Final Study Report For

North End Matters:
Using the People Assessing their Health Process (PATH) to Explore the Social Determinants of Health in the Black Community in the North End

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April 1st, 2015
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ACKNOWLEDGMENTS

I would like to thank the following individuals, agencies, organizations and businesses for their support.

PATH Participants
Black residents in the North End of Halifax

PATH Facilitator
Sandra Parker

Research Staff
Shelina Gordon, Research Assistant
Ashlee Hinchey, Graphic Artist

Project Partners
Rebecca Marval, North End Community Health Center
Shelina Gordon, Halifax Community Health Board

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Sheri Price, RN, Ph.D., Assistant Professor, School of Nursing, Dalhousie University
Jill Grant, FCIP, LPP, Professor, School of Planning, Dalhousie University

Catering for PATH Discussion Group
South Park Catering

Venue for PATH Discussion Group
Johanna B. Oosterveld Centre (North End Community Health Center)

Funding Agency
Nova Scotia Health Research Foundation Development Innovative Grant

Special Thanks to COADY International Institute, St. Francis Xavier University for Funding the PATH Facilitator’s Training During the Pilot Phase for the Project in 2013

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

Summary of Project Description
The study outlined in this report examines the social determinants of health in the Black community in North End, Halifax in the context of the socio-economic transformation this area of the city has been experiencing over the past several years. The study, which builds on a pilot study that was completed in June 2014, comes at a time when many Black residents in the North End are among those most negatively impacted by the social and economic challenges brought on by gentrification.

Recognizing that some individuals attribute poor health outcomes, illness and disease to “bad genes” or biological, genetic, cultural or lifestyle choice differences between racial groups, the study used the People Assessing their Health (PATH) discussion group process to engage Black North End residents in discussions on the social, economic, and political factors and processes that impact community health and well-being (i.e., the social determinants of health). 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). The CHIAT 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 health and well-being in their community.

Research Objectives
The study had two main objectives:

• To examine the effectiveness of using the People Assessing their Health (PATH) process to engage the Black community in the North End in articulating the social determinants of health and

• To obtain participants’ vision of a healthy North End community.
Summary of Study Findings

Study findings were categorized into two main themes based on the research objectives: 1) the effectiveness of the PATH discussion group process in helping participants articulate the social determinants of health and 2) participants’ vision factors for a healthy North End community.

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

Findings indicate that the PATH discussion group process was effective in helping participants articulate the social determinants of health for several reasons: 1) it broadened their perspectives on health; 2) it provided them with opportunities to articulate gentrification as a social determinant of health that serves to deepen existing social and economic inequalities; and 3) it impressed upon participants the importance of community cohesiveness, mobilizing and capacity building in addressing the social and economic factors that impact community health and well-being.

Broadened Perspectives on Health:

- Increased participants’ awareness of the various social, educational, economic and environmental determinants that affect health and wellbeing.
- Provided community members with a broader and more holistic view of health that went beyond a focus on the physical body, illness and disease.
- Helped participants recognize how systemic inequalities embedded within various social institutions affect community health and well-being.

Gentrification as a Social Determinant of Health:

- Lack of representation of the Black community in the new businesses that are opening up in the North End.
- The loss of various resources that were mainstays in the Black community in the North End.
- Difficulties finding affordable housing in the North End.
- The importance of developing community resources and services in the North End that respond to the needs of the Black community.
- The lack of recreational activities for youth in the community.

Community Cohesiveness, Mobilizing and Capacity-Building:

- The importance of having a “sense of community” and a “community spirit” in the Black community in the North End.
- The importance of engaging in more action-oriented collaborative efforts around the social determinants of health.
**Vision Factors for a Healthy North End Community**

The following four vision statements developed by PATH participants capture many of the pertinent social and economic determinants affecting health and well-being in the Black community in the North End:

- Our vision of a healthy African Nova Scotian community in the North End is one that is a healthy, diverse community that shows and embraces respect, acceptance and security.
- Our vision of a healthy African Nova Scotian community in the North End is one that has good community relations, is action-oriented, diverse, prosperous, united and has opportunities for exposure that empowers inclusivity, partnership and ownership.
- Our vision of a healthy African Nova Scotian community in the North End is one that offers equal employment opportunities, affordable and quality housing, equitable education and policing that is respectful and inclusive.
- Our vision of a healthy African Nova Scotian community in the North End is one where recreation, health and mental health, housing and other services are accessible, user-friendly and lead by culturally competent teams; where our schools (P-9) are high performing and arts-based.
Dr. Ingrid Waldron was born and raised in Montreal. In addition to Montreal and Halifax, she has lived, worked and studied in Ferney-Voltaire (France), London (England), Geneva, Trinidad, Ottawa and Toronto. She 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. Dr. Waldron’s research and teaching focus on the sociology of race and ethnicity, the sociology of health and mental health, 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. Dr. Ingrid teaches “Social & Cultural Determinants of Health”, “Women & Ageing”, “Community Health Assessment & Planning” and “Community Development & Advocacy” at the undergraduate and graduate levels. In addition, to university teaching, Dr. Waldron was hired as a consultant by Correctional Service Canada to deliver workshops on the mental health of ethno-racial populations to prison staff (program officers, correctional officers, psychologists, etc.) in Nova Scotia and New Brunswick. 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. 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, poverty, women’s studies and environmental justice. Dr. Waldron’s methodological expertise is in critical anti-oppression approaches, including Black feminist, anti-colonial, antiracism, African-centred, and Indigenous knowledge theories. She currently serves on several community-based and university advisory committees, including Health Association of African Canadians, Poverty Intervention Tool Network, Immigrant Services Association of Nova Scotia, Diversity Committee (School of Nursing, Dalhousie University), Promoting Leadership in Health for African Nova Scotians (Dalhousie University), Access & Retention of Aboriginal and Black/African Canadian Students (Dalhousie University) and Imhotep Legacy Academy (Dalhousie University).
Dr. Sheri Price 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. Dr. Price 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. Dr. Price 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. Dr. Price 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. Her research is predominantly qualitative in nature, using both interpretive (narrative) and post-structural methodologies. Dr. Price 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. She 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. Dr. Price 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.
Professor Jill Grant began her career in anthropology, but switched to planning because of her interest in helping people find strategies for improving their living conditions. She has conducted field research throughout Canada, and also in Papua New Guinea, Japan, Europe, the US and UK. Her work looks at the cultural context of community planning, exploring the values that planners, developers, and residents bring to the places they design and inhabit. After 22 years of teaching environmental planning at the Nova Scotia College of Art and Design, Ms. Grant joined Dalhousie University in 2001, as part of the merger of the NSCAD and Dalhousie planning programs. From July 2002 to December 2008, and from March to December 2013, she served as Director of the School of Planning at Dalhousie. Her teaching areas include planning and environmental history, planning philosophy, internship, community design, and community analysis. Through the years Ms. Grant has also taught research design, practical writing, and planning theory. She has served on the editorial boards of Plan Canada, Journal of the American Planning Association, Landscape and Urban Planning Journal, Canadian Journal of Urban Research, CJUR / Canadian Planning and Policy, Planning Theory and Practice, International Planning Studies, and the Encyclopedia for Quality of Life and Wellbeing Research. Ms. Grant is one of the series editors for the RTPI Library Book Series (Routledge UK). From 2004 to 2007, she was a member of the Joint Canada / Nova Scotia Environmental Review Panel for the Whites Point Quarry Proposal. In 2014 she was appointed to Housing Nova Scotia's Interim Advisory Committee. Ms. Grant’s research projects examine topics such as coordinating multiple plans, examining trends in residential environments, the theory and practice of planning suburbs, the influence of new urbanism on Canadian planning practice, the planning response to gated communities in Canada, planning for creative cities (with special interest in music and cultural sector workers), neighbourhood change, and health and the built environment. Her general research interests include the cultural context of community planning and focus on the relationship between planning theory and planning practice. Ms. Grant has often involved colleagues and students in her research during the last two decades.
The study presented in this report examines the social, economic, educational and health experiences of Black residents in the North End of Halifax in the context of the socio-economic transformation this area of the city has been experiencing over the past several years. The study builds on a pilot study that was completed in June 2014. 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 concept, it is important to state at the outset that the term “Black” 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. As such, the study included Black residents who were born in Nova Scotia (i.e. African Nova Scotians), as well as recent and long term immigrants from various African countries. 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 this area of the city. 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, developers, planners and media.

Gentrification as a Social Determinant of Health

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 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 there their entire lives in the area (i.e. African Nova Scotians) 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 and the conversion of industrial buildings to residences and shops, 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.

Existing studies that focus on the social, economic and political implications of gentrification have largely failed to consider how these issues affect community health and well-being, particularly for those residents who are among the 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 significant determinant of health. Gentrification 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).

This study comes at a time when many Black North End residents are among those most negatively impacted by the social and economic transformations 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 inequalities that have deepened over the past few years. 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 engaged Black North End residents in discussions on how these inequalities have affected health and well-being in their community, as well as their vision for a healthy North End community. The PATH process increases people’s understandings on 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.

**Research Objectives & Questions**

This study had two main objectives:

- To examine the effectiveness of using the People Assessing their Health (PATH) process to engage the Black 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 Black residents in North End, Halifax in articulating the social determinants of health.
- What is Black participants’ vision of a healthy North End community?
People Assessing Their Health (PATH)

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 understandings 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, which took place between 1996 and 1997, helped 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 experiences 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 pertains to 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 study outline 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 collaborated 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.
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, 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).
This study builds on existing studies on experiences of inequality, the social determinants of health and health outcomes in Black Canadian-born and immigrant communities in Nova Scotia and Canada. It also builds on 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 of 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
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 in African Nova Scotian, African Canadian & Immigrant Communities

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 subject racialized individuals to differential treatment 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 everyday 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 and Ng (2002) note that these social determinants produce a number of health and mental health problems, including accidents; anxiety; alcoholism; substance dependence; 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 significant health outcome.

