
- A local steering committee (referred to as an Advisory Committee in this study) was formed;
- The facilitator conducted a citizen meeting (PATH discussion group) where participants were asked to consider health in the broadest sense of the term;
- An Editorial Committee was formed to develop a CHIAT based on data collected during the citizen meeting; and
- The project partners (North End Community Health Center; Community Health Board), along with some members of the Advisory Committee will work with key leaders in the community to ensure the CHIAT is used in decision making. Community Health Boards, in particular, can play an important role in raising awareness and eliciting participation on community health issues.

The Community-Driven Health Impact Assessment Tool (CHIAT) is a unique community resource that can be used to assess the impact that a policy, program, service or project will have on the health and well-being of a community.
Community-Driven Health Impact Assessment Tool (CHIAT)

The Community-Driven Health Impact Assessment Tool (CHIAT) is a unique community resource that can be used to assess the impact that a policy, program, service or project will have on the health and well-being of a community. Experience shows that the process of creating the tool is one of community empowerment and is every bit as valuable as the CHIAT itself. The CHIAT is based on the idea that the development of HPP requires broad citizen involvement. It identifies or suggests strategies or actions that can be taken to maximize the benefits (positive effects) and minimize the harm (negative effects) of that activity. Mittlemark (2001) proposes the following key functions or uses for the CHIAT:

- To address the question: “What does it take to make and keep our community healthy?”;
- To examine a broad range of factors determining health;
- To articulate what community members consider to be important for building health in their community, including concerns and priorities; and
- To encourage community participation in decision making.

The CHIAT can then be used to undertake a Community Health Impact Assessment (CHIA), which brings the health concerns of the community forward in discussions on HPP (Forsyth, Slotterback, & Krizek, 2010). CHIA is useful for assessing a project, policy or program according to the priorities already developed by the community by focusing on community values and priorities articulated by the community (and represented by the CHIAT). CHIA adds a new and often unheard of voice when decision-makers look at the potential impact that a policy, program, project or service might have on the population and specific groups within that population because it brings the community’s perspective, through the priority and value lens of the community members themselves.

CHIA derives from Health Impact Assessment (HIA), which was introduced as a HPP intervention in the late 1990s. A study by Harris, Kemp and Sainsbury (2012) examines the relationship between HIA and HPP. HIA offers HPP a technical prediction about the potential population health consequences of public policy proposals. It also offers HPP a process for structured dialogue, thereby making transparent considerations of policy problems, proposed solutions and their potential population health impact. HIA enables communities to have a democratic voice within policy development. However, despite this promise, the HIA has been found to be difficult to institutionalize within policy development cycles. It has also lacked a community voice. Further, despite equity being a conceptual driver for HIA’s use, evidence suggests this has had limited translation into practice (Elliott & Francis, 2005; Harris-Roxas, Harris, & Kemp, 2011; Morgan, 2009). Consequently, CHIA was developed out of the need for the community to have a stronger voice in HPP, particularly around the social inequalities that impact health (social determinants of health).

The CHIAT produced from this study will be owned by the African Nova Scotian community in the North End and will be given to the project partners (North End Community Health Centre; the Halifax Community Health Board) to use on behalf of the community.
CONTEXT & BACKGROUND

This study builds upon existing studies on experiences of inequality, the social determinants of health in African Canadian and African Nova Scotian communities in the North End and health outcomes in these communities. It also builds upon the existing literature on PATH and CHIAT.

African Nova Scotians: A Profile

Historical Overview

People of African descent represent the largest minority population in Nova Scotia (Maddalena, Thomas Bernard, Etowa, Davis-Murdoch, Smith & Marsh-Jarvis, 2010). Statistics Canada (2001) indicates a population size of approximately 19,670 African Nova Scotians or about 2% of the province’s total population. People of African descent have been residing in Nova Scotia for almost 300 years. Two general categories of people of African descent can be identified in Nova Scotia: those often referred to as Indigenous African Nova Scotians who were among Nova Scotia’s earliest inhabitants, and those immigrants that have arrived more recently from African and Caribbean countries (Maddalena, Thomas Bernard, Etowa, Davis-Murdoch, Smith & Marsh-Jarvis, 2010). In Acadia, from the early to mid 1700s, there were more than 300 people of African descent in the French settlement at Louisbourg, Cape Breton. Between 100 and 150 people of African descent were among the new settlers, now known as the Planters, who came from New England after the British gained control over Nova Scotia in 1763. Planters were slaves who were used by plantation owners to do field work and other jobs. Peoples of African descent who came from slavery and war were called Black Loyalists. They left New York and other ports for Nova Scotia between 1783 and 1785 as a result of the American Revolution. They were also taken to the West Indies, Quebec, England, Germany, and Belgium. Between 1783 and 1785, over 3,000 Black people came to Nova Scotia as part of the Loyalist migration. They settled in Annapolis Royal and in areas such as Cornwallis/Horton, Weymouth, Digby, Windsor, Preston, Sydney, Fort Cumberland, Parrsboro, Halifax, Shelburne, Birchtown, and Port Mouton. In New Brunswick, Black Loyalists were settled in Saint John and along the Saint John River. In 1796, 550 people known as the Maroons were deported from Jamaica to Nova Scotia and were then relocated to Sierra Leone in 1800.

Approximately 2,000 escaped slaves came from the United States during the War of 1812 (under conditions similar to those of the Black Loyalists), were offered freedom and landed in Nova Scotia. They moved into the Halifax area to settle in such areas as Preston, Hammonds Plains, Beechville, Porter’s Lake, Lucasville Road and the Windsor area (Nova Scotia Museum, 2010). The majority of Indigenous African Nova Scotians continue to reside in rural and isolated communities as a result of institutionalized racism during the province’s early settlement (Maddalena et al., 2010).

Racialized communities in Nova Scotia experience some of the lowest income levels. The low income rate among African Nova Scotians is significantly higher than the average Nova Scotian low-income rate.
Experiences of Inequality

In 2006, 13.8% of Nova Scotians were living in low income. The highest rate of living in low income occurred in Yarmouth at 27%, and the second highest was Amherst at 19.4%. Halifax had a low-income rate of 14.3%. The lowest low-income rate in Nova Scotia was in Antigonish County at 9.4%. Nova Scotia was found to have the second-lowest average weekly earnings in Canada in 2006. Poverty rates in Nova Scotia, unlike other Canadian provinces, were higher in rural areas than urban centers. This was attributed to the shift from an economy that was primarily resource-based to a more service-based economy between the 1970s and 1990s (Saulnier, 2009).

Poverty is experienced by people across all age groups, family types and educational achievements. Racialized communities in Nova Scotia experience some of the lowest income levels. The low income rate among African Nova Scotians is significantly higher than the average Nova Scotian low-income rate. Women in all groups experience higher low income rates than their male counterparts. Low-income rates in Nova Scotia in 2006 were higher in women than in men, at 10.3% and 8.9%, respectively. In elderly residents (65 years or older) in Nova Scotia, women had a higher incidence of low-income (17.4%) than men (7.5%). The Task Force of Government Service reports that the challenges faced by African Nova Scotia seniors, in particular, can be attributed to little or no access to quality education or decent employment opportunities when they were younger. Consequently, most have lived in low income with all of the barriers associated with this way of living (Saulnier, 2009).

Lone parents and their children experience a higher risk of poverty, as well as more persistent poverty. Female lone parent families are more likely to experience low income and higher rates of poverty than two-parent families and male lone parent families. Forty-four percent of Black children in Canada live in low-income households and of that number, 19% live in Nova Scotia (MacEwan & Saulnier, 2010; Saulnier, 2009).

When gender intersects with race, it creates disproportionately high levels of low income and poverty for African Nova Scotian women — double the Nova Scotia average for all women. In 2000, 39.7% of African Nova Scotia women were living in low income, which was one of the highest rates of poverty in Canada. Several factors accounted for this, including lower levels of education, racism, and higher rates of chronic disease (Saulnier, 2009). Also facing high rates of poverty in Nova Scotia are unattached individuals (especially those 45-64), recent immigrants and Aboriginals. For example, 15% of unattached African Nova Scotian women were living below the low-income cut off in 2005, compared to 13.8% of the total Nova Scotia population (MacEwen & Saulnier, 2010).

Compared to White Nova Scotians, African Nova Scotians experienced higher rates of unemployment, educational
underachievement, illiteracy, incarceration and poor housing in 2003. African Nova Scotians with a university degree were earning on average $12,000 less than other Nova Scotian graduates. Educational attainment does not explain the differences in low income between groups, however. The income gap for African Nova Scotian men and women with a university degree can be attributed to persistent systemic social exclusion (Saulnier, 2009).

**Social Determinants of Health**

Until recently, frameworks in medicine and health research attributed racial disparities in illness and disease to biological, genetic, cultural or lifestyle choice differences between racial groups. However, it is now believed that an analysis of the social context of inequality (income, poverty, education, incarceration, etc.) is important for understanding why race and other social factors are such important predictors of health status. Health disparities between more and less-advantaged groups can be attributed to racial, socio-economic and other inequalities that impact negatively on health, deter or prevent individuals from accessing health services and result in the mistreatment of racialized groups by health professionals. While many patients may be unaware of the often subtle and seemingly benign institutional processes within healthcare that jeopardize their health, they are often acutely aware of how attitudes about race, class, socio-economic status, gender, religion, sexual orientation, language, disability and other social identities influence the treatment they receive from healthcare professionals.

