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“BLACK WOMAN THE PILLAR OF STRENGTH”
BLACK AFRICAN, CARIBBEAN, CANADIAN WOMEN’S
HEALTH: THEIR LIVED EXPERIENCES

by

Melissa Rowe, B.S.W.

A Thesis Submitted to
Faculty of Graduate Studies and Research
In partial fulfillment of the Degree of
Master of Social Work

School of Social Work
Carleton University
Ottawa, Ontario

September 2001

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“BLACK WOMEN THE PILLAR OF STRENGTH”
Black African, Caribbean, Canadian Women’s Health: Their Lived Experiences

submitted by

Melissa Rowe, B.S.W.

in partial fulfillment of the requirements for

the degree of Master of Social Work

Thesis Supervisor

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September 17, 2001
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ABSTRACT

Melissa Rowe, B.S.W

This exploratory study is an investigation of Black African, Caribbean Canadian Women's Health Experiences in Ottawa Ontario. I have found that barriers to these eleven Black women's health is directly linked to their historical position in Canadian society, and is influenced by their race, class, gender, and socio-economic position. A number of findings have emerged from the data. First, the literature review revealed little knowledge about Black women's health in general. Second, Black women are not accessing the health care system as they should, because of systemic and societal barriers. Third, Black women's approach to health care is from a holistic perspective that is different from the Canadian medical model. The data further reveal that spirituality and faith are positive preventative ways of coping for these women. Further, immediate and extended families are essential components of Black women's health and well-being. Finally, Black women do not access the health care system mainly because of fear, and lack of trust for health professionals and the care system that treats the illness rather than the symptoms utilizing a medical model rather than more preventative approaches.

A Black Feminist framework was employed to inform the study and a qualitative methodological approach was used to gather the data for this research. The significance of the investigation is to begin a dialogue among Black women about their health particularly in Ottawa. I believe that there is a need for health service providers including social workers, policy makers, educators and health agencies to acknowledge the existence of this social problem and the need for the Black community to support the women in breaking the silence about their health in all areas of their lives.

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I owe a debt of gratitude to many people for the completion of this work. While words are never enough, it is my hope that the thanks expressed here may serve as a starting place for expressing that gratitude.

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CHAPTER ONE

BLACK AFRICAN, CARIBBEAN, CANADIAN WOMEN'S HEALTH: THEIR LIVED EXPERIENCES

Introduction

The health of Black women in Canada today is a subject of major importance for those of us who are committed to progressive change in all areas of the Black community. Through writing, teaching, learning and conducting research on Black women's health issues, we are discovering how we can revolutionize the lives of us, Black women, and thus improve the health of the Black community. In spite of the strides that we have made in this endeavour (including education and employment), very little is known about Black women's health experiences in Canada. In order to bridge this gap, I have conducted this study with two purposes in mind: to explore the experiences of eleven African, Caribbean, Canadian women in Ottawa, Ontario; and to examine Black women's access to the Canadian health care system. It is my contention that Black women's socio-economic, political and historical position in Canadian society, which is influenced by race, class, gender, historical slavery, systemic racism, poverty, inability to access health services, impact their health status.

I have found that Black women's access to adequate, appropriate, and holistic health care services, through a collection of facilities, physicians, specialists and other health professionals, is only a part of their problem. The quality of health care resources, and the ability and willingness of Black women to actually access them when needed are

equally significant. Together, all these elements, that can be defined as accessibility are likely to be critical in determining the degree to which the health needs of these Black Canadian women are successfully being met.

Furthermore, this study guided by a Black feminist approach, that advocates for a theoretical standpoint of Black women (Moreau 1996; Collins; 1990; Hooks, 1994), assisted me in explaining the women's health experiences as they informed me. In addressing Black women' health from this Black feminist perspective, it is important to look at the historical and ideological context of Black women to effectively examine their experiences. Such a context allows me to link their current experiences with the historical and cultural health behaviours of the women. Throughout the study the term "Black women" is used interchangeably with women of colour, and immigrant women of African descent from the diaspora, with the full acknowledgement of the diversity within this group.