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.

Hyman (2009) identifies a number of barriers that contribute to racial inequities in the quality of health care experienced by racialized groups. As Hyman outlines “the direct impact of racism on health behaviors includes resorting to high risk health behaviors such as substance abuse, self-harm and other negative coping responses, as well as delays in seeking healthcare” (p.9). The correlation between racism and other social determinants of health is also explored in addition to the impact of institutional racism, health inequities and healthcare access. Hyman explores six policy actions to address the key factors she outlines as contributing to the ethnic and racial disparities in Canada. These include: 1) increase public awareness of racism and its impacts on health, access to healthcare and quality of healthcare; 2) implement and enforce policies and procedures to eliminate institutional racism in all sectors; 3) undo institutional racism in health policy, administration and practice; 4) reduce the negative impact of racism on health; and 5) allocate funding for research and monitoring activities.

Rodney et al (2009) note that visible minority and other vulnerable groups in Canada experience higher rates of poverty, lower education, poorer housing and poorer working conditions. These inequalities often lead to higher rates of chronic disease, substance consumption and abuse, poorer diets, inactivity and higher rates of prolonged stress. In Canada, addressing inequities in accessing healthcare programs and services is slowly being addressed through health policy, planning and research. It is important to note, however, that research on African Canadians does not distinguish between those who are native born and those who are born in regions outside of Canada. This complicates the accuracy of research because it masks important differences in health outcomes and health behaviors between these two groups. There are few provincially-led quantitative studies on African Canadians. Those conducted indicate that African Canadians experience higher rates of circulatory disease, diabetes, and psychiatric disorders compared to whites. Other studies suggest that African Canadians have similar or better self-reported health than whites. For example, Lebrun et al (2013) focus primarily on native born African Canadians in their study compare health outcomes in African Canadian and white communities. Whites reported higher rates of smoking and chronic conditions such as hypertension, diabetes, heart disease and cancer. African Canadians reported higher rates of smoking abstinence and asthma. The data shows no difference regarding obesity and fair/poor health status. The study also found that overall, native born African Canadians report comparable or better health than Whites.

Hancock (2009) examines the experiences of Aboriginals and African Canadians and found that various social determinants converge 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 African 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 African 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 African Canadian populations. PHAC also found that African 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.

Joseph et al (2009) examine the relationship between culture, individual values and beliefs and coping responses
to discrimination among African Canadians. They found that they use various coping strategies, including problem
solving, cognitive/emotional debriefing, spiritual-based coping, collective and ritual-based methods to respond to
racial discrimination.

Church also plays an integral role in providing support to African Canadian communities, as Tomlinson (2011)
points out. Consequently, church-based health programs such as wellness seminars and workshops have been
implemented to promote healthier habits. This has resulted in positive results in areas such as weight loss, dietary
adjustments and blood pressure.

A review of the literature indicates that immigrants experience various health disparities that are rooted in their
newcomer status. The migrant experience may result in mental distress, frustration, aggression and violence, all of
which may be misdiagnosed by psychiatrists who may undermine social causation (e.g. migration and settlement)
in explaining mental health problems whilst emphasizing scientifically based and biological understandings of
mental illness. Many of these clients have not been pre-diagnosed with mental health problems before
immigrating to Canada because of the stigma surrounding psychiatry and psychiatric labels in their home countries
(Gee, Kobayashi & Prus, 2004; Haws, 2005; Waldron, 2013). Several studies (Access Alliance, 2007; Gee,
Kobayashi & Prus, 2004; Haws, 2005; Waldron, 2008) indicate that migrants (immigrants, refugees etc.) may suffer
from a number of emotional, mental and physical health problems, including low self-esteem; headaches; anxiety;
high blood pressure; insomnia; loss of energy; trauma; psychosis; clinical depression; self-harm; suicidal ideation;
substance use; and gambling addiction (particularly for individuals dealing with poverty).

Hyman (2009) found that recent immigrants are less likely to visit their doctor regularly and less likely to utilize pre-
screening programs. Baffoe (2009) examines the experiences of African immigrants from Ghana, Nigeria, Senegal,
Cameroon, Kenya, Uganda and Somalia who often struggle with integrating into Canadian society. An important
component of settlement for African immigrants is the “emotional reconstruction of home” as they slowly begin
the process of accepting and adopting Canada as their new home. Compounding this issue are the systematic
barriers and marginalization they experience that often take a toll on their health and well-being. The “healthy
immigrant effect” is a term that was coined to characterize the decline in immigrant health and mental health
status after arrival in Canada. Immigrants’ health and mental health at the time of migration to Canada are
generally better than that of Canadian born residents. However, their health and mental health status gradually
erodes as they settle in Canada, leading to the development of chronic conditions, weight gain, and depression
(Access Alliance, 2007; Halle and Anchan, 2005). The “healthy immigrant effect” highlights the role of various
social determinants (social inequality, unemployment, the migrant experience, poverty, marginalization and
discrimination) in putting immigrants and refugee groups at risk for a number of health and mental health
problems. For example, DeMaio et al (2010) and Kirmayer et al (2011) note that a decline in immigrants’ self-
reported health status is greatly influenced by unfair treatment and discrimination. Kirmayer et al also found that
as the settlement process increases, immigrants are at a higher risk for psychiatric disorders related to their
exposure to violence, torture, war, exile and forced migration in their homelands. These disorders include post-traumatic stress disorder, depression and chronic disease. He suggests that assessment and treatment effectiveness in primary care settings can be improved with the use of interpreters, cultural brokers and primary care practitioners who possess a good understanding of culture and its effect on the health of immigrant communities.

Structural, institutional and everyday inequalities shape the health experiences of African Nova Scotian communities 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 forms of racism that operate within various 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 to accessing cancer care health services. These include: delays in accessing cancer specialist services; challenges communicating with health professionals; transportation barriers; medication costs; other financial issues; 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; 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 observes 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 community perspectives on key issues that affect community 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).

HIA was 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, HIA 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 affecting health and well-being. It also addresses how existing or planned policies, programs or projects currently or are 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 in the Black community in the North End. While this approach argues that an analysis of racialized peoples 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 Black communities 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 resist the culture of dominance and positions of marginality through individual agency and collective will and action. This does not suggest, 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 and the privileged spaces within which Euro-Western thought operates (Dei, 1996). It argues that a critique of inequality (including racism) must extend beyond mere skin colour privilege to the discursive spaces and practices that sustain the cultural normativity of Euro-Western thought and, consequently, the ideological status quo. Therefore, it illuminates the co-existence of white ideology with systems of economic, political, psychological, emotional and social privilege, advantage and disadvantage.
METHODOLOGY

This study used an interpretive, narrative approach (Polkinghorne, 1983; 1988; 1995) to collect and analyze the data. This qualitative approach involves data collection methods that enable participants to articulate, define and give meaning to their experiences. Within Polkinghorne’s narrative methodology, humans are recognized as self-interpreting beings and their interpretation of phenomena is embodied in social, cultural and linguistic practices. Polkinghorne (1988) observes that narratives are the “primary scheme by means of which human existence is rendered meaningful” (p.11). Therefore, narrative inquiry is not a mere retelling or description of an individual’s story, but a dynamic process of interpretation that alters and contributes to the meaning of the story. The importance of individual experience to reality is a key characteristic of an interpretive approach to narrative inquiry. Individuals come to know themselves and others through stories and storytelling. Narrative knowing is a type of meaning that draws together events and actions and notes the contributions that they make to a particular outcome (Polkinghorne, 1988). Human experience is organized along a temporal dimension. Attention to the past, present and future is a key feature of narrative inquiry and temporality an essential component of narrative theory. Temporality denotes that an event is more than a temporal occurrence but is instead located in relation to other events, both in the past and the future (Polkinghorne, 1988). Understanding how a community defines health, and the implications of this process, can be achieved through the use of narrative configuration, in that human experience is understood as an unfolding and developing story. Narratives provide a useful framework for understanding evolving events. Emplotment is defined as the process of organizing life events into a coherent story (Ricoeur, 1991).

This study, which began in June 2014 and was completed in March 2015, comprised of four main stages:

- Recruitment;
- Data collection;
- Development of the CHIAT; and
- Data analysis

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

- PATH discussion group;
- Follow-up focus group; and
- In-depth interview with PATH Facilitator

Sample & Recruitment

Recruitment was ongoing throughout the study, commencing in the spring of 2014 and concluding in August 2014, when the final PATH discussion group was held. Purposive and snowball sampling were used to recruit participants. Purposive sampling involves selecting participants based on specific traits or characteristics that researchers deem important to a study. For this study, the traits deemed most important were race (Black), culture (e.g. Indigenous African Nova Scotian; African; Caribbean etc.), immigrant status, geographic/residential location (i.e. North End resident), gender and age. In addition to the initial plan to recruit participants who self-
identified as “Black”, African Nova Scotian or African residing in the North End, attempts were made to recruit participants who were diverse across a number of age and gender identity categories. Snowball sampling was also used to recruit participants. It involves asking participants who have already been recruited to recruit future participants from among their acquaintances.

The objective was to recruit 50 participants, however one participant dropped out a day before the discussion group, resulting in a sample of 49 participants. This included the PATH facilitator, who was interviewed about her experiences facilitating the discussion groups, and 48 discussion group participants, nine of whom were recent and long-term immigrants from Africa. Participants included 33 women and 15 men and ranged in ages from early 20s to participants in their 60s.

Data Collection

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

- Four six-hour PATH discussion groups, which involved audio-recorded data on participants’ “vision of a healthy community” (the only portion of the six-hour PATH discussion groups that were recorded);
- Four one-hour audio-recorded follow-up focus groups with PATH participants that took place immediately following the PATH discussion groups; 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.