In Canada, racialized, immigrant and refugee communities are most at risk for experiencing the negative health effects that result from persistent social inequalities arising out of historical, structural (e.g. laws, policies), institutional (e.g. education, health, etc.) and every day processes and events (e.g. relationships and interactions with others). Raphael (2007) identifies some of these social determinants of health as Aboriginal status; race; early life; education; employment and working conditions; food security; health services; income and income distribution; social exclusion; social safety net; unemployment; employment insecurity; and poor housing. A report by Access Alliance Multicultural Community Health Centre (2007) also found that the following social determinants compromise health and well-being: lack of access to services and transportation; lack of formal or informal child care; exposure to violence; criminalization and racial profiling; educational streaming; racial/cultural stereotyping; unequal access to information; and concentration in racially segregated neighbourhoods. Wilkins, Berthelot & Ng (2002) note these social determinants produce a number of health and mental health problems, including accidents; anxiety; alcoholism; drug dependency; depression; suicide; and homicides.

Other Canadian studies show that the main determinants of health are not rooted in medical or behavioural factors, but, rather, in a number of social and economic barriers, such as race, immigrant and refugee status, poverty and neighbourhoods (Etowa, Bernard, Oyinsan & Clow, 2007; Etowa, Wiens, Thomas Bernard & Clow, 2007; Jackson, McGibbon & Waldron, 2013; Kisely, Terashima & Langille, 2008; McGibbon, Waldron & Jackson, 2013; O’Mahony & Donnelly, 2007; Raphael, 2007; Tang, Oatley & Toner, 2007; Waldron, 2010a; Waldron, 2010b; Waldron, 2008; Waldron, 2005; Waldron, 2003; Wilkins, Berthelot & Ng, 2002). For example, McGibbon, Waldron and Jackson (2013) observe that cardiovascular disease in racialized communities is often due to long-term racism-related stress and intergenerational trauma, even in the absence of other risk factors. The stress...
of racism results in the body’s physiological stress-handling systems becoming over-taxed, with cardiovascular disease becoming a central result.

Wilson, Elliott, Law, Eyles, Jerrett & Keller-Olaman (2004) investigated the association between perceptions of neighbourhoods to the self-assessed health of the residents in neighbourhoods in Hamilton, Ontario. The authors wanted to compare both physical and social perceptions of these neighbourhoods and their association with three health outcomes - self-assessed health status, chronic conditions and emotional distress. They found that individuals in neighbourhoods with lower socio-economic status reported poorer health and more emotional distress. Measures of socio-economic status, age, and lifestyle were all associated with poor health outcomes.

Hancock (2009) examines the experiences of Aboriginals and African Canadians and found that various social determinants converged to impact on their physical and mental health, resulting in higher rates of HIV/AIDS, cancer, cardiovascular disease, depression, suicide and other health problems when compared to the general population. Individuals living in low-income households or in at-risk neighbourhoods, individuals with lower levels of education, and racially diverse individuals also experience lower rates of health.

Walcott-Francis (2010) provides statistics that indicate that HIV is at a crisis level in Black Canadian communities, who are over-represented in the new HIV infections and AIDS cases. The Public Health Agency of Canada (PHAC) indicates that test reports from 1985 to 2007 show that Black Canadians represented 10.3% of the total reported HIV cases in the country. And, while the virus is on the decline in the White population (down from 75.7% to 58.4%), it has been on the increase in Aboriginal and Black populations. PHAC also found that Black Canadian women are over-represented among persons living with the virus, representing 16.3% of all the reported cases in the country between 1985 and 2007.

Social Determinants of Health in the African Nova Scotian Community in the North End

The pilot study presented in this report builds upon and extends a research study and report by Dr. Waldron on the social determinants of health in the African Nova Scotian and Mi’kmaw communities in the North End entitled “Challenges & opportunities: Identifying meaningful occupations in low-income, racialized communities in the North End” (Waldron 2010). The main objective of this research was to identify how community agencies in the North End could more effectively engage Mi’kmaw and African Nova Scotian communities in meaningful everyday activities. Findings from that study showed that community members faced the following barriers engaging in meaningful activities at community agencies in the North End: 1) lack of inclusive services and programs; 2) not feeling welcomed and accommodated by community agencies; 3) exclusion and discrimination in the wider society and at community agencies; 4) lack of interest and motivation; 5) lack of affordable childcare; 6) scheduling conflicts and lack of time; 7) lack of access to affordable transportation; and 8) fear of violence and crime.

The study also found that the following social determinants operate independently or in tandem to compromise health and well-being in the African Nova Scotian and Mi’kmaw communities in the North End: 1) exclusion and discrimination; 2) exposure to violence and crime; 3) lack of access to transportation; 4) low education and literacy levels; 5) low income and poverty; 6) lack of access to jobs; 7) lack of meaningful connections and relationships; 8) lack of social support networks; 9) lack of access to culturally specific and inclusive programs and services (recreation, childcare, youth and seniors programs and healthcare); and 10) lack of access to information about available programs and services.

Findings also reveal that the most effective strategies for engaging Mi’kmaw and African Nova Scotian
communities in the North End include developing programs and services that are reflective of and responsive to the needs of those communities, engaging in more proactive community outreach, promotion and publicity and developing inter-agency partnerships. Accessing appropriate health and mental health services was found to be particularly challenging for many of the participants in the study for a number of reasons, including lack of information, unavailability of culturally-specific health and mental health services in the area, lack of education and the stigma surrounding mental illness in both communities. Moreover, participants stated that health and mental health promotion must be a collaborative effort that involves inter-professional partnerships involving health professionals, community members, educators and the church. The 2010 study indicates the importance of using research findings to not only positively impact the health of residents, but to also engage them in the creation of healthy public policy. Consequently, PATH and the CHIAT fill a gap by providing an avenue to connect the experiences and stories of community members with a tool they can use to assess policies, programs and interventions that impact health and well-being. The following activities specific to the North End carried out by Dr. Waldron and her research team also informed this pilot study:

- Community seminars that shared research findings from the 2010 study report with community-based agencies (2011-2012);
- A documentary film based on Dr. Waldron’s 2010 study findings entitled “The North End: In search of a new beginning” (Waldron, 2011);
- A documentary film screening and community dialogue event entitled “Can We Talk?: About New Visions for the North End” (February 2012);
- An email newsletter entitled “North End Matters” to share project information to subscribers who attended the “Can We Talk?” event (February 2012-present);
- A Facebook page entitled “North End Matters: A Multi-Phase Project” (created in 2012);
- A report based on the documentary film screening and community dialogue event entitled “Can We Talk?: About New Visions for the North End” (Waldron, 2012a);
- A 15-part online, live-streamed talk show series entitled “North End Matters”, which was live streamed at Haligonia.ca (an online broadcaster) between June and December 2012 (Waldron, 2012b);
- Televised, audio and print interviews about the North End Matters project with CBC Television, Doc Talks (Eastlink TV), Chronicle Herald, Media Co-op, Peninsula News, and Metro News (2012-2013); and
- A community engagement event entitled “Pathway to Health”, which took community members through a “mock” PATH process (2013).

**Health Outcomes in the African Nova Scotian Community**

Structural, institutional and everyday inequalities shape the health experiences of African Nova Scotians in unique ways. While African Nova Scotians residing in rural and remote regions experience similar barriers accessing culturally specific health care services to those living in urban environments, their experiences are further compounded by geographical isolation. This makes it even more difficult to find culturally sensitive health professionals, programs and facilities available in close proximity to their community. These issues contribute to higher incidents of heart disease, cancer, high blood pressure, diabetes and death in this community compared to white Nova Scotians (Saulnier, 2009).
Also important to consider is how gender intersects with race to expose racialized women to a number of health and mental health problems. An understanding of health and illness for racialized women must acknowledge their history as a racialized group (slavery, genocide, relocation), the existence of gender inequalities that accord them secondary status in the social, legal, economic and political institutions of society (e.g. discrimination in employment, housing and society; unequal protection under the law) and their complex relationships to their own communities that simultaneously buffer them from the hard edge of discrimination and subject them to lingering internal problems due to a legacy of oppression that is inherent to racialized communities. Etowa, Thomas Bernard, Oyinsan & Clow (2007) investigated health status, health care delivery, and the use of health services among African Nova Scotian women living in remote and rural regions of Nova Scotia. They found that these women are particularly vulnerable and more prone than White women to illnesses associated with social and economic deprivation, including heart disease and diabetes. In addition, racism, poverty, unemployment or under-employment, limited access to appropriate social, economic and health services, and unpaid care-giving roles were key determinants of poor health for these women. Thomas Bernard (2003) found that for African Nova Scotian women, the cumulative effect of systemic racism in their lives puts them at an increased risk for a number of chronic diseases and other health and mental health problems, including depression and suicide; fear; mistrust; despair; alienation; loss of control; damaged self-esteem; drug and alcohol abuse; violence; high stress and stress related diseases; short lifespan; poor paediatric care; hypertension; cardiovascular disease; high blood pressure; stroke; psychological stress; diabetes; lupus; and breast cancer.