This exploratory study employs a qualitative and historical methodological approach (Patton, 1990). In-depth-face-to face interviews and focus group were conducted to explore the health experiences, of eleven Black women in their own words, their understanding of health, and their diverse methods of coping with health related issues. The aim of the interviews was to capture and record thematically the health complexities in the lives of the women. The format of the interviews offered the necessary flexibility in exploring Black women's knowledge and feelings about their health experiences. The interviews were open-ended and appropriate questions were used as probes that provided the participants with the opportunity to discuss their stories freely and honestly without fear of appraisal. One of the main contributions of this type

of academic research is to inform, and hopefully lay a foundation for social work practice about the issue of Black women's health. A content analysis was utilized to better understand and interpret the collected data on the Black women's health experiences. With the help of this unobtrusive research analysis I was able to identify significant themes that emerged from the data (Grinnell, 1997 Kirby and McKenna, 1992).

The history of Black women's health experiences in Canada is still virtually unknown. In part, this study is the beginning of a search for those historical roots of Black Canadian women's health experiences in an environment where their health experiences have been impacted by numerous forms of oppression such as race class and gender dynamics. Therefore, one of the main purposes of this thesis is to record the concrete knowledge about a group of Black women's understanding of their own health issues and their struggles in accessing the Canadian health care system both currently and historically. A second contribution of this study is an explanation of the influence of race, class, gender as interrelated systems of oppression that shape Black women's health care needs. Finally, the study adds new knowledge to the field of social work and offers social workers a more definitive understanding of Black women's health needs. This thesis is premised on the belief that we, as social workers, need to learn how to appropriately address Black women's health needs that affect them socially, economically, and politically. It is my hope that this understanding, that the present situation of Black women's health in Canada is a result of historical oppression, will help in promoting equality of access to health services to Black Canadian women. Thus, it impacts on encouraging Black women to access the health system resulting in progressive healthy Black communities. The final contribution of this thesis is to assist health care

professionals, policy makers, and feminist researchers to acknowledge and recognize Black women's ability to identify their health care needs from their own standpoint and to increase their ability to access appropriate health care thus to initiate change for themselves.

Political Stance

I am a Black Afro-Caribbean, Canadian woman and a professional social worker whose experience includes thirty years of working with women in community development and health promotion at the grassroots level. I have also experienced being the only Black professional woman working in a mainstream health and social service agency. I have experienced personally the difficulty of accessing appropriate and culturally sensitive health care. As a "so called" woman, of colour the term "Black" has special meaning for me. "Black" indicates my human self, the essence of my spirit, the psyche that distinguishes me as a human being within a Black culture. It also refers to the essential qualities, characteristics, habits and disposition that give me a distinct identity as the Black woman, I am.

Most of the women who participated in the study originally came from the Caribbean and Africa. This starting place of shared language, culture, experience, and social meaning assisted me in the development of my relationship with the women. This common history allowed me to offer a more accurate interpretation of the women's health experiences and to understand some of the issues identified and discussed and to ask questions that elicited useful information.

Research Questions

Relevant questions that address the social problem of Black African, Caribbean, Canadian, women's health experiences include: How do the women define their health experiences within Canada and their countries of origin? What are some of their major health experiences in Canada that affect their families and community? Has their health experiences in Canada affected their families and community? What are some of their major health concerns in Canada today? Are their health experiences historically linked? And if so, how have they impacted on the Black women's ability to effectively build, maintain and strengthen Black families and communities? Are there any patterns or connections that exist between Black women's health experiences historically and currently? Finally, what are some of the barriers that Black women face in accessing holistic health care in Canada?

Definition of Terms

The following terms are defined in an attempt to provide clarity to their meanings within the scope of this thesis.

Holistic Health

For the purpose of this study, holistic health is defined as a state of physical, mental, emotional, economic, spiritual, communal and cultural well-being. Holistic health also involves the ongoing responsibility of improving our lifestyle, the health of our families and communities, thus avoiding and reducing harm of any type (mental physical and so on) Black women, traditionally and in most cases currently, view health from a holistic perspective (i.e. mental, emotional, spiritual, economic and cultural). Our

way of seeing and accessing health care is more than the bio-medical, unit-cultural individualistic system of health care that dominates the Canadian health care system.

The United Nations Definition of Health

The United Nations defines health as: “A state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Women’s health involves their emotional, social and physical well being and is determined by social, political and economic context of their lives as well as by biology” (United Nations Platform for Action, Beijing, 1995:3). The difference between the United Nations definition of health and holistic health is that, it does not include the cultural, spiritual, family, and the community as aspects of well being. On the contrary, for Black women the latter are essential elements for “good health”

Health Determinants

Recently, Lee (1998); National Forum on Health; (1997) and others called attention to the interest in women’s health in general in response to new global perspectives on health (Lee, 1998; National Forum on Health, 1997; and others). According to these writer’s, factors in the achievement and maintenance of good health involve recognition of the effect that the social, physical and economic environments have on our well-being. These factors are referred to as determinants of health and include income, social support, employment, unemployment, and poverty. It may be argued, that health is a fundamental human right and that women in Canada are not merely consumers, but are also citizens who have the right to proper nutrition, housing, freedom from poverty, access to health services and the opportunity to make informed decisions regarding their health concerns. However, I would argue that while Canadian

women may be said to have the right to proper health, most Black Canadian women, because of historical neglect, racism, and other forms of oppression, are often left without adequate health care, which has serious consequences for them, their families and community.