The first PATH discussion group and follow-up focus group took place on June 21st, 2014 and included a total of 13 participants (12 women; 1 man). The second PATH discussion group and follow-up focus group took place on June 28th, 2014 and included 12 participants (9 women; 3 men). The third discussion group and focus group took place on July 26th, 2014 and included 13 participants (8 women; 5 men). The final discussion group and focus group were held on August 16th, 2014 and included 10 participants (4 women; 6 men).

The study’s strengths pertain to the data collection methods. First, it built on the pilot study, which was the first-ever research study conducted on the PATH process, providing the researchers with an opportunity to evaluate the process. In addition, the study was enhanced by the collection and analysis of self-reported data obtained from the PATH discussion groups.

PATH Discussion Group Process

The PATH facilitator used a variety of activities and resources to engage participants in discussions on how various social determinants affect their health and well-being. One of these resources was the list of health determinants outlined 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 table on the next page provides a descriptive account of how each PATH discussion group unfolded over the course of six hours.
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 about their opinions about the effectiveness of the PATH discussion group process in helping them articulate the social determinants of health. Interview questions focused on participants’ experiences participating in PATH process; how their knowledge about the social determinants of health changed after participating in the PATH process; and how the process helped them understand health and well-being in the Black community in the North End.
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 about her opinions about participants’ ability to articulate the social determinants of health during the PATH process; the extent to which participants experienced a shift in their thinking about the social determinants of health after the PATH process concluded; the most important learning outcomes for participants; ideas for new initiatives that came out of the PATH session; and the extent to which participants were empowered and mobilized to take action before, during and after participating in the PATH discussion groups.

Data Analysis

The following information was analyzed after all of the data were collected: 1) data on participants’ discussions on their vision of a healthy North End community during all four PATH discussion groups; 2) data from the follow-up focus groups with PATH participants; and 3) data from the interview with the PATH facilitator. The data were analyzed based on the research objectives and research questions. In other words, themes were generated about the effectiveness of the PATH process in helping participants identify and articulate the social determinants of health, participants’ vision of a healthy North End community and the facilitator’s opinions about the effectiveness of the PATH process in helping participants articulate the social determinants of health.

An interpretive, narrative 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, which is inductive in nature, is to allow research findings to emerge from the frequent, dominant or significant narrative 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 this approach. First, data analysis is determined by both the research objectives (deductive) and interpretations of the raw data (inductive). Therefore, 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 by participants and from the raw data by the researcher (data analyst). These interpretations involve the researcher making decisions about what is more 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); feedback from participants in the research; and feedback from users of the research findings. The following steps were used to analyze the data:

- 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
groups, 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.

**Study Limitations**

The main limitation of this study is its failure to capture a more diverse perspective on health, despite the great efforts made to recruit participants who were diverse based on gender, culture and age. Similar to the pilot study that was completed in June 2014, the under-representation in the study of Black men compared to Black women (33 women; 15 men) is, perhaps, one of the study’s key limitations. While considerably more men participated in this study compared to the pilot study, the recruitment of more men would have provided the study with a more varied account of the ways in which gender shapes community members’ experiences of the social determinants of health. Perhaps the lower participation rates of men in this study compared to women is due to the fact that men are generally less likely than women to participate in discussion groups about health. Given that culture and immigrant status shape health and well-being in specific ways, this study would have also been strengthened by the participation of a larger number of recent and long term Black immigrants from Africa, the Caribbean and other regions. While African and Caribbean immigrants represent a significantly smaller population in the North End as compared to indigenous African Nova Scotians, the diversity of experiences of immigrants can’t be fully captured by the nine African immigrant participants in this study. Finally, while considerably more youth participated in this study as compared to the pilot study, their numbers were considerably lower than the adult participants. Capturing a youth voice remained an important goal throughout the study since Black youth in the North End experience barriers accessing employment, educational and recreation activities. The challenges they experience accessing these resources significantly impact their emotional development and self-concept as they transition from childhood to adulthood.

Despite these limitations, the study’s purpose was not to be representative of the Black community in the North End. Rather, it sought to provide some insight into the impact that various social, economic, educational and political factors have on health and well-being of some members of the Black community in the North End. Therefore, while the study would have undoubtedly been strengthened by the recruitment of individuals who were more diverse with respect to gender, culture, immigrant status and age, it does not seek to make claims or generalize about how the Black community in the North End as a whole experiences the social determinants of health.
FINDINGS

As mentioned earlier, this study builds on a pilot study that was completed in June 2014. Similar to the pilot study, the PATH discussion groups conducted for this study engaged participants in discussions on how the following social determinants (defined in Appendix A) affect community health and well-being: 1) income and social status; 2) social support networks; 3) education and literacy; 4) employment/working conditions; 4) social environments; 5) gender; 6) culture; 7) healthy child development; 8) biology and genetic endowment; 9) physical environments; 10) personal health practices and coping skills; and 11) health services.

Findings from the pilot study indicate the following: 1) 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 for the community; 2) the PATH discussion group enabled participants to appreciate how these determinants of health relate to their everyday lived experiences; 3) participants were more motivated to take action on some of the health issues facing the Black community in the North End, including becoming more involved in committees or community groups to address issues affecting their community; 4) participants expressed that the PATH process can be an important catalyst for developing leadership in the Black community in the North End; and 5) 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 Black residents in the North End; and as community advocates. Findings from the final study (outlined in this report) support these findings.

Effectiveness of PATH in Helping Participants Articulate the Social Determinants of Health

Findings indicate that the PATH discussion group process was effective in helping participants articulate the social determinants of health for three main reasons: 1) it broadened their perspectives on health; 2) it provided them with opportunities to articulate gentrification as a social determinant of health that serves to deepen existing social and economic inequalities; and 3) it impressed upon participants the importance of community cohesiveness, mobilizing and capacity building in addressing the social and economic factors that impact community health and well-being.

The PATH Effect

A participant observed that the PATH discussion group validated community members’ experiences:

I think everything that everyone said today was validated. And basically, bottom line, that’s what people are looking for, is to be validated. So, it just made it more comfortable to kind of talk about some private things and some personal stories because they all seemed to be validated today.

Participants expressed that the informal structure of the PATH discussion group process made them feel comfortable and relaxed. For example, one participant shared the following:

I liked that right at the beginning you stated that there was no right or wrong. Like it is your own take on things and your own perspective. So, it just made it a little easier to voice your opinions about things when you know that it’s your life that’s being validated and not necessarily, you know, trying to come up with the right...with things that you think people should be saying.
The PATH facilitator shared that she structured the discussion groups in a way that fostered a sense of comfort and safety among participants:

Well, I don't really feel I had a problem engaging them with the determinants the way that I did it. What I felt that I needed to do was to make sure that everyone in the room knew who was in the room. And that's why I did the okay, let's break up into groups or to partner and find out what...let's talk about who's in the room. So there are no elephants in the room, you know. Because some people, they may not be comfortable...I wanted to be sure that nobody was uncomfortable. And to know that we are all...really our issues are all the same. And sure enough, that was the case.

According to the PATH facilitator, the discussion group helped some participants address and deal with some of their suspicions about group discussions:

I think it's the fear of... When I say fearful, I think it's the fear of not knowing. Not knowing this process. They did not know what this process was. And, I think they're intimidated. You know, it's like okay, I'm going to go into a room. Like you know, okay, what's this going to be? But I think now that, oh, okay, it's a safe environment. I think that they will be much more comfortable in interacting or participating in other sessions of something, of community events. Hopefully they will come out. Mind you, there are a lot of other things happening in their life that might prevent them. I think that there's a safety in community groups that they're okay with.

Another participant stated that she valued the diversity of participants in her discussion group:

I think the inclusiveness of it with our new folks to our neighbourhood...sharing in their vision of the neighbourhood...I think that's a valuable experience for all of us. Because we tend sometimes to have shutters on and we only see things the way we see them. So to have the diverse voices around the table, I think is absolutely critical.

A participant voiced his opinion on the usefulness of the PATH process in the following way:

It's already proven its usefulness. Look at what we've done. I think it's a different approach to problem-solving. I think it's a new approach in terms of engaging community. So I can see this kind of a process being used in the future because it is so non-demanding, relaxing, everyone's input is welcome. And you feel it and you know it. It's not just said. So, I can see some really good future uses of this process.

The PATH facilitator discussed her overall impressions of the PATH process and its benefits to the Black community in the North End:

I think I said before that the PATH process is a particular type of process. And I appreciate that process. I do believe if you have facilitation skills, that you can do the process. You know, a lot of the training was very facilitation skills as well. But then you need to know the process and how to facilitate the process. And I think for our community, I think the process is a good process. Because of the storytelling aspect... I'm actually really surprised. And okay, that's one thing, to go back, you asked about how I would
change the process. And in thinking, I really thought that... I didn’t think that I would have people be so willing to tell their stories because some of those stories were really personal stories....And, people share their guts. Like wow! But they felt safe. They felt safe that they could really do this.

Holistic Perspective on Health

The PATH discussion groups increased participants’ awareness of the various social, educational, economic and environmental determinants that impact health and wellbeing. Several participants expressed that the PATH discussion group broadened their perspective on health that was inclusive of various social factors. For example, one participant stated that the process provided community members with a broader and more holistic view of health that transcended a focus on the physical body, illness and disease, upon which the medical model is premised:

I thought we were going to talk about, you know, breasts and ovaries and stuff.

Similarly, another participant stated the following:

And thinking about like when you say the word health, like after you got in here and you started talking, it got you thinking outside of that health box. You know, you’re not thinking of the diseases, the sickness. You’re thinking of the community health-wise. So that was very interesting.

Another participant shared that the PATH discussion group helped her understand how important it is for discussions on health to focus on well-being and not simply illness:

I think that now like having good health and taking care of yourself isn’t just about, I don’t know, not having a disease or just like any type of sickness. It’s about like your well-being too. Like just like your upbringing, your education, your stress level. Like I think that like, you know, my definition of health like kind of expanded, I guess.