Benton and Loppie’s 2001 study (commissioned by Cancer Care Nova Scotia) found that African Nova Scotians had a higher cancer mortality rate than the general population, which can be attributed to systemic racism which operates within social institutions, including the health care system. A preference for herbal and natural remedies handed down from African ancestors, the unavailability of medical care until the late 1930’s, the use of medical services in emergencies, a legacy of diseases contracted by early African settlers (tuberculosis, cancer, heart disease) and racial discrimination dating back to the enslavement of members of this community may also help explain health disparities between African Nova Scotians and other populations. A follow-up report by Cancer Care Nova Scotia (2013) found that African Nova Scotians continue to face barriers in accessing cancer care health services. These include: delays in accessing cancer specialist services; challenges in communicating with health professionals; barriers with respect to transportation, medication costs, other financial issues and geographic isolation; delays in screening and in obtaining a definitive diagnosis of cancer while in the care of a primary care practitioner; lack of access to family physicians in some rural communities, which may contribute to poor screening participation and late diagnoses; and racism and lack of cultural awareness and sensitivity among health professionals.

Evans, Butler, Etowa, Crawley, Rayson & Bell (2005) examine the ways in which gender, class, race, culture, and other social determinants shape the experience of African Canadians living with cancer by exploring the cultured and gendered dimensions of African Nova Scotians’ experiences of breast and prostate cancer. They conclude that there is a need for culturally appropriate and meaningful health interventions and that health care professionals need to consider how the health experiences of African Nova Scotians are shaped by various social inequalities.
Using PATH to Create Healthy Public Policy

Mittlemark (2001) identifies the following social determinants of health as most important to community members who participate in the PATH process: jobs/employment; healthy childhood development; lifelong learning; lifestyle practices; physical environments; safety and security; social support; stable income; and good quality health services. He states that PATH produces three major outcomes: 1) helps citizens shift their thinking beyond illness experienced by individuals to broader consequences associated with community level decision making; 2) highlights socio-economic inequalities at the local level and supports a community’s ability to influence conditions that positively impact the health of that community; and 3) confirms the value of the CHIAT as a capacity building strategy that empowers communities to make change.

The CHIAT should involve individuals from different sectors, use the broadest vision of health and acknowledge and respect community timelines. It illuminates a community’s perspectives on key issues that affect the community’s health, including communication (including lack of information and poor communication), community involvement, local control, opportunities for leadership development, confidence in one’s community, coordination and cooperation in service delivery, ethics, values and spirituality and respect for one’s culture and history. CHIA, which derives from HIA, is a process that validates community knowledge at the local level, allows for community input and, consequently, ensures that a diverse cross-section of the community have an opportunity to share their priorities and concerns and be involved in decision-making related to the health of their community (Gillis, 1999).

CHIA is introduced as a healthy public policy (HPP) intervention in the late 1990s. It is an important tool for creating healthy public policy and for promoting health, especially at the local level where local leaders are less likely than decision makers at the “macro” level to encounter bureaucratic complexities that make policy implementation difficult. In addition, local leaders are more likely to be attuned to the needs and priorities of residents, leading to greater opportunities for intersectoral collaborations at the local level than at regional or national levels. Harris, Kemp and Sainsbury (2012) identify the following four essential elements of HIA: 1) assesses the impacts of a policy proposal on population health and equity; 2) provides a structured stepwise process to enable stakeholder discussion of policy problems, solutions and their potential impact; 3) provides recommendations to influence the development and implementation of healthy public policy; and 4) accommodates the incremental nature of public policy development and implementation. While all of the recommendations from an HIA are not always addressed, it can be a key strategy for achieving HPP. Therefore, CHIA is an effective tool for facilitating locally-based decision-making that incorporates the perspectives of individuals who are directly impacted by various social, economic and political determinants that impact on health and well-being. It also addresses how existing or planned policies, programs or projects are currently or likely to affect people’s health and should occur prior to implementing a proposal and not during or after (Mittlemark, 2001).

Once the CHIAT is disseminated to local leaders, decision-makers and organizations, the steering committee is responsible for following up with these individuals and organizations to ensure that the CHIAT is being used.
CONCEPTUAL FRAMEWORK

This study uses a critical integrative anti-racism framework (Dei, 1996) to show how race, income, social class, gender, and other forms of social marginality intersect to shape the lived experiences, health and well-being of African Nova Scotians in the North End. While this approach argues that an analysis of racialized peoples (e.g. African Nova Scotians) demands that race become a fundamental analytical entry point in understanding the experiences of racialized communities, it also acknowledges that one cannot fully understand the social effects of race without an appreciation for how it intersects with other forms of social difference, such as income, socio-economic status, social class, poverty, gender, sexual orientation and disability.

A critical integrative anti-racism perspective can also provide an understanding of how these various forms of marginality converge to create unique social positionings, inequalities, and oppressions for African Nova Scotians throughout Nova Scotia. Consequently, it offers a critique of how differential power relations are embedded in social relations marked by various axes of difference and, consequently, how social groups have unequal access to decision-making power and the valued goods and resources of society (health care, jobs, education, etc.). A critical integrative antiracism analysis also allows for an interrogation of how subordinated communities can resist the culture of dominance and positions of marginality through individual agency and collective will and action. This does not mean, however, that those who control the apparatus of the state i.e. (members of the racially, socially, economically and politically dominant group) don’t also have a responsibility to affect change by challenging structural and institutional forms of oppression and discrimination. Therefore, a critical integrative antiracism framework centers the saliency of race alongside a critique of “whiteness” by interrogating white male dominance, power and privilege (Dei, 1996). In other words, the framework particularizes whiteness by questioning the privileged spaces within which Euro-Western thought unfolds and operates. It understands that a critique of inequality (including racism) must extend beyond mere skin colour to the discursive spaces and practices that sustain the cultural normativity of Euro-Western thought and, consequently, the ideological status quo. It also illuminates the co-existence of white ideology with systems of economic, political, psychological, emotional and social privilege, advantage and disadvantage.
METHODOLOGY

The pilot study presented in this report began at the end of May 2013 when the first meeting was held with the research team, Advisory Committee members, and PATH founders to discuss the research design. The study comprised of six main stages:

- Creating visibility for the study;
- Recruitment;
- Data collection;
- Developing the CHIAT; and
- Data analysis.

The study used naturalistic inquiry, a philosophical foundation that acknowledges the complexities of the human experience and the implications of historical, social, economic and political factors and processes in the lives of individuals and communities. The main purpose of naturalistic research is exploration, understanding, description, and explanation. Adhering to the principles of naturalistic research, the pilot study was bounded along a number of dimensions, including location or physical setting (the North End), cultural groups (African Nova Scotians), and the range and nature of experiences examined (social, economic and political determinants of health).

Qualitative methods were used to collect and analyze the data. Qualitative methods allow for a complex articulation of the broad range of human experiences and validate knowledge that emerges from subjective, personal, emotional, experiential and intuitive frames of reference. Three main data collection methods were used:

- A PATH discussion group with African Nova Scotian North End residents;
- A focus group with residents; and
- An interview with the PATH Facilitator.

Creating Visibility for the Study

The following strategies were used to create visibility for and awareness about the study and PATH/CHIAT in the African Nova Scotian community, engage the community and enhance recruitment:

- A project Facebook page entitled “North End Matters: A Multi-Phase Project” created one year before the pilot study commenced to share information, updates, and news about the multi-phase project (that commenced with the 2010 research study), monthly project meetings and information about activities and events in the North End (February 2012-present);
- An email newsletter entitled “North End Matters” created one year before the pilot study commenced to share information, updates, and news about the multi-phase project. Newsletter subscribers include individuals who attended the “Can We Talk? About New Visions in the North End” event, which was discussed earlier (February 2012-present);
Monthly project meetings held at the Johanna B. Oosterveld Centre in the North End, which were advertised and open to the public (2013);

Information, updates and news about the study posted on various Facebook pages, including the Facebook page for Black Nova Scotian News (2013-present);

Information, updates, and news about the study shared via the email newsletter sent out by Councillor Jennifer Watts (HRM Councillor for District 8 - Peninsula North) (2013-present);

Information about the study shared with Halifax Community Health Board’s networks (2013);

An interview with Dr. Waldron for the Chronicle Herald newspaper (September 2013);

A community engagement event entitled “Pathway to Health” that took participants through a “mock” PATH discussion group process (October 2013);

An interview with Dr. Waldron for Halifax Media Co-op, an online broadcaster (October 2013);

An interview with Shelina Gordon (Research Assistant), Sylvia Parris (Advisory Committee member) and Dr. Waldron for Gottingen: Two Sides of the Street, an online broadcaster (November 2013);

A live chat with Dr. Waldron for Gottingen: Two Sides of the Street (November 2013); and

An interview with Dr. Waldron for Doc Talks, a television program that airs on Eastlink TV (December 2013).

Recruitment

Recruitment for the pilot study commenced in February 2014. A total of 12 African Nova Scotians residing in the North End participated in this study, including 11 PATH participants and one (1) PATH facilitator who was interviewed about her experiences facilitating the PATH discussion group. **Purposive sampling** was used to recruit participants. Purposive sampling involves selecting participants based on specific traits or characteristics that researchers deem important to a study. In the case of this study, the traits deemed most important were race, geographic/residential location, gender and age. In addition to the initial plan to recruit participants who self-identified as African Nova Scotians residing in the North End, attempts were made to recruit participants who were diverse across a number of age, gender identity, and disability categories.

When initial attempts to recruit such a diverse and inclusive group of participants failed to yield the required number of participants in a timely manner, a decision was made to be less restrictive about the number of participants required for each category. Once this was done, recruitment proceeded much more quickly. While the research team understands the value of being inclusive when recruiting participants, it also recognized that attempts to be inclusive were also simultaneously restrictive for a study with such a small sample size. Despite this, the participants that were recruited represented some level of diversity across gender identity, age, and ability/disability categories. Although 12 participants were initially recruited to participate in the PATH discussion group and follow-up focus group, 11 participants eventually participated since one participant had to withdraw from the study for personal reasons. The following participants were eventually recruited for the study:

- Two (2) men between the ages of 44 and 51;
- Nine (9) women between the ages of 19 and 63; and
- One (1) PATH facilitator.