Black

The term “Black” is a political category that identifies women from the group of African descent south of the Equator in the diaspora. The word “Black” is capitalized in this study as a political statement identified by some Black writers to signify the social changes that are taking in our existence in Canada and globally. Along with Moreau, (1996) I am declaring that all Blacks have a common African ancestral root that must be recognized and respected. Terborg-Penn supports our stance when she claims, “In the United States for example, by law, people with any measurable degree of African ancestry are considered Black. As a result, since slavery, women of African descent, regardless of their skin colour, have been identified, and often have identified themselves as Black. In this sense, Black symbolizes a cultural and political milieu, more than it does a colour”(Terborg-Penn, 1996:29).

However, terms such as; Black, African, Women of Colour, Canadian Black women of Caribbean Descent, Afro-Caribbean, Afro-American, Immigrant women, and so on, are used interchangeable throughout the study, due to its utilization in the literature available to the researcher. The term ‘Black’ has seldom meant literally Black skin colour. It symbolizes the oppression of “non-white” by the white ideology of ‘racial purity’, and at once puts brown, gold-coloured, and beige-coloured people together in the same category. Neither does the term ‘white’ stand for skin colour that is literally white

(Essed, 1990:29). The term white, dominant or mainstream is used interchangeably and will not be capitalized because, “as a rule, whites in Canada do not claim their colour as a distinctive heritage. It is in reality an identification of power, prestige and wealth”

(Moreau, 1996:9).

Systemic Racism

In Elliott’s and Fleras’ discussion of racism, at the institutional or societal level, they claim that it can be regarded as impersonal, unconscious, unintentional and covert. Systemic racism is the name given to this subtle, yet powerful form of discrimination that is entrenched within the institutional framework of our society. With systemic racism, it is not the intent that counts, though the intent is also there at times, but rather the consequences. Policies, rules and priorities might not be inherently racist or discriminatory in intent of dominant ideology. However, they have discriminatory effect in that they exclude certain groups from access to equality (Elliot and Fleras, 1992).

Diaspora

This term refers to the scattered, and historical forced dispersion of Black Africans from the African continent by the white Europeans, as chattel slaves from 1502 to 1864, in the Caribbean, North and South America.

Black Family

Because of the historical oppression that Black people in the Western Hemisphere experienced for over four hundred years (slavery/segregation), the definition of the Black family warrants attention. A Black family may be comprised of many forms: the nuclear family of mother, father and children; single parent (mother or father) and children; the extended family which may be comprised of grandparents, great-grandparents, and/or

uncles, aunts, and non- blood relatives, who have decided to live together as a family for communal support. There are so many different family types in the Black community necessary for survival support and identify. Therefore, it is extremely difficult to arrive at one definition of the Black family (Winks, 1971).

Spirituality

Spirituality refers to an individual's way of thinking, believing and living.

"Attachment to all that concerns, the life of the soul" (Websters Encyclopaedic Dictionary, 1988: 958). The data has revealed that religion and spirituality have played significant roles in the survival of Black people in the diaspora. First, it gave the slaves and their descendants the courage and strength to continue their laborious toils under barbaric conditions and helped to keep them together as a community. Second, following slavery the Black church, which emerged from the religion of the slaves, was for a long time the most effective and only institution allowed in the Black communities. The church provided them with a sense of identity, support, community and the courage to face the world with pride and confidence. This legacy continues in modern day Canada as an important aspect of maintaining physical, mental, social, economic, cultural and spiritual well-being in most Black women's lives. All eleven women, who participated in the study, cited spirituality as essential aspects of their health and well-being.

Spirituality was also identified as one of the themes from the data and will be discussed later in the thesis.