Another participant shared that the discussion group impressed upon her how important it is to address the systemic inequalities and injustices affecting people’s health:

We can’t lose sight of the systemic issues that confront us as a people in terms of our health. Because I still... And so we cannot lose sight of taking a look at policies, procedures, the systemic things within the system, to see how it negatively impacts on us. We can take our initiatives and do what we need to do but we’ve got to look at the system internally.

For example, one participant stated that employment remains an important determinant of health for members of the Black community, in general. He attributed the declining numbers of Black people employed in the federal government to Eurocentric testing that created barriers for gaining access to employment opportunities:

Because a lot of the problems are the tests, the federal government tests, I don’t know if... They’re Eurocentric. Our minds don’t even think that way. But we need to be able to train some people to take these tests because there is... Like the number of Black people that are now down there in the federal
government offices now, it's dwindling quickly. People are retiring. Some more people are coming in but they're not like us. They're French-speaking people. They worry about the accents of the Africans or the people from the continent. "Oh, no, we don't understand them. Their accents are so thick." What about the French people with the thick French accents? Who knows what they're saying half the time? But because they're French, it's accepted. It's a lot more accepted than an African accent. So anyway, it's a research topic for another day, I'm sure. But anyway, I just had to get that out, my take.

One participant indicated that the discussion group helped her to recognize how oppressive factors impact health and well-being:

Yes, because who wants to fight every day? Because realistically, let's be clear about this, I have to pay rent, look after children, manage their health, take them to all their appointments, drop them off, pick them up. I have to do all of this juggling. Do I need all these other added stresses because I was born Black? I don't think so. However, it's my reality. And I was born and raised here so I guess I'd like to remain part of this struggle. And these are the barriers that I have to fight. You've got to teach your children different...your young men, different stuff. I have to have conversations with my sons when they're 13. I have to ask them not to go places. I have to prepare them for this nice world that we have here. These things are all a part of my reality. Would I have signed up for this stuff? No. But this is the hand that I've been dealt. I've been raised in a Christian home, to God be the Lord because it's given me a great faith. And I know who's in charge no matter what it looks like. So I'm very grateful that I am rooted in something bigger than all of this stuff. But this stuff can be very heavy. Because at the same time, I still got all this other stuff that I have to manage – take the kids to school, doctors. I've got to pay bills. I have all the real life things that everyone else has. Then I have this other set of stuff that I inherited because of my heritage. So no, I wouldn't sign up for it. But I guess I'm going to have to stay in the battle. And I'm just grateful that I know God because realistically this can really take people out.

Religion and church participation are important sources of strength for Black communities, according to one participant:

The Black communities that I've known all my life have always had religion in their life and they've always had God in their life. And I think that as a Black culture, we need to get back to that game. And we need to get back to the church, and we need to get back to God. Because I'm telling you, what would we do without him? I don't know.

Taking Our Neighbourhood Back: Gentrification & the Impact on Community Health & Well-Being

Participants discussed how the gradual “pushing out” of Black and lower-income residents in the North End amidst ongoing gentrification has affected the well-being of Black North End residents. For example, a participant discussed how important it is for indigenous African Nova Scotian North End residents to reclaim “some piece” of their community at a time when others are increasingly claiming it as their own:
Like there’s ownership and agency and partnership and a presence in the community. Because it’s happening all around us and it’s happening in some really wonderful ways. You can look down the street and see people sitting out on patios and some really nice restaurants in the community. But you don’t see us. You see us in that one area around the Square. You see the kids walking back and forth to school. But it’s almost like we don’t own this community anymore, and other people are claiming it. I’m in spaces where there aren’t a lot of black people. And what I’m hearing up at FRED’s place up on the corner and at Edna and at these other places is ‘our community, our community’. And I don’t see one person in that room that looks anything like me. They’re not from the community. They are claiming this community. We need to claim it too.

A participant also discussed the lack of representation of the Black community in the new businesses that are opening up in the North End:

Gentrification…and how do we address that and reverse the gentrification? Because we need to take our community back. I came down… Me and my sister walked up the street maybe about a month ago, and it was like late at night, like maybe 9:00 or 9:30 or something like that. I’m telling you, Gottingen Street was booming. The white people have…they’ve got about five or six different clubs. Honest to God. We walked like from that end of Gottingen Street. We were coming home. There’s a club there, a restaurant there. And over there. Oh my goodness, you go down there and…There’s Edna, there’s Company House, Alter Egos. But Black people are not represented. And then if we were to come back, you know the police would be outside waiting because they don’t want us. You know, they don’t want to see us. Well, a lot of times, you know, we end up fighting at the end of the day. But no, we’re older now and we have to have a place that we can go too.

Gentrification has also resulted in the loss of various resources that were mainstays in the community, according to another participant:

I don’t like the fact that, like you said, they’re putting all these businesses, all these condos. What happened to everything that we used to have? Like we lost our grocery store, our little…you know, where we could go shopping, like our bank. Like everything we had on the street is gone. We literally have to travel to get somewhere. So I mean us as a community, we should have been able to keep that.

According to another participant, one of the most significant impacts of gentrification in the North End is the difficulty in finding affordable housing:

It’s not affordable. They’re staying with the market rent, they said. That’s what they told me. There’s no non-profit housing. You know the story. We talked. It’s no longer non-profit. I think they’re bringing all these condos and stuff in because they’re really trying to push us out of this neighbourhood. Like you know what I mean? Like, we’ll put this here because they can’t afford this. They won’t be able to afford that.

Participants also shared how important festivals such as the Gottingen 250 Festival (held in September 2014) are for demonstrating pride and ownership in their community in the context of ongoing gentrification. There was,
however, some confusion among participants about the location of the festival. Participants expressed some concern that the Festival would not be inclusive of historically African Nova Scotian areas of the North End, such as Uniacke Square. One participant put it this way:

_I understand the philosophy behind the Gottingen Street 250 but what Gottingen Street are they celebrating? Are they celebrating Gottingen Street now or are they going to celebrate the Gottingen Street that we grew up on and that we know?_

**Health Services & Other Community Resources**

Discussions on the impact of gentrification on the health and well-being of Black residents in the North End impressed upon participants how important it is for health to be understood and articulated as a communal issue rather than simply an individual one. For example, a participant discussed the importance of community resources and services for creating and maintaining good health in a community:

_A banking machine…. Like things that you would find in other communities. A gas station. You don’t find here. A Tim Hortons. You know, things that you would normally find in other communities that we don’t have here. Why don’t we have a bank that we can actually go into?_

Recreation was also discussed as a significant determinant of health for Black youth in the North End. While recreational programs do exist in the community (hockey, basketball), they are being used by individuals who don’t reside in the community. In addition, many Black youth in the community don’t access available recreational programs because of their high cost and limited hours, according to one participant:

_And that’s why our kids are not healthy. They are healthy but they could be healthier. Because they're not getting their outside activities, they're not exercising. Like, they’re just going around in the same circles._

Another participant discussed the need for more high quality health services for the community:

_We need better health services but we also need our community members to also know to take their health seriously. Like you said, what they're doing in Hammonds Plains, right. Some people just refuse to go see a doctor. You need to go for regular check-ups._

Some of the male participants discussed Black men’s hesitance to seek support for health and mental health problems from partners, friends and health services. Many of them attributed this to societal expectations and ideologies about masculinity and male vulnerability, as well as a desire to hold onto the tough façade that many men have difficulty relinquishing. A participant pointed out that societal expectations about masculinity have an impact on how men seek help for health and mental health problems:

_You need kind of like a group of men… When we did the diabetes thing, there were only two men there. And then when we recognized what was missing from the information people had on diabetes…then we developed some things. We got flyers, we went out and did things in the community. And then the two men would meet with men to talk about diabetes and what you have to look out for. Men accept things_
like that from other men but they don’t really have that community like women do. You know, women can always get together and talk about things and get information. But men don’t seem to do that.

Community Empowerment, Capacity Building & Mobilizing

The PATH discussion groups impressed upon participants the importance of engaging in more action-oriented collaborative efforts around the social determinants of health. They stated that the vision statement provides an important catalyst for community mobilizing around these determinants. However, they pointed out that they would only be willing to do that work in partnership with other Black community members in the North End and after they had participated in more informal community discussions and training sessions. The discussion groups also helped them to recognize how much more work they need to do as a community on the social determinants of health, as one participant pointed out:

I feel like I was not really involved in the community. Now after this discussion, I feel like if we don't do anything, I'll feel guilty. You see, that's how I'm feeling, you know. I'm feeling that, you know... The little one that I have with me, at least I have to do my best to give back to the community where I belong. And I've decided on Monday, I'm going to the Black Educators Association, talk to them and see how we can arrange something. Like my family, we can provide French classes and so on. At the same time, my son has a really good guitar or drum. He has all those instruments in his bedroom. So we think that we need now to share a little bit that we have with the community. Maybe there are some kids that don't have access to that. So why not give them what we have. So I feel like really I have to engage myself with the community. Without doing that, I will feel guilty because everyone here is trying to help. So why not me...?

According to one participant, the PATH discussion group raised her awareness about other community members’ experiences and impressed upon her how important it is to provide support to other community members:

I've learned something new. ...And also just hearing different stories, like how she was treated by the police, how she... You know, that's knowledge enough for me to know next time if anybody is in that situation...and also to know that people in this community that are caring enough. So that's another view too that I've learned in that area. And also to have me be responsible for the community that I live in. To know that, you know what, I'm here in this community, the North End, for a reason. And that's to help whoever is in that community if I have the capability to do that. If I know somebody who is in need of something, that maybe how do I approach them? You know, how do I become responsive enough and taking the deliberate decision to actually go and say ‘hi’ to them. If they need something to say ‘hi, how are you doing?’ And I don't know, that just hello may mean something to that person.