It is important to note that recruitment of African Nova Scotian and other racialized communities for research studies is often rife with challenges. As many researchers working with these communities come to realize, gaining
the trust and confidence of community members is often hard-fought, hard-won and, at times, easily lost and never to be found again. Therefore, the research team decided to use the following proactive approaches to recruit participants: 1) approaching participants directly and 2) asking community-based agencies to disseminate information on the study to their networks.

The challenges the research team encountered recruiting youth (especially male youth) and seniors for the pilot study will be addressed in several ways as the project moves forward to the larger study. First, more direct and targeted recruitment approaches will be used, such as developing different versions of a recruitment flyer to target different subpopulations in the African Nova Scotian community (youth; seniors) in the North End. In addition, snowball sampling will be used more widely to recruit participants. Snowball sampling is a technique where participants who have already been recruited recruit future participants from among their acquaintances. Since many of the participants who attended the PATH discussion group are well known members of the community with numerous connections to the African Nova Scotian community in the North End, snowball sampling will be particularly effective during the next phase of the study.

Data Collection

The following three main data collection methods were used in the study:

- A one-hour audio-recorded discussion on participants’ “vision of a healthy community”, which was the only portion of the six-hour PATH discussion group that was recorded;
- A one-hour audio-recorded follow-up focus group with PATH participants that took place immediately following the PATH discussion group; and
- A one-hour audio-recorded interview with the PATH facilitator that took place a few days after the PATH discussion group and follow-up focus group.

This study has several strengths, which are related to the data collection methods. First, it is the first-ever research study on the PATH process, providing the researchers with an opportunity to evaluate the process - which has never been done before. Moreover, the lack of prior research on the topic means that the research team was required to develop an entirely new research typology that was exploratory in nature. Another source of strength inherent to this study is that it collected and analyzed self-reported data, which is, of course, an important feature of the PATH discussion group process.

PATH Discussion Group Process

The PATH facilitator used a variety of activities and resources to engage participants in a discussion on how various social determinants affect their health, including the list of health determinants in Appendix A. These activities and resources enabled participants to identify various indicators that could be incorporated into the CHIAT. It is important to point out that participants’ discussion on their “vision of a healthy community” (including the vision statement developed based on that discussion) was the only portion of the PATH discussion group that was audio-recorded. This discussion involved participants identifying a list of important requirements for a healthy North End community. The facilitator observed that finding a definition for the determinants of health in plain language, explaining the determinants in lay terms and engaging participants in a discussion on the determinants helped them to grasp broader meanings of the determinants and their relationship to their own lived experiences. She used various strategies to get participants thinking about the determinants, including posting a list of determinants in bright coloured paper, which the participants were able to review during the break, engaging participants in a storytelling exercise and placing a paper roll on top of the table with the following question: “What make a
During the storytelling exercise, the facilitator invited participants to tell a story from their life experience. She then guided the group through a series of key questions to delve deeper into one of the stories in order to identify all of the factors that affect health and well-being (the determinants of health) and the ways in which these factors are inter-related. This process of exploration and reflection on these questions produced a group analysis of the factors that make and keep a community healthy.

The table below provides a descriptive account of how the PATH discussion group unfolded over the course of six hours.

### PATH DISCUSSION GROUP PROCESS

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>LENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductions, housekeeping announcements and a warm up team-building exercise</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Picture exercise (pictures from magazines) that enabled participants to discuss how individuals, activities and events highlighted in the pictures represent social determinants that affect their lives and health</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Morning break</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Storytelling session</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Lunch</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Team-building exercise to re-focus participants</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Storytelling wrap-up</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Discussion on a “vision of a healthy community”, including developing a vision statement</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Afternoon break</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Recap of the day’s activities and a debrief</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

**Follow-Up Focus Group with PATH Participants**

A semi-structured interview guide (see Appendix B) was used during the follow-up focus group with the PATH participants to capture information on their opinions about the effectiveness of the PATH discussion group process in helping them articulate the social determinants of health. Interview questions focused on how their knowledge had changed regarding the social, economic and environmental factors affecting their health and well-being; if or
how their views about the health needs of their community had changed after participating in the discussion group; and how the PATH discussion group process could benefit their community.

**Interview with the PATH Facilitator**

A semi-structured interview guide (see Appendix C) was also used during the interview with the PATH facilitator to capture information on her opinions about the effectiveness of the PATH discussion group process in helping participants articulate the social determinants of health. Interview questions focused on activities that were most and least successful in helping participants understand and discuss the social determinants of health; her opinion about how the process changed participants’ perspectives and understandings about the social determinants of health; the most important learning outcomes for participants; and the extent to which participants were now empowered and mobilized to take action on the social determinants of health affecting community health and well-being.

**Developing The CHIAT**

An Editorial Committee comprised of four individuals came together at the end of March 2014 to assemble the CHIAT (see page 46) for the pilot study. These individuals included the PATH facilitator, two PATH participants and one member of the Advisory Committee. The research assistant took notes during the session. The CHIAT can be used to do the following:

- Address the question: “What does it take to make and keep our community healthy?”;
- Examine a broad range of factors determining health;
- Articulate what community members consider to be important for building health in their community; and
- Encourage community participation in decision making.

The process used to assemble the CHIAT involved reviewing the vision statement, as well as further defining the vision factors by identifying three examples that met the definition intended by PATH participants and that reflected the voice of the community.

**Data Analysis**

A general inductive analytical approach (Bryman & Burgess, 1994; Dey, 1993; Elliott & Gillie, 1998; Jain & Ogden, 1999; Marshall, 1999) was used to analyze the data in this study. The main purpose of this approach is to allow research findings to emerge from the frequent, dominant or significant themes inherent in the raw data. In inductive analysis the patterns, themes and categories of analysis emerge out of the data rather than being imposed upon them prior to data collection and analysis. A theme can be defined as a statement of meaning that runs through all or most of the pertinent data or is one in the minority that carries heavy emotional or factual impact. Themes typically reflect the questions posed during an interview or focus group and, ultimately, reflect the research objectives and questions that were used to develop the interview and focus group questions.

There are several components to a general inductive approach. First, data analysis is determined by both the research objectives (deductive) and interpretations of the raw data (inductive). Thus, the findings are derived from both the research objectives and findings arising directly from the analysis of the raw data. Categories are developed from the raw data into a framework that captures key themes and processes that are considered to be important to the researcher. The research findings consequently emerge from multiple interpretations made from
the raw data by the researcher (data analyst). Therefore, the findings are shaped by the assumptions and experiences of the researcher who conducted the research and carried out the data analyses. These interpretations involve the researcher making decisions about what is more important and less important in the data. The trustworthiness of findings can be assessed by a range of techniques, such as independent replication of the research; comparison with findings from previous research; triangulation within a project (using more than one data collection method in the research study, such as was the case in this pilot study); feedback from participants in the research; and feedback from users of the research findings. An inductive approach was used in the pilot study outlined in this report to analyze the data in the following way:

- The transcripts were read to consider multiple meanings and how these reflected developing themes and categories. This involved a rigorous reading of the transcripts in order to allow major themes to emerge.
- Data from all sources (transcripts for “vision of a healthy community” discussion; follow-up focus group; interview with PATH facilitator) were extracted in terms of how well they related to individual themes or issues.
- The relationships between themes and the identification of themes important to participants were identified.
- Typologies or a classification system was developed to categorize patterns or phenomena based on the verbal categories utilized by participants in the audio-recorded data (e.g. participants’ vision of a healthy community; information provided by PATH participants and PATH facilitator about the effectiveness of PATH in helping participants understand and discuss the social determinants of health, etc.). Typologies are classification systems comprised of categories that divide some aspect of the world into parts.
- These patterns or phenomena were sorted into categories as recurring regularities as the data continued to emerge.
- This process was completed once all sources of information had been exhausted and when sets of categories had been saturated. Towards the end of the study no new themes emerged, which suggested that major themes had been identified.
- Clear links were established between the research objectives and the summary findings derived from the raw data.
- Finally, a brief report of the findings were written up that interpreted and summarized the data.

**Study Limitations**

Several methodological limitations are inherent to this study. The first limitation is the under-representation of African Nova Scotian men in the sample. Since only two African Nova Scotian men participated in the PATH discussion group and follow-up focus group, the study was limited in its ability to fully capture the varied experiences and perspectives of African Nova Scotian men (including male youth) residing in the North End. Given that African Nova Scotian men experience employment, education, the criminal justice system and other social determinants of health in unique ways, this insight and perspective would have been important to capture from a larger number of male participants.

Finally, although not a limitation of this study (since the objective of this pilot study was to recruit a small sample size), it is important to state the small sample size used in this study is not representative of the diverse experiences and views of the African Nova Scotian community in the North End. In other words, the study does not attempt to make claims or generalize about how the African Nova Scotian community in the North End as a
FINDINGS

The following themes emerged from data collected from the vision of a healthy community discussion during the PATH discussion group, the follow-up focus group with PATH participants and the interview with the PATH facilitator:

- An evaluation of the PATH discussion group process;
- The effectiveness of the PATH discussion group process in helping participants understand and articulate the social determinants of health;
- Community empowerment, mobilizing and advocacy; and
- Participants’ vision of a healthy North End community.