Slavery

For the purpose of this study slavery refers to the historical abuse, the buying and selling of Black Africans from early 1500's to late 1800's; the exploitation and forced

labour perpetuated against the will of Africans in the “New World” located in the Caribbean and North/South America. Slavery was a socio-economic and political system by which the dominant white European masters who capitalized on the African’s labour through the consistent threat of physical, mental, emotional, social, sexual, and spiritual violence. Slavery was a fundamental reality of Black people’s history in the Western Hemisphere of which Canada is included (1628-1834). This event might have affected Black women more so than men, by virtue of their gender. African women were stolen from Africa by white slave traders and sold. Black women in the slave era found themselves in a hostile, patriarchal, socio-economic slave society that stripped them of their humanity, including their femininity, status, families, community, health and thus rendering them beasts of burden in many instances. White European masters sexually raped and physically violated Black women’s bodies to ensure the destruction of the “prideful arrogant, and independent spirit of the African people. Such methods forced Black Africans... including women to conform to the white colonizers notion or proper slave demeanour... for the slave market” (Hooks, 1997:19).

Organization of the Material

The research is organized into seven chapters: **Chapter One** is an introduction of the research problem, “Black African, Caribbean, Canadian Women’s Health Experiences in Canada”. The assumptions, purpose and goals of the study are also outlined in this chapter. The chapter also defines the problem, of the study its significance, as well as terms used in the study.

Chapter Two describes the theoretical approach that guides the study. It also expands on some of the ideas outlined in the Introduction.

Chapter Three outlines the methodological approach used, the ethical considerations as well as the strengths and limitations of the study.

Chapter Four provides a summary of available information on the subject area of women's health experiences in general and an overview of Black African, Caribbean, Canadian Women's Health Experiences.

Chapter Five explores some of the themes that consistently emerged from the interviews with the women and identifies some of the barriers to accessing adequate and appropriate health services.

Chapter Six discusses some of the findings such as; traditional healers, alternative medicine, spirituality, empowerment as well as, the concern of how Black women's health experiences impact on their family relationships.

Chapter Seven summarizes the findings and conclusion of the study, and its implications for social work practice. Finally, recommendations are suggested for further research on Black African Caribbean Canada women's health experiences in Canada.

CHAPTER TWO

THE THEORETICAL FRAMEWORK: A BLACK FEMINIST APPROACH

Introduction

This study is informed by a Black feminist approach that advocates for Black women's freedom to voice their rights from their standpoint as Black women. Collins, 1991) a Black feminist scholar, asserts that Black feminism is a theoretical framework that assists us in better understanding the evolutionary plight of Black women's historical presence in the Western Hemisphere from slavery to present. Collins states that this shared experience warrants an alternative epistemology that is comprised of an Afrocentric standpoint that acknowledges and celebrates the unique values that characterize Black women in the diaspora through self, family and community life (Collins, 1990).

Moreover, the standpoint of Black women assists us in making sense of the contemporary world in which we interact on a daily basis (including how we deal with health issues). Black feminism encompasses both an Afrocentric epistemology and a feminist gender consciousness, which reveals as its key theme. self-definition. This theme reveals several realities such as, the interlocking nature of oppression, the importance of redefining cultural habits and disposition that give Black women a distinctive identity. Also, this feminist viewpoint allows Black women to have a clearer understanding of all areas of their lives, to reflect on these areas, and to articulate their health experiences within an African context (Collins, 1990).

A Black Woman's Standpoint

Collin's explication of a Black woman's standpoint is an integrated approach in its analysis of race, class, and gender. She maintains that race and class cannot be interpreted in isolation from a gender analysis in the everyday experiences of a Black woman. Moreover, Collins asserts that Black women's subordination under the auspices of oppressive structures of race, class, and gender are all socially constructed. Collins offers a comprehensive approach to Black women's oppression, as she understands that empowering Black women also requires the help of allies in eliminating oppressive structures, that maintain and support systems of inequality. Therefore, she recognizes that the key to the eradication of these oppressive structures, that maintain a power imbalance, can be attained through the building of social consciousness and allies among other oppressed groups (Collins, 1991:207).

The ability of Black women to self define and determine their reality is one of the concepts among of Black feminist thought that can be defined as a body of ideas which bring about Black women's liberation produced by and for Black women and clarify their standpoint. Black female scholars, Moreau, 1996; Collins 1990; Hooks 1984 and others have laid a theoretical foundation for a distinctive standpoint on the Black female self, family, community and ethnicity, and in doing so, have created a Black women's intellectual tradition. According to Collins, Black feminism positively acknowledges that we have a different and unique way of knowing, being and experiencing the world (Collins, 1990:5).