Also discussed was the loss of a “sense of community” in the North End over the past several years and a belief that community agencies in the North End have abandoned the community:

Because we’re not community-based no more...Every organization is for themselves. They want to do things by themselves. Nobody wants to do anything and call everybody together. They want to have a little party, when they could have a big bang. Like at the George Dixon years ago, that centre, George Dixon always had something going on during the weekends. And now there's nothing. The Y used to
have dances. The library used to have dances. Our kids don't know how to socialize because they've got nowhere to go. There's nothing.

A participant observed that the general perception that the Black community in the North End lacks unity has made it easy for “outsiders” to come into the community to implement various initiatives that have not been approved by the Black community. Consequently, she believes that the CHIAT can be an important catalyst for community unity and empowerment:

*And the thing is people see us as not united... That we can do what we want because we know that they're not together. This unites diverse voices, that toolkit, because we now say, ‘Oh, well, we came together and we said this. This is what we said and this is what we would like you to do.’ So they’re not banking on us for not caring, for not being united, they can just do whatever they want to us, run us over. This has to start from the community.*

Another participant expressed his concern that the sense of community spirit that the PATH discussion groups engendered could erode if social action and conversations on the social determinants of health were not an ongoing activity:

*It was a great opportunity for us all to come together and find out what our vision is. But then the skeptical side of me is this is something that needs to be done regularly until things are done. We can’t just come together and say, okay, we’re going to do this project and then it gets thrown on a back burner somewhere. If we don’t follow up on it and if we don’t continuously have the conversation. And this is something that should be ongoing. And then after, we get up and then somebody else is going to take it over after us. Because the next generation is going to have different insights of what the North End is going to look like. So it should be continuous. I mean it’s a great way to actually see the change and take ownership. Because if you own the neighbourhood, then you’ve got to be more willing to put in the leg work.*

Similarly, another participant mentioned how important it is for community members to come together after the research study is completed:

*I’m afraid that when we leave this door, everything is going to go like down. Something is coming to my mind that, you know, if there was a way maybe to create something that is going to bring all of us, even at least once a month, you know, even once a month, just we can come together and review, even just spend time. You know, we never know.*

The process was useful in that it gave community members a voice to express their experiences and take action on some of the concerns they brought forward, according to one participant:

*Yes. Try to bring more people and talk about that, and work on that to come up with a fix. Say for example, what she was saying right now, that one can be fixed just like that. You see? So there are things which I’m sure we need to do our best to bring our voice on so that those who are leaving in the
community or those who are above us, they have to listen to us and do what we want them to do. Because we... You know, we need to come in and live with it. We cannot just see and accept whatever is coming to our community. Oh, they are selling the school. Oh, the school is changing. No. If it's not right, we have to stand and say ‘no’.

When asked if she felt that the process was empowering to participants, the PATH facilitator stated the following:

I do believe if there's a call for their participation that they would be readily ready and able to participate. And I think that in itself is good. But I think that there were some participants that will, you know, hopefully use the skills and the knowledge they have, and pass it on to someone else. Like those that wanted to tutor.

The PATH facilitator also stated that while many of the participants have a strong interest in volunteering in the community, many of them lack of confidence in their leadership abilities:

People want to volunteer some of their services. I do believe that there are a group of women who... or a woman... a small group of women who want to begin a group, a support group for each other, you know. Now, it's a matter of realizing that they don't believe that they are leaders but they really are... worrying if you're going to fail. You know, it's failing. It's failing. But how do you measure success? How do you measure failure? You just do it... Well, as you say, there's no right or wrong, only different – is the term I like to use. Okay, well, if it didn't work this way then let's try it that way. So it's not that it failed. You know, we just need to do things I think a little differently.

One of the most valuable outcomes of the PATH process, according to the PATH facilitator, is the sense of empowerment it engendered in participants:

What I believe was most... what the participants gained from the process was empowerment. I really truly do believe that the majority of them wanted to move this process... They were empowered. They had a better understanding. They knew they weren't alone. Here you go, you're in the room, you know, with these people. Like some of you did not know. You don't know their experience. And I think that they're empowered. I think that when they're approached or if something is happening and they're reminded, you said you want to do something, I think that they will not be hesitant. I don't think that they'll be fearful. I think that they will be willing to participate. I do believe there's empowerment.

Vision of a Healthy North End Community

One of the more interesting aspects of the PATH discussion groups was the opportunity for participants in each discussion group to develop a list of vision factors for a healthy North End community, as well as vision statement that was inclusive of these vision factors and that represented their vision of a healthy community. The vision statements and vision factors for each PATH discussion group are outlined below.
Vision Statement & Vision Factors for PATH Discussion Group #1

Our vision of a healthy African Nova Scotian community in the North End is one that is a healthy, diverse community that shows and embraces respect, acceptance and security

- Cultural sensitivity within the police department
- Less racial profiling
- Positive creation of police-community relationships
- Diverse representation in the police department (when working in predominantly black neighborhoods)
- The Police Department should be responsible for the cost of an ambulance if they call community members
- Diversity training
- Decreased stereotyping
- Neighborhoods should be well lit
- Landlords need to respond and take responsibility for housing conditions
- Safe affordable and stable housing
- Useful surveillance
- Safer environments
- Positive presence
- Affordable/subsidized ambulance services
- Youth programming
- Need for various services, including delivery, taxi service, bank machines, local health stores, health services, access to doctors within community and dental clinics
- Schools
- Access and communication to city council
- Community based advocacy groups
- Strong relationships
- Social interactions
- Awareness session
- Collective community
- Respectful
- Community notice board

Vision Statement & Vision Factors for PATH Discussion Group #2

Our vision of a healthy African Nova Scotian community in the North End is one that has good community relations, is action-oriented, diverse, prosperous, united and has opportunities for exposure that empowers inclusivity, partnership and ownership

- Community growth
- Educational growth
- Relationships in the community
- Legitimate inclusion
• More sharing among community members
• Support for education
• Hiring a Black administrator at Joseph Howe, which has 89% Black students.
• Support for community members to help out others with their education
• Stronger social support in the education system
• More investment in time and money by the community in schools and churches
• Sensitivity training on sexism, racism, classism, disability
• More diversity amongst decision-makers
• More entrepreneurial opportunities
• More people owning businesses on Agricola Street and Gottingen Street, as well as more businesses in Black communities and downtown (e.g. corner stores).
• Leadership and good role modelling
• More Black people in authority roles, such as policing
• Better distribution of the many services currently being offered in the North End
• More representation of Black people in journalism and in broadcast news
• More discussion groups
• More open forums
• More outlets for people to heal and to take part in self-care, such as yoga and exercise
• More home ownership in the Black community
• Public education about the historic contributions indigenous African Nova Scotians have made in the Province

Vision Statement & Vision Factors for PATH Discussion Group #3

Our vision of a healthy African Nova Scotian community in the North End is one that offers equal employment opportunities, affordable and quality housing and equitable education and policing that is respectful and inclusive

• Increase in black-owned businesses
• More immediate services such as banks, laundromats and grocery stores
• More employment of Black people in banks, stores, businesses and agencies
• More hiring of Black North End residents (including youth) at grocery stores in the community
• More recreational activities, including those for youth
• Increased use of existing recreational resources in the community
• More hiring of Black North End residents on the police force
• Less surveillance, monitoring, profiling and harassment of Black North End residents by police
• Better relationships between the police and Black people
• Race and cultural sensitivity training in the police force
• More safe and affordable housing
• Increased home ownership in the Black community
• Playgrounds in the North End that are of equal quality to playgrounds in other parts of the city
• Increased funding for educational scholarships
• Education classes for youth (e.g. French classes)
More community meetings to share information and community concerns
Workshops that provide education about various issues, including residents’ rights with respect to police harassment
More community resources for residents to deal with emotional and mental health problems
Social clubs that enable the Black community in the North End to come together
Creation of a resource board (online and posted on community bulletins) with listings of community services and resources, such as volunteers, housing information and food banks

Vision Statement & Vision Factors for PATH Discussion Group #4

Our vision of a healthy African Nova Scotian community in the North End is one where recreational, health and mental health, housing and other services are accessible, user-friendly and lead by culturally competent teams; and where our schools (P-9) are high performing and arts-based.

- Healthier activities that encourage youth to become more active (e.g. outdoor gyms)
- More activities to promote physical health. For example, the Commons should have opportunities for people to walk and run
- Community helpers who initiate more activities for youth
- Wrap-around schools that address health, mental health and employment issues
- A full-service mental health unit that deals with mental and physical health, housing and employment
- Initiatives that focus on cleaning up drug issues in the community
- Moral support from family and friends
- Education about available supports in the community
- More Black-owned businesses
- Positive role models for youth
- Places for children to socialize (e.g. after-school hangouts)
- More access to after-school programs with tutors
- Mentoring programs that bring together professionals and youth
- Asset mapping in the community that provides data on existing resources and services in order to determine which services are missing and what is needed.
- Subsidized community programming
- Taking more pride in the neighbourhood, one’s property and one’s home

DEVELOPING THE CHIAT

An Editorial Committee comprised of three PATH participants, the research assistant and the PATH facilitator came together on September 20th, 2014 to review the vision statement developed by each of the four PATH Discussion groups and to assemble the CHIAT. The following process was used to create the final CHIAT:

- Reviewing the four vision statements developed by the PATH discussion groups;
- Identifying common themes across all four vision statements;
- Documenting these themes on flipchart paper; and
- Engaging in an in-depth discussion on these themes, including a discussion on the following topics:
- Health services
- Housing
- Services (banking, grocery stores, etc)
- Recreation
- Education
- Policing
- Black-owned businesses
- Diversity
- Sensitivity
- Respect
- Inclusion
- Communication

- Reducing duplication and redundancy across the four vision statements developed by the four PATH discussion groups; and
- Creating a list of the main vision statements

After much reflection and discussion, the Editorial Committee identified nine vision factors and one final vision statement that was inclusive of all nine vision factors and that represented the voice of the Black community in the North End. The community's final vision statement for a healthy North End community is:

**One of preserving an African Nova Scotian presence by fostering a safe, socially dynamic community and building capacity for inclusive and respectful resources and services that value diversity**

In addition to this vision statement, the CHIAT documents (on the following page) a list of nine main vision factors identified by study participants.
COMMUNITY HEALTH IMPACT ASSESSMENT TOOL

Black Community in North End, Halifax

Our Vision Of a Health Community

Please note that any reference to “community” within this document refers to the “Black community”.