An Evaluation of the PATH Discussion Group Process

The general perspective expressed by participants was that the PATH discussion group process worked better than expected. They described the process as interesting and informative. Participants indicated that the PATH discussion group process left them feeling renewed, hopeful, equal, respected and valued. Other statements that were used to describe how the PATH discussion group process made them feel include: “It was home” and “we all validated each other because of what each person had to say”. Participants stated that they felt actively involved in the process for a number of reasons, including their interest in the topic of health, the enjoyment they experienced sharing personal stories, the sense of connection they felt with the other participants, the interactive nature of the PATH discussion group exercises and the opportunity to express their opinions in a way that may otherwise be perceived as loud or “acting out”. Participants noted that they learned from one another, despite the fact that different age groups were represented in the discussion group. They mentioned that the process offered them an opportunity to express their feelings in a safe, non-threatening environment where they felt welcomed, validated and free to be themselves. Participants also observed that the PATH process made them feel more connected to the community because it gave them an opportunity to come together with other community members who live in different areas of the North End, particularly individuals they had never met before.

The PATH facilitator noted that some of the participants came to the process without any preconceived notions about what the process would involve, which resulted in some participants feeling slightly vulnerable. The activity that was most successful in engaging participants in a discussion on the social determinants of health was the exercise that required participants to read from a list of definitions for various social determinants of health and to provide their interpretations and opinions about these determinants. This exercise proved successful because it helped participants understand and articulate the social determinants in lay terms. Also successful was the picture exercise that enabled participants to further develop their understanding of the determinants of health, as well as to interpret them in other ways. Examples of pictures that were shown include pictures of children participating in a festival, a biracial couple, a garden, a blue sky, the recently released Africville stamp, a pregnant woman, and a young child attending class. The facilitator observed that these exercises proved quite useful in getting participants
to relate the determinants of health to their everyday lived experiences later on during the storytelling phase of the process.

When asked if she would facilitate the PATH discussion group differently in the future, the facilitator concluded that it is impossible to give a definitive answer since every PATH discussion group will be different. She did, however, give several explanations for why she would most likely facilitate a group with racially mixed or predominantly white participants differently from how she facilitated the African Nova Scotian discussion group for the pilot study. First, she observed that as an African Nova Scotian living in the North End, she had a natural connection with other African Nova Scotian residents with whom she shared a similar language, perspective and understanding of the issues and priorities that were of most concern to members of this community. Second, she pointed out that the success she experienced engaging participants had much to do with the fact that she has lived in the North End all of her life and was familiar with or knew most of the participants. Therefore, the existing relationship she has with the community and its residents helped create a dynamic that provided an element of safety for the group.

She acknowledged, however, that adjustments will need to be made to reflect the experiences of participants, regardless of the race of participants.

She also shared her insights into how the training she attended at the COADY Institute helped her facilitate the PATH discussion group with African Nova Scotian North End residents. She stated that the most valuable aspect of the training was the opportunity to interact and develop relationships with people from all over the world (e.g. Indonesia; Pakistan) who shared diverse experiences and ideas. This experience gave her a greater appreciation for the many privileges she enjoys as a Canadian compared to people who come from developing countries. For example, she recognizes the privileges that Canadians enjoy being able to access clean water by turning on the tap or drinking spring water from a machine, while individuals in some developing countries have to deal with drinking water that comes from a dirty stream. She noted, however, that participants in her training group who live in developing countries tended to trivialize some of the challenges that she and others in her community face compared to the challenges they faced. Despite these privileges, she stressed that all challenges and experiences must be placed in their proper context. Consequently, she believes that the challenges that African Nova Scotians face should be considered as important as the challenges that others face because their experiences are real for them. In conclusion, the facilitator expressed that facilitating the PATH discussion group gave her a broader perspective on how to engage participants in any type of discussion group.
The Effectiveness of the PATH Discussion Group Process in Helping Participants Understand & Articulate the Social Determinants of Health

Participants expressed that listening to other people’s opinions and experiences helped them gain a different perspective on the “social determinants of health” concept by helping them to think differently about how social, educational, economic and environmental factors affect their well-being as individuals and as part of a community. They noted that they were better able to appreciate how these determinants relate to their everyday lived experiences and that this new insight would be useful to them in the future. Although the social determinants of health was not a new concept for participants and did not change their views on the issues, it did help to reinforce and broaden their perspective about the relationship between various social determinants, the healthcare system and health outcomes for individuals and the community in general. It also provided them with an opportunity to discuss issues that they believed had been “pushed back”.

Participants also shared their perspectives on what they think makes and keeps African Nova Scotians in the North End healthy. First, participants indicated that one of the most important factors in making and keeping people healthy in the North End is acceptance of diverse African Nova Scotian subpopulations in the North End, regardless of cultural heritage, nationality and geographic location. They discussed ongoing divisions in the African Nova Scotian community in the North End and how important it was for residents in the “Park” (Mulgrave Park) to be accepted by residents in the “Square” (Uniacke Square) and the “Pubs” (public housing complex located in the west end of the city) since “we’re all black communities”. Also discussed were the challenges that CFAs (people who have “come from away” from other provinces and countries) experience being accepted by and integrating into the African Nova Scotian community. Participants noted that individuals are more likely to be accepted if a connection can be made between an individual’s last name and last names in the African Nova Scotian community. Cultural pride and love for the community were also discussed as important factors in making and keeping the community healthy. Finally, participants discussed how language has been used to stereotype the African Nova Scotian community in the North End. They were particularly concerned with how negative connotations associated with the term “the hood” impacted the well-being of their community.

The facilitator noted that while none of the exercises were ineffective in helping participants understand and articulate the social determinants of health, the
storytelling exercise was initially met with some hesitation by one participant who did not understand the relationship between the social determinants of health and the story discussed during the storytelling exercise. It was only after the facilitator proceeded to dissect the story did the participant come to appreciate how various elements in the story related to the determinants of health. The facilitator expressed how surprising it was that seven people in the group felt safe enough to volunteer to share one or more personal stories, including experiences of racial profiling and harassment by the police and racism by a healthcare provider. At the conclusion of the storytelling exercise, there was a unanimous decision about which story should be selected. The facilitator concluded that the most important learning outcome for participants was gaining a broader knowledge about the determinants of health and general well-being.

Participants discussed the various ways in which the PATH process could be used to support social action and advocacy in the African Nova Scotian community in the North End

Community Empowerment, Mobilizing & Advocacy

Participants discussed the various ways in which the PATH process could be used to support social action and advocacy in the African Nova Scotian community in the North End. There was a general consensus that the process made them more aware about what is happening in the neighbourhood, different cultural practices in the community, and how to address issues in the future. They recognized the value in having a tool (CHIAT) that documents the community’s views and responded with a resounding “amen” when asked if they felt more motivated or able to take action on some of the social determinants facing African Nova Scotians in the North End. Participants expressed that the “hands on” nature of the PATH discussion group process helped build trust amongst the participants and made them more motivated to get involved in committees or community groups to discuss and find solutions to ongoing problems affecting their community. They indicated how important it was that these discussions be held at a common meeting space that was accessible to all North End residents, regardless of residential location and other geographical divisions that exist between different subpopulations in the North End. Participants also identified various ways in which the PATH process could be more useful to the community, including being a catalyst for developing leadership in the community through the delegation of specific roles to individuals in the community, reinforcing what was learned to ensure it works effectively, and having the opportunity to apply the process to real-life events and situations in the community.
works effectively, and having the opportunity to apply the process to real-life events and situations in the community (e.g. proposed sale of the St. Patrick’s-Alexandra School site, school closures in the North End, etc.).

The facilitator observed that participants left the process with a heightened awareness of the social determinants of health. She also noted that the process resulted in participants experiencing a shift in thinking that extended beyond the social determinants of health to a broader conceptualization of their role in creating “community” on three levels: 1) as participants during the PATH discussion group; 2) as African Nova Scotians in the North End; and 3) as community advocates. Some participants indicated an interest in creating a sense of community by starting support groups for women and by generally appreciating the similarities and commonalities that connect them to others in the community. The facilitator concluded that the discussion group was a useful and healthy process because participants expressed an interest in doing more in the community, determining “next steps” and engaging in community mobilizing efforts. For example, several participants expressed an interest in participating in more dialogue about community development and in volunteering to sit on the Editorial Committee for the larger study to assist with the development of the CHIAT.