Therefore, in addressing Black women's health in Canada from this Black feminist perspective, it is important and necessary to look, even briefly, at the historical,

and ideological context of Black women's health in order to examine their adverse and positive health experiences. Such an approach has allowed me, the researcher, to make some connection between the health experiences of Black women in Ottawa, Ontario and those of women in slavery (1500s-1800s). This observation has enabled me to make a distinct correlation to this historical impact on Black women's families and community.

Therefore, by examining the health experiences of the Black women in the study, using the standpoint of Black women, allows me to identify the fundamental link to historical health practices of Black women in the African Diaspora and the African Continent (Canada, United States, Caribbean and South America). These historical lenses, do not merely portray the adverse and/or positive health experiences encountered by Black women, but also portray a history of Black women's struggle against the brutal forces of white and Black (male) oppression, which for centuries denied Black women their basic humanity. This resulted in problematic physical, mental, emotional and psychological health conditions. It was through Black women's support within their sisterhood solidarity, and their willingness to improvise their African cultural health habits, that many of them and their families found the strength to resist and survive ill health.

Tulloch argues that, "these African values are reflected in their ability to survive and navigate in harmony among nature; the passing down of culture and traditions from generation to generation to ensure the survival of the group" (Tulloch, 1975:48-49). Collins supports this idea by reminding us that, "this Afrocentric consciousness permeates the shared history of people of African descent through the framework of a distinctive Afrocentric epistemology" (Collins, 1990: 206). These values, which include

African tradition in health remedies, that have survived slavery, race, gender and class oppression are evident in a Black Feminist thought process.

Self Definition

Black feminists utilize a self-defined standpoint to reflect the process of self-determination needed in academia, and the white society at large. Moreover, Black women use this approach to explore issues of relevance to the Black woman's daily life experiences and other areas of Black oppression. Collins explains that:

Self-definition involves challenging the political knowledge-validation process that has resulted in externally defined stereotypical images of Afro-American woman-hood... that have been central to the dehumanization of Black women's labour (Collins, 1991 as cited by Moreau, 1996:18).

Black feminists assert that, self-defined standpoints are necessary mechanisms in reclaiming our pride in our Blackness, femaleness and historical legacy of our African foremothers. We need to conceptualize and reclaim this political process as a means of bringing our subjective and individual reality into a political social context of Black sisterhood. Therefore, as Collins reminds us:

Developing adequate definitions of Black feminist thought involves facing this complex nexus of relationship among biological classification, the social construction of race class and gender as categories of analysis, the material conditions accompanying these changing social constructions, and Black women's consciousness about these themes. One way of addressing the definitional tensions in Black feminist thought is to specify the relationship between a Black women's standpoint – those experiences and ideas shared by African-American women that provide a unique angle of vision on self, community, and society – theories that interpret these experiences (Collins, 1991:22).

Black Feminist Thought is born out of the lived experiences of women who share the heritage of the African Diaspora, and their ability to reflect critically and be engaged in the process of self-definition of the shared lived experience of their African

foremothers and their own connections. This body of knowledge and reflection postulate a complex, simultaneous relationship between various forms of oppression, specifically race, class and gender, that create unique problems (health) for Black women Collins, 1990; Hooks, 1984; Hull, Scott and Smith, 1982. At the core of this critical reflection are a number of key realities that include: the recognition of the “legacy of struggle”; “the interlocking nature of race, class; and the racist impositions of whiteness and maleness that require them to live simultaneously in separate and contradictory worlds (Collins, 1990). This accounts for the diversity of experiences that shape the lives of Black women. Thus, Black Feminist thought challenges the notion of an essential, or universal experience of being women and our uniqueness of ‘Blackness’ (Moreau, 1996).

Furthermore, Black womanhood throughout history to the present day, has been defined as deviant and abnormal and this lends itself to depictions of the mammy’, matriarch, washer woman, aggressor and controller of the Black man, images that might have been internalized and then externalized resulting in health problems. Sadly, these images have been and continue to be used to devalue Black women and justify societal rejections and their ill treatment by others. These depictions have transcended any positive and acceptable actual images of many Black women who are successful, gentle, and caring mothers, partners, teachers, engineers, scholars and so on. This misunderstanding of maternal and biological deterministic images of Black women in slavery, colonialism, and class hierarchy, “offer us a more complex conception of power as exercised in all manner of social interactions” (Aziz, 1997:75).

The acknowledgement of the centrality of slavery, colonialism and class hierarchy, also facilitates the recognition of the ways in which Black women recreate or

self define the strategies that allow them to survive contradictions. One of these strategies can be the involvement of Black women as leaders and active participants within Black, male dominated institutions (including the Black Church) and communities, even while they struggle to confront the sexism within. It is the legacy of “shared resistance” that Black men and women possess, which allows them to stand together to confront racism, and to refuse to be seen as well as a means to combat sexism within the Black and dominant community (Hooks, 1984).