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

- Employing African Nova Scotians within the community
- Equal employment opportunities for African Nova Scotians
- Adequate and affordable local health stores, bank machines, pizza delivery services, taxi services, laundromats, health services, doctors within the community and dental clinics
- More black-owned businesses and entrepreneurial opportunities for African Nova Scotians

A healthy community values education, which means:

- Creating holistic schools that respond to the health, mental health and employment needs of the African Nova Scotian community
- Investing more time and money in schools located in the community
- Hiring African Nova Scotian administrators
- Increased funding for educational scholarships

A healthy community builds community capacity, which means:

- There are opportunities for leadership, role modelling and mentorship
- There are opportunities to create community information forums, workshops, training sessions, discussion groups, advocacy groups, community notice boards and social clubs

A healthy community is one that has affordable and respectable housing, which means:

- Affordable rental and home ownership for people with various levels of income
- Pride in one’s property and home
**A healthy community is a crime-free and safe area, which means:**

- It has less drug-related activity
- It is a well-lit neighbourhood
- There is more effective surveillance in the neighbourhood

**A healthy community values improved community-police relations, which means:**

- There is less stereotyping by police officers
- There is less racial profiling by police officers
- Cultural sensitivity training is provided within the police department
- There is increased hiring of African Nova Scotian police officers

**In a healthy community, community unity is created through recreation, which means:**

- There is youth-based recreational programming
- There is subsidized programming
- There are playgrounds that are of equal quality to playgrounds in other parts of Halifax
- There are after-school programs with qualified tutors for African Nova Scotian learners

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

- Service providers participate in sensitivity training on racism, classism, sexism, homophobia and ableism
- There is community respect for and awareness and inclusion of diversity based on race, gender, sexual identity/orientation, class and disability

**A healthy community has positive physical and visual representation, which means:**

- Banners and signage represent the history and culture of African Nova Scotians

**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 on 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 factors listed in the Assessment Worksheet are based on priorities identified by the Black community in the North End.

**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.

This CHIAT lists 20 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 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. These health determinants include the following:

- Race
- Culture
- Immigrant Status
- Gender
- Gender Identity
- Sexual Orientation
- Disability
- Income & Social Status
- Social Support Networks
- Education & Literacy
- Employment & Working Conditions
- Healthy Child Development
- Biology & Genetic Endowment
- Social Environments
- Physical Environments
- Neighbourhood
- Housing
- Personal Health Practices & Coping Skills
- Health Services
- Food Security

“Health” in our community is broadly defined as being inclusive of physical, mental, social and spiritual wellbeing. It is determined by many factors outside as well as inside the health care system.
**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 Has Representation Within the Economic Structure of Our Community**

<table>
<thead>
<tr>
<th>WILL________ HAVE AN IMPACT ON THE FOLLOWING AREAS</th>
<th>YES POSITIVE</th>
<th>YES NEGATIVE</th>
<th>NO OR NEUTRAL</th>
<th>NEED MORE INFO</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Employing African Nova Scotians within the community</td>
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<tr>
<td>Equal employment opportunities</td>
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<tr>
<td>Adequate and affordable local health stores, bank machines, pizza delivery services, taxi services, laundromats, health services, doctors within the community and dental clinics</td>
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<tr>
<td>More black-owned businesses and entrepreneurial opportunities for African Nova Scotians</td>
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</table>
## A healthy community values education

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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>
<th>NEED MORE INFO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CREATING Holistic schools that respond to the health, mental health and employment needs of the African Nova Scotian Community</td>
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<tr>
<td>Investing more time and money in schools located in the community</td>
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<tr>
<td>Hiring African Nova Scotian administrators</td>
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<tr>
<td>Increased funding for educational scholarships</td>
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<tr>
<td>WILL _______ HAVE AN IMPACT ON THE FOLLOWING AREAS</td>
<td>YES POSITIVE</td>
<td>YES NEGATIVE</td>
<td>NO OR NEUTRAL</td>
<td>NEED MORE INFO</td>
<td>COMMENTS</td>
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<td>Opportunities for leadership, role modelling and mentorship</td>
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<tr>
<td>Opportunities to create community information forums, workshops, training, discussions groups, advocacy groups, community notice boards and social clubs</td>
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</table>
### A Healthy Community is One That Has Affordable and Respectable Housing

<table>
<thead>
<tr>
<th>WILL __________ HAVE AN IMPACT ON THE FOLLOWING AREAS</th>
<th>YES POSITIVE</th>
<th>YES NEGATIVE</th>
<th>NO OR NEUTRAL</th>
<th>NEED MORE INFO</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>Affordable rental and home ownership for people with various levels of income</td>
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<tr>
<td>Pride in one’s property and home</td>
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### A Healthy Community is a Crime-Free and Safe Area

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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>
<th>NEED MORE INFO</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>A well-lit neighbourhood</td>
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<td>Less drug-related activity</td>
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<tr>
<td>More effective surveillance in the neighbourhood</td>
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</tbody>
</table>
### A Healthy Community Values Improved Community-Police Relations

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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>
<th>NEED MORE INFO</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>Less stereotyping by police</td>
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<tr>
<td>Less racial profiling by police</td>
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<td>Cultural sensitivity training provided within the police department</td>
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<td>There is increased hiring of African Nova Scotian police officers</td>
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</table>
**In a healthy community, community unity is created through recreation**

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<tr>
<th>WILL ____________ HAVE AN IMPACT ON THE FOLLOWING AREAS</th>
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<th>COMMENTS</th>
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<tbody>
<tr>
<td>Youth-based recreational programming</td>
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<tr>
<td>Subsidized programming</td>
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<tr>
<td>Playgrounds that are of equal quality to playgrounds in other parts of Halifax</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After-school programs with qualified tutors for African Nova Scotian learners</td>
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</tbody>
</table>
**In a healthy community, diversification is valued**

<table>
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<tr>
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<tbody>
<tr>
<td>Service providers participating in sensitivity training on racism, classism, sexism, homophobia and ableism</td>
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<td></td>
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<tr>
<td>Community respect for and awareness and inclusion of diversity based on race, gender, sexual identity/orientation, class and disability</td>
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</table>

**A healthy community has a positive physical and visual representation**

<table>
<thead>
<tr>
<th>WILL_________ HAVE AN IMPACT ON THE FOLLOWING AREAS</th>
<th>YES POSITIVE</th>
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<th>NO OR NEUTRAL</th>
<th>NEED MORE INFO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banners and signage representing the history and culture of African Nova Scotians</td>
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</tbody>
</table>
**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

<table>
<thead>
<tr>
<th>PAGE</th>
<th>CONSIDERATION</th>
<th>OVERALL IMPACT</th>
<th>ACTION REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>A healthy community</td>
<td>has representation within the economic structure of our community</td>
<td></td>
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<tr>
<td>A healthy community</td>
<td>values education</td>
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<td>A healthy community</td>
<td>builds community capacity</td>
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<tr>
<td>A healthy community</td>
<td>is one that has affordable and respectable housing</td>
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<td>is a crime-free and safe area</td>
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<tr>
<td>A healthy community</td>
<td>values improved community-police relations</td>
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<tr>
<td>In a healthy community,</td>
<td>community unity is created through recreation</td>
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</table>
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

<table>
<thead>
<tr>
<th>NEXT STEP</th>
<th>WHO TO INVOLVE</th>
<th>WHEN</th>
<th>PERSON RESPONSIBLE</th>
<th>REPORT BACK (BY WHEN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a healthy community, diversification is valued</td>
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<tr>
<td>A healthy community has positive physical and visual representation</td>
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</tbody>
</table>
PATH STUDY FOLLOW-UP ACTIVITIES

Several follow-up activities were carried out by the author of this report after the final PATH discussion group took place in August 2014, including a final PATH event where a PATH participant agreed to lead future community initiatives related to PATH and the CHIAT. The author also consulted with individuals who are coordinating new initiatives in the North End. The purpose of these consultations was to obtain information on new initiatives that community members can assess using the CHIAT developed for this study. Details about all of these initiatives were communicated in January 2015 by email to the project partners (Community Health Board; North End Community Health Center), PATH participants, the PATH facilitator and the Advisory Committee that was brought together in 2013 for the pilot project.

Final PATH Event

A final PATH Event was organized and held by the author on September 22, 2014 to discuss next steps forward in using the CHIAT and mobilizing community members on new initiatives and services in the North End. The author of this report did a brief presentation on the project, reviewed the CHIAT and discussed the role of the project partners (Community Health Board; North End Community Health Center) in engaging community members in using the CHIAT to assess future programs, services and other initiatives in the North End. Also discussed was the importance of identifying community members interested in leading CHIAT assessments in partnership with the project partners (Community Health Board; North End Community Health Center), organizing community information sessions, workshops, social clubs and events, as well as strategies for staying connected to other community members, including using social media and other approaches to connect with other community members. As was mentioned earlier, one of the PATH participants at this event agreed to take on a leadership role (in collaboration with the project partners) in educating other Black North End residents about the CHIAT and engaging them in using the CHIAT to assess new initiatives in the North End.