Participants’ Vision of a Healthy North End Community

Data were collected on participants’ one-hour discussion on their vision of a healthy North End community during the six-hour PATH discussion group. This discussion was the only portion of the PATH discussion group that was audio-recorded and used in the pilot study. Participants expressed a general sentiment about the lack of awareness among new residents in the North End about the role they could play in the gentrification of the community. This was followed by a discussion on vision factors for the North End, with participants identifying the following list of important requirements for a healthy North End community (These vision factors were further refined when the Editorial Committee met to develop the CHIAT in March 2014):

- Affordable and respectable housing;
- Crime free/safe area “where people look out for one another”;
- Guidance and support from the community and from people “higher up” in the community;
- Opportunities for people to socialize and get to know one another (festivals, events);
- More positive media coverage of the community;
- Communication at community forums and community groups;
- Visual representation that involves developing community leaders;
- Empathy and compassion by the dominant group on “our issues”;
- Educating health care professionals about cultural competency;
- A diverse and inclusive community, which leads to a broader understanding of and appreciation for one another;
- More services and resources in the community (grocery stores, banks, services);
- Equal employment opportunities, including employment of people within the community;
- Welcoming environment: non-residents have a misunderstanding of the North End, but when they visit the neighbourhood they understand why the neighborhood is home for many African Nova Scotians;
- More free or affordable educational and recreational programming;
- More opportunities for artistic expression, such as murals and street art (i.e. art at Black Street and Northwood Terrace intersection);
- Opening a Halifax Sexual Health Centre (formerly Planned Parenthood Clinic) in the neighbourhood, which will reduce the number of “kids having kids”;
- Living in harmony in a way that is inclusive and respectful of racial, cultural, religious, sexual, gender differences; and
- Equal treatment for all.
After these vision factors were identified, the PATH facilitator reviewed the list of vision factors developed by her and the other participants that attended the PATH training session at the COADY Institute in June 2013. She noted that there was little difference between the one her group had created and the one created by the African Nova Scotian participants (listed above). The “vision of a healthy community” portion of the PATH discussion group concluded with participants developing the following vision statement based on vision factors they believed to be most fundamental to a healthy North End community:

**VISION STATEMENT DEVELOPED BY AFRICAN NOVA SCOTIAN NORTH END RESIDENTS**

“Living in a safe, socially dynamic, inclusive and respectful community that values diversity”

Participants’ general sentiment was that reading the vision statement made them feel “good and wanted”. They stated that they loved the attention-grabbing nature of the vision statement they had developed. They also noted that the vision statement symbolized something they wanted to be involved in because it offered them a place to go. Finally, they expressed their hope that their vision of a healthy community will prevent dehumanizing incidents from occurring to members of their community – incidents that were discussed during the storytelling phase of the PATH discussion group process.
VISION FACTORS

The process that the Editorial Committee used to assemble the CHIAT involved reviewing the vision statement and refining the vision factors (listed earlier) by identifying examples that met the definition intended by the PATH participants and that reflected the voice of the community (please see page 47 for these examples).

The vision factors include the following:

- Affordable & Respectable Housing
- Crime Free/Safe Area
- Positive Visual Representation
- Creating Community Unity through Recreation & Artistic Expression
- Valuing Cultural Proficiencies
- Diversification
- Representation within the Economic Structure of Our Community

The CHIAT will be owned by the African Nova Scotian community in the North End and given to the project partners (North End Community Health Centre and the Halifax Community Health Board) to use on behalf of the community. Ultimately, the CHIAT can be used as evidence that a proposed change will positively or negatively affect the community before that change is implemented.
A healthy community is one that has affordable and respectable housing, which includes:
- Affordable housing for people with various levels of income
- Respectful housing that is free of pests and has timely repairs and quality workmanship
- Value placed on sweat equity, which can be defined as economical with a standard of value placed on home owners or home renters

A healthy community is a crime free and safe area, which means:
- It has well-lit areas
- It has community watch programs that are enforced
- It values accountability that involves community input into how the community is policed
- It has sidewalks that are cleared and trees that are pruned
- It has law enforcement officers who respond to crime in a manner that demonstrates input from and respect for the community

A healthy community has positive visual representation, which means:
- There are opportunities for leadership development
- There are opportunities to develop community information forums

In a healthy community, community unity is created through recreation and artistic expression, which means:
- Programs are structured to be inclusive and representative of the community
- Programs are reflective of the needs or preferences of the community
- Programs are available within the geographical parameters of the community
- There is a central database for recreational and artistic endeavors
- There is more educational and recreational programming for youth
A healthy community values cultural proficiencies, which means:

- Valuing cultural uniqueness
- Adhering to policies and practices that are inclusive of the racial and cultural diversity of the defined demographic
- Healthcare and education professionals collaborate with the community to develop understandings of holistic approaches
- Healthcare and educational professionals receive training and apply knowledge of cultural proficiencies

In a healthy community, diversification is valued, which means:

- Living in harmony in a way that is respectful and inclusive of gender, sexual, racial and religious diversity
- Respecting the historical richness that makes our community unique

A healthy community has representation within the economic structure of our community, which means:

- Employing people within the community
- Equal employment opportunities
- Access to more stores, grocery stores, banks and other services as defined by the community

The Purpose Of The Community Health Impact Assessment

Community health impact assessment is a way to bring the health concerns of the community forward in discussions of public policy.

- It allows us to estimate the effect that a particular activity (a policy, program, project or service) will have on the health of the community.
- It suggests things we can do to maximize the benefits (the positive effects) and minimize the harm (the negative effects) of that activity.

Community health impact assessment is not a substitute for decision-making but it is one tool we can use to guide thinking and discussion.

Most policies or programs have both positive and negative effects on a given population (a geographic community or a specific “community” of people within that geographic area). For this reason, community health impact assessment is not meant to determine if a policy is “right” or “wrong”. Rather, it helps to identify how a particular activity will enhance or diminish the many factors that the community considers to be important for its overall health.

The North End Community Health Center and the Halifax Community Health Board have developed this Community Health Impact Assessment Tool to assist groups and organizations in thinking about what it takes to make and keep our community healthy.

The factors listed in the Assessment Worksheet are based on the priorities identified by the community during a PATH discussion group that was held in the North End of Halifax on February 8, 2014.
The Broad Determinants of Health

There is growing evidence that the health of people and the communities in which they live – is influenced by much more than the contribution of medicine and health care.

Health Canada has identified 12 key factors, known as the determinants of health, that are crucially important for a population to be healthy. Each of these factors is important in its own right. At the same time, the factors are interrelated.

In this community health impact assessment tool, two of the factors – social support networks and social environments – have been grouped together.

In order to assess the impact that a particular activity (a policy, program, project or service) will have on the overall health of the community, we need to look at **all** of the determinants of health as well as the various factors **within** those determinants that the community considers to be important.

- Income and social status
- Social environment and support networks
- Education
- Employment and working conditions
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture

How To Use This Tool

**Determine What to Assess**

Community health impact assessment should be used to assess major policies, programs, projects or services that will have a significant effect on the overall health of the geographic community (or a particular “community” within the geographic area).

**Involve the Right People**

This community health impact assessment tool is designed for **group discussion**, not as an individual activity. It can be used by various decision-making groups, groups that represent people within the community, or groups that are composed of members of the community. Where possible, it is best to include those who will be most affected by the proposed policy or program that is being assessed.
Prepare for the Discussion
Gather all of the information available about the proposed activity. Before you begin, please read the sections:

- Our Vision of a Healthy Community
- The Purpose of Community Health Impact Assessment
- The Broad Determinants of Health

Give Yourself Time
It will take approximately 2 – 2 ½ hours of group discussion to work through the factors in the Assessment Worksheet and to complete the Summary Worksheet. Be sure to set aside enough time so that all opinions are heard and valued.

Facilitate Discussion

- Every factor in the Assessment Worksheet is important. Be sure to invite comment on each one of the factors.
- The impact on some of the factors will be negligible or not applicable. Simply check the “NO/NEUTRAL” column and move on.
- If the discussion gets bogged down on some of the factors, encourage the group to “flag” that issue and come back to it when completing the Summary Worksheet.
- Respect different opinions. If the group cannot agree on an impact, check the “NEED MORE INFO” box or make a notation in the “COMMENTS” column.

Keep in Mind
This tool is designed to assess the impact of an activity on all of the factors affecting community health, not to determine if a proposed activity is “right” or “wrong”. Encourage people to make an honest and open-minded assessment.
### STEP 1: ASSESSMENT WORKSHEET

**A healthy community is one that has affordable and respectable housing:**

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<tr>
<th>WILL_______ HAVE AN IMPACT ON THE FOLLOWING AREAS</th>
<th>YES POSITIVE</th>
<th>YES NEGATIVE</th>
<th>NO OR NEUTRAL</th>
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<td>Affordable housing for people with various levels of income</td>
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**A Healthy Community is a Crime Free and Safe Area:**

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A healthy community has positive visual representation:

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WILL_______

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HAVE AN IMPACT ON THE FOLLOWING AREAS

Opportunities for leadership development

Opportunities to develop community information forums

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**In a healthy community, community unity is created through recreation and artistic expression:**

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**A Healthy Community Values Cultural Proficiencies:**

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In a healthy community, diversification is valued:

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<th>WILL_______ HAVE AN IMPACT ON THE FOLLOWING AREAS</th>
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<td>Living in harmony in a way that is respectful and inclusive of gender, sexual, racial and religious diversity</td>
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<td>Respecting the historical richness that makes our community unique</td>
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A healthy community has representation within the economic structure of our community:

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<th>WILL _______ HAVE AN IMPACT ON THE FOLLOWING AREAS</th>
<th>YES POSITIVE</th>
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<td>Employing people within the community</td>
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<td>Equal employment opportunities</td>
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<td>Access to more stores, grocery stores, banks and other services as defined by the community</td>
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**STEP 2: SUMMARY WORKSHEET**

Now that you have assessed the impact that the proposed activity will have on the many factors affecting the health of the community, it is time to develop a **summary** and identify the **actions** that need to be taken.

- Carefully consider the results of your reflections in each section of the Assessment Worksheet. Try to **develop a statement of the “overall impact”** for that section.

  Keep in mind that this is not simply a “tally” of the results, since one or more negative (or positive) impacts may outweigh a number of positive (or negative) impacts. For example, your statement might be something like “Generally positive but special attention needs to be paid to..”.