New Services & Initiatives in the North End

Community Health Teams (Capital Health)

The Community Health Teams (CHT’s) are an initiative of Capital Health. Their intent is to support people who live, work, or have a family doctor in their community to better manage their health, both from a risk factor and a wellness perspective. They offer free health and wellness programs at different times/locations in the community (mainly physical activity, nutrition and weight management, and emotional wellness), wellness navigation (helping people navigate the health, community and government systems etc) and community connectiveness/partnership building. They have two existing teams in Dartmouth and Spryfield, which have been running since 2010. They recently opened two new teams on the Halifax Peninsula and in the Bedford/Sackville areas. Although their programs/services are open to all community members, they target low income and marginalized populations. For the Halifax Peninsula Team, what they have heard (through clinical services planning data and many partner conversations) is a need to target the North End of Halifax (and more specifically, the deep North End). Since there is a higher percentage of African Nova Scotians living in the North End, they are interested in learning as much as they can about their health needs and best ways to engage this community. A key component of the work they do involves community engagement, which helps to inform the programs/services they offer. To do this, they hold citizen engagement events (open to anyone who lives/works/has family doctor in that community), partner engagement events - for those who offer programs/services generally, and physician engagement.
They do this when they are forming their teams, but also on an ongoing basis to ensure the programs they offer continue to meet the needs of the community. The teams consist of health care professionals - PT's, Social Workers, OT's and Dietitians.

**Contact** Sarah Manley: Sarah.Manley@cdha.nshealth.ca  
**Website:** http://www.cdha.nshealth.ca/community-health-teams

**Nova Scotia Brotherhood Initiative**

The Nova Scotia Brotherhood Initiative (NSBI) is a community-based health initiative that is being funded by Capital Health. It was developed by the Department of Health and Wellness in partnership with African Nova Scotian Affairs. It focuses on providing cultural and gender-specific care to African Nova Scotian men. Research has shown that Black men are at higher risk for some chronic conditions, and may face barriers to accessing health care because of issues like socio-economic status, racism or under-employment. Adapted from the successful Project Brotherhood in Chicago’s South Side, the initiative seeks to address health disparities often faced by males of African descent. Project Brotherhood in Chicago found creative ways to engage and support African-American men to access health care. These strategies included free haircuts and meals at the weekly clinic, extended hours, help with transportation to and from the clinic and personalized care from doctors and health care workers of African descent. The NSBI will deliver wellness programming, Primary Care and Chronic Disease Management, and navigation. The NSBI works in collaboration with other provider groups and services to offer programming and supports. While the NSBI is a district-wide initiative, it will focus its work on three key regions: North End, Halifax and North End, Dartmouth; East Preston, North Preston, Cherrybrook and Lake Loon; and Hammonds Plains, Lucasville and Beechville.

**Contact** Colin Campbell: Colin.Campbell@novascotia.ca  
**Website:** https://ansa.novascotia.ca/brotherhood

**In My Own Voice Arts Association**

In My Own Voice Arts Association (iMOVe) engages youth from geographic and cultural communities across the HRM with a variety of arts and technology based programs. The Association takes a grassroots approach to community development, providing space and support to residents, community groups and non-profits who wish to have positive impacts in their neighborhood. iMOVe puts media in the hands of the people, providing training experiences and broadcast opportunities using audio, video and Internet technologies so that all the voices in the community are heard. In its approach, iMOVe offers restorative solutions to problems of community conflict and public safety, providing programs for offender reintegration and restorative justice.

**Contact** Sobaz Benjamin: sobazb@yahoo.com  
**Website:** http://inmyownvoice.ca/

**Neighbourhood Placemaking Project in the North End**

A new Placemaking Project (street painting) on Creighton Street is providing a meaningful way for the community to get together and ‘own’ some road space with community art. Placemaking brings a community together to
create public art and creates spaces that people can identify with. The initiative is encouraging neighbours to get to know each other and work together (and have a party) while planning and painting a street intersection. Neighbourhood Placemaking provides guidance and support to community members interested in hosting a project in their neighbourhood. This could be intersection painting, the building of benches for a local gathering space, a community garden, or any idea that brings together community members to create public art that activates shared public spaces to give a sense of place and build community. The idea for the proposed Placemaking Project on Creighton Street was originally borne out of a frustration that many community members have long had with the heavy and fast-moving traffic that cuts through Creighton Street as a shortcut from the bridge to downtown. They contend that this intersection is dangerous for families and children who walk to school every morning during the week. The project coordinators for the proposed Placemaking Project argue that Gottingen Street and Creighton Street should be treated as a residential street and wrote to the City to request that they implement a traffic calming policy that would ensure that traffic slows down in that area. They were successful in receiving a grant from the City to fund the Project. The coordinators believe that a Placemaking Project that provides opportunities for North End residents to create art in that area would not only slow down traffic significantly, but would create a sense of community. They would like to bring North End residents (particularly Black North End residents) together to determine the best location for the Placemaking Project and the nature of the street painting. Joseph Howe School has agreed to be involved in the project and will be engaging their student body in helping to create and make the project happen.

Contact Amy Schwartz: Amy.Schwartz@novascotia.ca
Website: http://www.halifax.ca/culture/CommunityArts/Placemaking.php
DISCUSSION

This section discusses some of the more pertinent social determinants of health discussed by participants (listed in Appendix A), including:

- Transcending the medical model (social determinant: health services)
- Religion and spirituality (social determinants: personal health practices and coping skills)
- Gentrification (social determinants: physical environments, neighbourhoods, housing)
- Employment
- Diversity (social determinants: race, culture, immigrant status, gender identity, masculinity)

TRANSCENDING THE MEDICAL MODEL

The PATH process helped broaden participants’ perspectives about health in a number of ways. First it provided them with a more holistic perspective on health and well-being that acknowledges the interconnections between physical, emotional, spiritual and mental health. Second, the PATH discussion groups helped participants develop a more complex and critical understanding of health that moves beyond the medical model’s focus on the body as the main site of illness and disease to an appreciation for how illness and disease can also be attributed to the social environment (a social etiology of disease model). The medical model is premised on several principles that are important for understanding health and illness but that largely fail to capture social causation: 1) illness results from some malfunctioning of the body; 2) the body is the main site of illness, disease and healing; 3) illness and disease can be explained scientifically and biologically; 4) “fixing” illness and disease involves “fixing” the body; 5) illness causation and treatment can be understood through an analysis that perceives the mind, body, spirit and emotion as separate, distinct and unrelated phenomena; and 6) focusing more on the bodies of clients is more important than focusing on the social context from which illness originates and evolves.

Indigenous health systems around the world are predicated on knowledge systems that are often at odds with the rationalist and positivist ideologies upon which Western medicine is premised. These “indigenous” health epistemologies or belief systems are based on the following factors: 1) non-material explanations for illness and disease, including psychic, spiritual and cosmological explanations; 2) holistic perspectives that view the mind, body, emotion and spirit as interconnected phenomena; 3) importance of addressing the underlying emotional or spiritual cause in healing physical illness; 4) value placed on health beliefs and practices that have been inherited from past generations; and 5) a pluralistic view of health that is inclusive of biological approaches and culture-bound illness. African health systems across the globe are considerably pluralistic, focusing both on biological approaches that are concerned with disease and illness originating in the body, as well as culture-bound illnesses that are understood within the context of specific cultural histories and traditions (Bojuwuye 2005; Marshall 2005; Waldron, 2010 c; Waldron 2002).
Religion & Spirituality

Participants discussed the role that spirituality and a belief in God play in helping them deal with the many stressors that affect their health and well-being. The common belief in a transcendent, divine and almighty power has been an important source of strength for African peoples around the world. It has helped to offset the stresses and anxieties that may lead to depression and other health problems for African-heritage peoples, particularly in the face of racism and other forms of discrimination and oppression.

African styles of worship, forms of ritual, systems of belief and fundamental perspectives have been preserved and revitalized on this side of the Atlantic and provide evidence that the structural dimensions of African spirituality have been retained. Religion and spirituality have long been used to explain mental illness in Caribbean, African American and African communities. Moreover, the influence of religious beliefs and practices, as well as the reliance on religious social networks for fellowship and emotional support often replace or delay the need to seek treatment for some members of the Black community in the North End (Bojuwoye 2005; Marshall 2005; Waldron, 2010c; Waldron 2002).

Gentrification

A sense of loss was a central aspect of participants’ discussions on gentrification throughout this study. Gentrification has had many negative impacts on the well-being of Black and low-income North End residents, including lack of representation of Black community members in new businesses in the North End, the loss of various resources that were mainstays in the community, lack of affordable housing and, consequently, the pushing out of long-term residents. The deepening segregation that gentrification has fostered has lead some of the participants to express a general sentiment about the importance of reclaiming “some piece” of their community from others who were now claiming it as their own. Participants shared that the Gottingen 250 Festival (held in September 2014) symbolized the pride and sense of ownership they have in their community. They also discussed several ideas for increasing representation of Black community members within the economic structure of the North End in the context of ongoing gentrification. These include creating more Black-owned businesses, entrepreneurial opportunities, co-ops, equal employment opportunities and employment training programs. The links between employment and health have been well-documented in the literature. For example, poor health is associated with unemployment, underemployment and stressful and unsafe work environments (Mikkonen and Raphael, 2010).

The “settings” or environments where we live, learn, work and play throughout our lives have a considerable influence on our health. The “revitalization” and restoration (i.e. gentrification) of public spaces and neighbourhoods is often perceived to be beneficial to local residents. However, despite the perception by middle class residents that gentrification creates less segregated and sustainable communities and more social cohesion, these individuals tend to ‘self segregate’, resulting in social polarization and social displacement. Terms such as “social mixing” and “urban renaissance”, which are most often used by policy makers, urban scholars and local and
national governments, neutralize and often masks the detrimental impacts of gentrification and fail to address the root causes of inequality (Belanger, 2012; Berry, 2007; Lees, 2008). Consequently, tensions may arise when new residents bring values, socioeconomic status, lifestyles, meanings and understandings of public spaces and neighbourhoods that contrast to those of longer term residents. Therefore, while gentrification attracts a new class of residents, business owners and investors, it may be perceived as threatening to longer term residents who fear that gentrification will compromise their social networks, public spaces and neighborhoods and lead to the displacement of the most economically marginalized community members.

**DIVERSITY**

Respect for diversity in its many forms was discussed as an important determinant of health during the PATH discussion groups. Participants discussed the importance of community members and service providers acknowledging and respecting diversity based on race, culture, gender identity, sexual orientation, social class and disability. Participation by service providers and police in sensitivity training programs on racism, classism, sexism, homophobia and ableism was also discussed as important for addressing everyday and systemic forms of discrimination within social services, health services and the police department. Participants also discussed how impressed they were with the diversity of participants in their discussion group, particularly with respect to gender, age and culture. A concerted effort was made by the researcher to ensure that both immigrant Black communities (recent and long-term) and Canadian-born indigenous African Nova Scotians were well-represented in this study because of their unique experiences with various social, economic and educational determinants affecting their health. For example, it is important to note that while Black immigrants from the Caribbean and Africa bring to Canada valuable resources, such as high level academic credentials and skills and rich and unique cultures, their immigrant or newcomer status often creates unique and specific social and economic barriers that impact on their emotional, mental and physical health and well-being (well documented in the literature outlined earlier in this report). These include: culture shock; language barriers; difficulties accessing institutions (employment, education, health); isolation; barriers obtaining accreditation for degrees and job skills; difficulties finding employment; unemployment and underemployment; low-income and financial instability; poor quality housing; lack of support and social networks in Canada; difficulties adapting to norms and belief systems that may be different from those in their home country; and marginalization, exclusion, racism and other forms of discrimination (Gee, Kobayashi & Prus, 2004; Haws, 2005; Waldron, 2013).

Gender as a defining factor in the experiences of Black North End residents was also discussed during the PATH discussion groups, particularly as it related to Black men’s experiences accessing health and mental health services. For example, some of the male participants indicated that Black men’s hesitance to access health and mental health services can be attributed to strongly held views about masculinity, strength and “toughness”. A study conducted by Courtenay (2000)
examined masculinity as a social determinant of health and a health risk for men and boys and found that: 1) men’s health problems are related to the social construction of gender, masculinity and male power and privilege, which leads to men’s hesitance or refusal to admit to or acknowledge pain, denial of weakness and vulnerability, emotional and physical control, appearance of being strong and robust and a dismissal of any need for help; 2) many men neglect their health, engage in risky behavior, ignore their bodies and are reluctant to seek medical assistance for suspected health problems since men and boys are socialized to be strong and invulnerable; 3) excess mortality among men can be attributed partly to masculine identity, men’s role in society and gendered patterns of socialization; and 4) socially constructed notions of gender result in different expectations of behavior and roles for men and women, leading to different behaviours and health risks for men and women.

**COMMUNITY COHESIVENESS, MOBILIZING & CAPACITY BUILDING**

Community cohesiveness, mobilizing and capacity building are important determinants of health. They involve diverse sectors of a community sharing knowledge and expertise and engaging in collaborative community-based efforts to create a healthy community that has equal and full access to and participation in the social, economic, educational and political spheres of society. Participants shared that a healthy community is one that builds community capacity through the identification of opportunities for leadership, role modelling and mentorship. They discussed the following factors as important requirements for their community’s health and well-being: 1) community resources; 2) social services; 3) community involvement; and 4) community support. Participants discussed several avenues through which community involvement and support can be encouraged, including community information forums, workshops, training sessions, discussion groups, advocacy groups, community notice boards and social clubs.

The PATH discussion groups sensitized participants to other community members’ experiences (particularly those experiences that reflected their own experiences), made them more aware of “health as a communal issue” and incited in them an interest in becoming more actively involved in their community. For many of the participants, the PATH discussion group was an important catalyst for further discussions on community health and well-being, social action and community advocacy. They expressed that passive advocacy is largely ineffective and that the PATH discussion group impressed upon them how important it is to ensure that advocacy leads to action. Participants shared that the PATH discussion group made them more motivated and able to take action on some of the health issues facing Black North End residents. They also discussed several types of advocacy that community members can become involved in and that often lead to action. These include writing letters to government about the concerns they have about the social, economic and political issues affecting their community, how these issues impact community health and well-being and how government can address these issues. The importance of community members developing political action skills in order to become change agents in their community was also discussed, particularly with respect to building alliances and coalitions with community groups, community agencies, educators, health professionals, policymakers and other individuals and agencies.
Finally, while many participants indicated a strong interest in volunteering in the community and participating in community advocacy, many of them shared that they struggle with a fear of failure and lack of confidence in their leadership abilities. Therefore, courageousness in the face of opposition was discussed as an important leadership trait that community members must develop if they are to address the social, economic, educational and political inequalities affecting their community’s health and well-being.

**KNOWLEDGE SHARING ACTIVITIES**

Diverse and innovative knowledge sharing activities were at the core of this study. These activities have been used to share the study findings with diverse stakeholders, including North End residents; community agencies; service providers; health agencies; health professionals; policy makers; university professors; researchers; students; and the general public.

**Facebook Page**


**Live-Streamed Talk Show**

Live-streamed talk show entitled North End Matters (Halogonia.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](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](http://www.youtube.com/watch?v=o7AQhaO4YYM&feature=BFa&list=PL649C5F10AE296771)

**Television**

Interview on CBC News Halifax (Channel 11) about the pilot study 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**


**Radio**

Interview on *CBC Mainstreet* about Dr. Waldron’s projects on the social determinants of health in the North End of Halifax, aired June 9, 2014

**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, “North End Matters: Using the People Assessing their Health Process to Explore the Social Determinants of Health in the African Nova Scotian Community in the North End”, Dalhousie University, Halifax, May 2014

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


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APPENDICES
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.

**Race** - Refers to the visible markers of difference, including skin colour, hair texture and facial features. Assumptions, perceptions and stereotypes based on these differences are used to include, exclude and discriminate.

**Culture** – Refers to how individuals are organized based on customs, traditions, beliefs, values, worldviews and patterns of living which are learned through tradition and transmitted intergenerationally.

**Immigrants** - A person who has chosen to settle permanently in another country. The term includes recent and long-term immigrants.

**Gender** – Refers to socially prescribed notions about men’s and women’s roles and responsibilities within the social, economic and political spheres. Gender is shaped by social and institutional guidelines, values and norms, as well as ideological representations and expectations about male and female behavior.

**Gender Identity** – Refers to a person's private sense, and subjective experience, of their own gender, i.e. their acceptance of membership into a category of people: male or female (or as someone outside of that gender binary). It is important to note, however, that some individuals do not identify with some (or all) of the aspects of gender that are assigned to their biological sex. For example, for transgender people, the sex they were assigned at birth and their own internal gender identity do not match. Transgender is an umbrella term for people whose gender identity differs from what is typically associated with the sex they were assigned at birth.

**Sexual Orientation** – Emotional, romantic and sexual attraction to persons of another gender and/or same gender (includes individuals who identify themselves as gay, lesbian, heterosexual, queer and/or transgender identities).

**Disability** – Refers to individuals with developmental differences related to sight, hearing, physical and cognitive/intellectual proficiencies that have been unfairly stigmatized by society and that result in exclusion from mainstream society.

**Income & Social Status** – Refers to an individual’s social position based on income, occupation, education, prestige, privilege and power. Health status improves with prosperity and social standing. High income determines living conditions such as safe housing and ability to buy sufficient good food.

**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. It improves people’s ability to access and understand information to help keep them healthy.

**Employment/Working Conditions** - Unemployment, underemployment and 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.

**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.
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.

**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.

**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.

**Neighbourhoods** – Refers to the extent to which a neighbourhood is healthy, which is based on the extent to which that neighbourhood has affordable and quality housing, green space, recreation, jobs, affordable transportation, access to healthy foods, good schools and is safe.

**Housing** – Refers to the extent to which there is affordable, safe and secure housing that is free of environmental hazards and toxins (clean air and water) and good infrastructure.

**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.

**Food Security** – Availability of and opportunities to access affordable, healthy and nutritious food. The term includes the following: 1) availability: sufficient food for all people at all times; 2) accessibility: physical economic access to food for all at all times; 3) adequacy: access to food that is nutritious and safe and produced in environmentally sustainable ways; 4) acceptability: access to culturally acceptable food, which is produced and obtained in ways that do not compromise people’s dignity, self-respect or human rights.

**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 speak 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 the 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 group?
   - 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 Black people 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 group about what you think makes and keeps Black 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 Black people in the North End after participating in the group?
   - 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

Since you facilitated all four of the six-hour PATH Discussion Groups, I would like to interview you about your experiences facilitating the 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. What was your experience like facilitating all PATH discussion groups, in general?
   - Can you describe how your knowledge about social determinants of health changed after facilitating in the Pilot PATH group with 12 people and the four PATH groups, if it did?
   - Was your experience facilitating the four PATH groups different from the experience you had facilitating the group with 12 people during the pilot phase? How?
   - What did you do differently in the most recent phase (different from what you did during the pilot)?
   - Which tasks/activities were most successful and least successful in engaging participants in articulating the social determinants of health in the most recent study?
   - Would you have done 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?

2. What is your opinion about participants’ ability to articulate the social determinants of health during the PATH process during this final phase of the study?

3. To what extent were participants aware of the social determinants of health before the PATH process during this phase?

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

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

6. Were there any interesting outcomes or initiatives that came out of the sessions during this phase?

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 the PATH discussion groups?