- **Identify any actions** you need to take in order to complete the community health impact assessment. Some examples of actions include:
  
  a)  Seeking more information (from where? by when? etc.)
  b)  Consulting with other groups
  c)  Returning to particular points in the Assessment
  d)  Worksheet at a later date

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<tr>
<th>PAGE</th>
<th>CONSIDERATION</th>
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<td>A healthy community is one that has affordable and respectable housing</td>
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<td>A healthy community is a crime free and safe area</td>
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<td>A healthy community has positive visual representation</td>
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<td>In a healthy community, community unity is created through recreation and artistic expression</td>
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<td>A healthy community values cultural proficiencies</td>
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<td>In a healthy community, diversification is valued</td>
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<td>A healthy community has representation within the economic structure of our community</td>
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NEXT STEPS – AN ACTION PLAN

The community health impact assessment is not complete until you have developed a plan for the “next steps” that your group will take. You may wish to work on this section at a subsequent meeting.

Use this planning grid to help keep track of the various tasks and strategies that emerge from the group’s discussion.

Some of the “next steps” that can be included in the grid are:

- Seeking more information (from where? by when? etc.). This information can be extracted from the “Action Required” column of the Summary Worksheet.
- Presenting your concerns to another group or decision-making body (what group? how? etc.)
- Inviting further discussion that involves the affected groups

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<th>NEXT STEP</th>
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<th>PERSON RESPONSIBLE</th>
<th>REPORT BACK (BY WHEN)</th>
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DISCUSSION

Although gentrification brings with it many socio-economic advantages, it may also contribute to a deepening of already existing income and social inequalities. While more affluent residents who migrate to a neighbourhood often experience gentrification in positive ways, lower income residents often find that their social and economic challenges persist, even in the face of so-called “revitalization”. For many of these residents, gentrification does little to increase their access to jobs, nutritious foods, safe and affordable housing and affordable transportation – all of which are important determinants that affect health and mental health. Without these important resources, residents are at risk for a number of health problems that result from chronic stress and constant worrying about unpaid bills, living in substandard housing or not having good access to fresh food and affordable and reliable transportation.

The vision statement that participants developed is: **Living in a safe, socially dynamic, inclusive and respectful community that values diversity.** The vision statement integrates the following vision factors participants deemed as important requirements for a healthy community during the PATH discussion on their “vision of a healthy community”:

- Affordable and respectable housing
- Crime free/safe area
- Positive visual representation
- Creating community unity through recreation and artistic expression
- Valuing cultural proficiencies
- Diversification
- Representation within the economic structure of our community

It is important to point out that these vision factors are social determinants of health because they reflect structural, institutional and everyday factors that affect the lives, well-being and health of a community. Consequently, the PATH process was successful in helping participants understand and articulate the determinants of health in the context of their everyday lived experiences.

A few of the vision factors identified by participants relate closely to the built environment – an important determinant of health that is inclusive of several other determinants of health discussed by participants in this study. The built environment can be defined as the physical surroundings in a neighbourhood and includes the buildings, parks, schools, road systems, level of crime and safety and other infrastructure that residents encounter in their daily lives. People who live in communities characterized by stores in walking distance from their homes, well-connected street networks, high residential density, accessible transportation, and accessible recreational activity are often healthier than those who do not. Vision factors identified by participants which are examples of the built environment include creating community unity through recreation and artistic expression and living in a crime free and safe area. Participants identified the following specific requirements for creating community through recreation and artistic expression: 1) inclusive programs that are representative of the community; 2) programs that reflect the needs or preferences of the community; 3) programs that are available within the geographical parameters of the community; 4) a central database for recreational and artistic endeavors; and 5) more educational and recreational programming for youth. Participants also identified the following requirements for a crime free and safe area: 1) well-lit areas; 2) community watch programs that are enforced; 3) accountability, including community input into how the community is policed; 4) sidewalks that are cleared and trees that are pruned; and 5) law enforcement officers who respond to crime in a manner that
demonstrates input from and respect for the community.

Also closely related to the built environment is “neighbourhood”, which is a particularly significant determinant of health. The concept of neighbourhood takes on a particular significance in the North End, which is currently experiencing neighbourhood gentrification (discussed earlier). The “settings” or environments where we live, learn, work and play throughout our lives have a considerable influence on our health and well-being. Disparities in neighbourhood characteristics often produce health disparities between advantaged and less advantaged communities. Aspects of neighbourhood which impact health include nutritious foods, good quality schools, transportation, green space, access to jobs and affordable housing.

Affordable and respectable housing were identified by participants in this study as important vision factors for a healthy North End community. They discussed the following specific requirements for affordable and respectable housing: 1) affordable housing for people with various levels of income; 2) respectful housing that is free of pests and that has timely repairs and quality workmanship; and 3) value placed on sweat equity, which can be defined as economical with a standard of value placed on home ownership and home renters. Some of the most significant housing characteristics that can put some North End residents at risk for poor health outcomes include neighbourhood or area-based characteristics and internal housing conditions. Neighbourhood or area-based characteristics include gentrification, migration of newcomers to the neighbourhood and relocation of current residents to other areas of the city, stresses in the physical and social environment, neighbourhood opportunity structures (e.g. jobs) and public housing. Internal housing conditions that have implications for health include the physical infrastructure, environmental housing conditions (exposure to pathogens, air quality, etc.) and access to the water supply. In addition, representation within the economic structure of the community was a vision factor identified by participants which relates closely to neighbourhoods. This vision factor was discussed with respect to: 1) employment of people within the community; 2) equal employment opportunities; and 3) access to more stores, grocery stores, banks and other services as defined by the community.

Social networks (i.e. opportunities to socialize and get to know others in the neighbourhood) was also deemed an important vision factor for a healthy community by participants in this study. A participant’s comment that non-residents who initially have a misunderstanding of the North End come to understand why the neighbourhood is home is illustrative of Merton’s (1968) argument that localized subcultures emerge in neighbourhoods where residents have limited life chances, are highly segregated and have dense local social networks. Berry and Park (2007) observe that residents who are marginalized due to income, race or other social factors often have fewer links outside their neighbourhood, resulting in more intense social bonds within their community. Strong social networks and bonds can often facilitate community engagement and organizing, both of which are central to good public health because they help to decrease health disparities. Participants in this study identified positive visual representation as an important vision factor for a healthy community, including opportunities for leadership development and creating community information forums. For many of the participants in this study, the PATH discussion group engendered an interest in community engagement and in creating a sense of community in the North End. Participants shared that they were interested in being more involved in their community, including

**PATH and CHIAT can both play a pivotal role in the development and implementation of health equity policies targeted to African Nova Scotians**
participating in discussions about community development, joining committees and community groups and using the CHIAT for social action and advocacy on health and well-being in the community. This vision factor is reflective of the following seven key criteria of community engagement identified by the Tamarack Institute for Community Engagement (2010; 2005): 1) a broad range of people are participating and are engaged; 2) people are trying to solve complex issues; 3) the engagement process creates vision, achieves results, creates movement and/or change; 4) different sectors are included in the process; 5) there is a focus on collaboration and social inclusion; 6) the community determines local priorities; and 7) there is a balance between community engagement processes and creating action. As community engagement processes and advocacy tools that address all of these concerns, PATH and CHIAT can both play a pivotal role in the development and implementation of health equity policies targeted to African Nova Scotians. They can also empower residents to take action on social justice issues by highlighting structural and institutional inequalities that disadvantage certain communities and prevent equal access to various resources.

Social justice is a public health issue. Health is determined by the fair distribution of and access to valuable resources in society (food security, adequate housing, gainful employment, adequate income, etc.). Differences in population health, or health disparities, can be traced to unequal economic and social conditions that arise out of historical, structural, institutional and everyday inequalities. Health disparities between more and less advantaged populations describe the differences in health experience and health outcomes based on social structure (education system; labour market); an individual’s social position (socio-economic status; geographic area; age; disability; race; gender; sexual orientation, etc); intermediary factors (environment; health behaviour; health access; and social care) and health outcomes (e.g. illness or good health). While diverse social positionings may result in health disparities, diversity also has many advantages. For example, participants discussed diversification as an important vision factor for a healthy community, seeing it as a strength that can contribute to community capacity-building and stronger communities. According to participants, respecting the historical richness that makes the African Nova Scotian community unique, as well as living in harmony by being respectful and inclusive of gender, sexual, racial and religious diversity are important sources of strength that need to be tapped in the North End.

Social policies drive health. It is the absence of policies that create the social and economic inequalities that negatively affect health. Health equity policies are concerned with improving health by first focusing on the organization of society, particularly how social and economic resources are distributed unequally by gender, race, class and other factors. It involves tackling health disparities by broadening our lens to bring into view the ways in which jobs, working conditions, education, housing, transportation, crime, income insecurity, food insecurity, social inclusion, discrimination and political power impact individual and community health. Consequently, eliminating the challenges African Nova Scotians in the North End face around those issues is as much a health promoting initiative as traditional health promotion strategies such as healthy eating and exercise campaigns. Some of these challenges can be tackled by valuing cultural proficiencies, which is another important vision factor identified by
According to participants, respecting the historical richness that makes the African Nova Scotian community unique, as well as living in harmony by being respectful and inclusive of gender, sexual, racial and religious diversity are important sources of strength that need to be tapped in the North End.

PATH can be a useful tool for empowering the African Nova Scotian community in the North End to advocate for better social policies, which can potentially improve health and well-being in the community. Given the many external and environmental determinants that continue to impact health and well-being in the African Nova Scotian community in the North End, health equity policies are integral for reducing and eliminating long-standing health disparities in Nova Scotia that are the consequence of public policy and the unequal distribution of societal resources along race, gender, class and income lines. Furthermore, developing more culturally-specific health services and programs will assist health professionals in responding more effectively to the specific social, economic and political factors that drive health in the African Nova Scotian community in the North End and in other areas of Nova Scotia.
RECOMMENDATIONS

Recommendations in the following areas need to be considered as the project moves forward to the next phase of the study: 1) community engagement and advocacy; 2) recruitment; and 3) Using the CHIAT.

Community Engagement & Advocacy

Effective community engagement and community advocacy require that African Nova Scotian North End residents, project partners (North End Community Health Center; Halifax Community Health Board) and the Advisory Committee collaborate on the following activities:

- Develop a community engagement plan to specifically target and engage a broad range of individuals and sectors in the African Nova Scotian community in the North End, including agencies and diverse individuals (youth, men, seniors, members of the LGBTQ community, individuals with disabilities, and newcomers).
- Ensure that the engagement process creates a vision, incites social action, achieves results, and creates change.
- Host a series of community engagement events to engage diverse sub-populations.
- Raise awareness and elicit participation on health issues in the African Nova Scotian community in the North End.
- Provide a forum for residents to come together to determine local priorities and to develop collaborative strategies for advocating around some of the social, economic and political factors that impact health and community well-being.

Recruitment for Larger Study

Effective recruitment requires that the research team do the following:

- Collaborate with project partners and the Advisory Committee to recruit participants.
- Use community engagement activities carried out by project partners, residents and the Advisory Committee to facilitate participant recruitment.
- Disseminate and post different versions of the recruitment flyer to target diverse sub-populations in the North End.
- Ensure that recruitment is inclusive of diverse African Nova Scotian residents, including newcomers, youth, men, seniors, etc.

Using the CHIAT

Effective use of the CHIAT requires that the project partners collaborate with the Advisory Committee to carry out the following activities:

- Hold community workshops to test the CHIAT and strategize for its continued use.
- Disseminate the CHIAT to local leaders, decision-makers and organizations.
- Follow up with these individuals and organizations to ensure that the CHIAT is being used.
KNOWLEDGE SHARING ACTIVITIES

Diverse and innovative knowledge sharing activities are at the core of this pilot study. These activities have been used to share the study findings with diverse stakeholders, including North End residents and other community members in Halifax; community agencies; service providers; health agencies; health professionals; policy makers; university professors; researchers; and students. The knowledge sharing activities listed below were used at the inception of the multi-phase project on the North End and throughout the pilot phase of the project to share information about project news and activities:

Facebook Page

Live-Streamed Talk Show
Live-streamed talk show entitled North End Matters (Haligonia.ca) about Dr. Waldron’s study on the social determinants of health in the North End of Halifax (archived on Haligonia.ca), aired between June-December 2012: http://live.haligonia.ca/halifax-ns/north-end-matters.html

Documentary Film
Documentary film entitled The North End: In search of a new beginning about Dr. Waldron’s study on the social determinants of health in the North End of Halifax, released October 2012: http://www.youtube.com/watch?v=o7AQhaO4YYM&feature=BFa&list=PL649C5F10AE296771

Television
Interview on Global Halifax Morning News (Channel 6) about the pilot study outlined in this report, which focuses on the social determinants of health in the African Nova Scotian community in the North End, aired May 26, 2014

Interview on Doc Talks (Eastlink TV, Halifax) about Dr. Waldron’s projects on the social determinants of health in the African Nova Scotian community in the North End and the health effects and socio-economic outcomes associated with toxic industries and waste dumps in Mi’kmaw and African Nova Scotian communities, aired December 9, 2013.

Interview on CBC TV News Daily Segment (CBC, Halifax) about Dr. Waldron’s study on the social determinants of health in the North End of Halifax, aired February 15, 2012.

Newspapers


**Online Broadcasters**


Audio and text interview about Dr. Waldron’s study on the social determinants of health in the North End at Dalhousie Experts website, October 1st, 2012:
[http://media.dal.ca/?q=node/232](http://media.dal.ca/?q=node/232)


**Community Events & Meetings**

Presenter & Organizer, “Can We Talk? About New Visions for the North End”, North Branch Library, February 2012.


**Sharing Findings & Knowledge from the Pilot Study**

An event was held by the research team on May 26, 2014 to share findings from this pilot study, share the preliminary CHIAT and identify next steps as the research team moves forward to the larger study. The pilot study report will be disseminated by email at the beginning of June 2014 to key agencies (including community-based, social service and health agencies in Halifax and Nova Scotia) and the general public using the activities listed earlier. In addition, the following activities will be used to share information about the study outlined in this report, as well as other activities related to the study:

- Media (newspapers, television, radio)
- Facebook page for the project entitled “North End Matters: A Multi-Phase Project”;
- Other Facebook pages;
- Email newsletter for the project entitled “North End Matters”;
- Online broadcasters;
- Seminars; and
- Community meetings and other events.
REFERENCES


Appendix A: List of Determinants of Health Used by the PATH Facilitator

There is a growing body of evidence about what makes people healthy. Each of these factors is important on their own but at the same time is interrelated with other factors. The following list provides an overview of what we know about the ways the determinants influence health.

Income and Social Status - Health status improves with prosperity and social standing. High income determines living conditions such as safe housing and ability to buy sufficient good food. A number of studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems.

Social Support Networks - Support from families, friends and communities is associated with better health. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems.

Education & Literacy - Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people’s ability to access and understand information to help keep them healthy.

Employment/Working Conditions - Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

Social Environments - The array of values and norms of a society influence in varying ways the health and well being of individuals and populations. Social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health.

Gender – Boys and girls and men and women get different kinds of disease and conditions at different ages. They also tend to have different income levels and different kinds of jobs, which often a results in different ways in which society views and treats males and females.

Culture – People’s customs, traditions and the beliefs and values of their family and community all affect their health. These factors influence what people think, feel, do and believe in.

Healthy Child Development – Prenatal and early childhood experiences have a positive impact on brain development, school readiness and health in later life. At the same time, all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth.

Biology & Genetic Endowment - In some circumstances inherited predispositions appears to predispose certain individuals to particular diseases or health problems.

Physical Environments - Factors in our natural environment (e.g. air, water quality) and human-built environment (e.g. housing, workplace safety and road design) play a role in individual and public health.

Personal Health Practices & Coping Skills – Learning how and what individuals can do to prevent diseases and promote self-care, cope with challenges, develop self-reliance, and solve problems will help people make choices that enhance health.

Health Services – High quality, accessible health services and health promotion contribute to public health.
Appendix B: Follow-Up Focus Group Interview Guide for PATH Discussion Group Participants

Introduction:
Thank you for taking the time to talk with me about your experiences participating in the PATH Discussion Group process. I am also interested in hearing your opinions about the effectiveness of that process. This focus group will be audio recorded. It will last 60 minutes.

Questions

1. Could you please share your experiences overall about participating in PATH process earlier today?
   ♦ What is your general opinion of the PATH process?
   ♦ Can you describe how it felt to be a part of this process?
   ♦ Did you feel actively involved in the process and if so, what helped to engage you?

2. Can you please describe how your knowledge has changed regarding the social, educational, economic and environmental issues that impact health and well-being in a community?
   ♦ What new information did you obtain about these social determinants of health after participating in the discussion groups?
   ♦ How, if at all, did your views about the health needs of your community change after participating in the groups?
   ♦ Can you give an example of something related to your health that you now think differently about?

3. How, if at all, has the PATH process helped the group highlight and prioritize issues that relate to the wellbeing of African Nova Scotians in the North End?
   ♦ Is there anything else you would like to address or share now that you did not get a chance to discuss during the groups about what you think makes and keeps African Nova Scotian people healthy in the North End?

4. Can you describe how, if at all, you think the PATH process will be useful to you now or in the future?
   ♦ Do you feel motivated or more able to take action on some of the health issues facing African Nova Scotians in the North End after participating in the groups?
   ♦ How would you like to be involved in action related to these health issues in the future?

5. Can you identify ways in which the PATH process can be more useful to your community?
   ♦ Can you share any ideas on how this process may be improved?
   ♦ Are there ways this process could have helped you get more actively involved?
Appendix C: Interview Guide for PATH Facilitator

I would like to thank you for agreeing to do this interview about your experiences facilitating the PATH Discussion Groups. I would also like to hear your opinions about the effectiveness of the process in enabling participants to articulate the social determinants of health.

Questions

1. Before the study began, you participated in a certificate training program on community-driven health impact assessment and PATH. Could you tell me about your experiences participating in this training program?
   - What is your general opinion about the PATH process?
   - What are some of the most important things you learned?
   - Which aspects of your training were most helpful to you in preparing for facilitating the PATH process?

2. What was your experience like facilitating the PATH process?
   - Can you describe how your knowledge about social determinants of health changed after participating in the PATH process?
   - Which tasks/activities were most successful and least successful in engaging participants in articulating the social determinants of health?
   - Would you do anything differently? Why and why not?
   - Do you see yourself using your training and experience facilitating the PATH process in future? If yes, how? If not why not?

3. What is your opinion about participants’ ability to articulate the social determinants of health during the PATH process?

4. To what extent were participants aware of the social determinants of health before the PATH process?

5. Do you think there was a shift in their thinking about the social determinants of health after the PATH process concluded? How?

6. What do you think were the most important learning outcomes for participants around the social determinants of health?

7. How empowered and mobilized to action do you think participants were around the social determinants of health impacting their community before, during and after participating in PATH?