Thus, feminist thought provides a critical entry point by which I use self-definition as a means to reflect on the complexity of the lives of Black Afro-Caribbean women’s health experiences. It facilitates an analysis that allows discussion of the multi-dimensionality of the issues that we face as it addresses our history of slavery, colonialism and other forms of oppression. I have found that this legacy of oppression is a critical starting point for examining the health issues that Black women experience, and their response to its impact on their family relations. In most instances, as the data demonstrates, cultural health values are practiced among Black women. These values have met some of their needs and thus tend to protect their family relations.

Collins argues that her approach is derived from the everyday experience of the Black woman, and that it acknowledges a classification system that places Black women in the ‘Other’ category. This denies them the protection that maleness and wealth can provide (Collins, 1991: 207-208). Being a white middle to upper class male and/or female allows this elite group to experience white privilege and benefits that are not usually afforded marginalized groups such as Black women. This privilege leaves Black women no option, but to establish a forum where their voices can be heard and where

they can define themselves as opposed to being defined by Black men, whites, patriarchy, capitalism, imperialism, colonialism and racism. It demonstrates the importance of knowledge in deconstructing oppressive institutions as a route to empowerment. The standpoint of Black women calls for change to an individual's consciousness and social transformation, and change in the way public institutions, such as health care, operate. In this, new knowledge becomes the major component in inspiring both mediums to make change (Collins, 1991: 221).

The concept and application of a Black woman's standpoint is not a recent endeavour. Many feminist writers advocate for understanding the everyday world of women from their own standpoint. Its application is significant in that it allows women to express their truths based on where they stand in the world looking out. According to Moreau:

In most cases, these writers (Ramazanoglu, 1989; Collins, 1991; Smith, 1987; and others.) employ the standpoint of women to explicate conceptually. And experientially women's location outside the white male centres of power, prestige, privilege and knowledge as evident in the socio-economic, political, religious and educational institutions of society (Moreau, 1996:13-14)

Black feminists utilize a self-defined standpoint to reflect the process of self-determination needed in every area of Black women's lives especially as it pertains to their health and its impact on their relation to their families. Moreover, Black women use this approach to explore issues of relevance not only to their daily life experiences but other areas of Black oppression (including health care).

Finally, Black feminists believe that the source of Black women's empowerment is derived from Black women's consciousness in defining our own reality. By utilizing a self-defined analysis we give credence to our ways of knowing which reject the dominant ideology that has traditionally silenced us and imposed systems of oppressive structures of race, class, and gender to further control us. In order for us Black women to dismantle these destructive structures we need to redefine our self-worth in terms that challenges a 'power over' mentality replacing it with a 'power within' ourselves. This process will encourage us women to develop self-love that politicizes and validates our own strengths, worth and value. Furthermore, Moreau states that: "Black women's self-defined standpoint permits us to reframe the entire dialogue of Black women's oppression from the past to the present, from Black Africa to white North America" (Moreau, 1996:19).

With this said, Collins and other Black feminists, myself included, assert that, self-defined standpoints are necessary mechanisms in reclaiming our pride in our Blackness, femaleness and the historical legacy of our African foremothers, which includes healthy existence. We need to conceptualize and reclaim this political process as a means of bringing our subjective and individual reality into political and social context of Black sisterhood (Walker, 1999). The utilization of this feminist alternative epistemology enabled me as a Black woman to explore Black women's health experiences in Canada and its relationship between economic, race, class, and gender and how these experiences have impacted our family relations and our Black community.

CHAPTER THREE

THE METHODOLOGICAL APPROACH

Introduction

This study, of the health experiences of a group of Black women of African and Caribbean descent, is exploratory in nature. It employs a qualitative approach in which in-depth, face-to-face interviews and focus group interview were conducted, in the exploration of this issue in their own voices, using their own understanding of health and their methods of coping. The aim of the study was to capture the complexities of the women's health experiences and to discuss briefly the various themes that emerged. The study is guided by a Black feminist theoretical approach that advocates for a Black women's standpoint.

Profile of the Women

A total of eleven Black women participated in this study, of which six were involved in a focus group discussion and five consented to face-to face interviews. The women came from several different geographical communities in Africa and the Caribbean. All of the women lived either in Africa or the Caribbean prior to coming to Canada. They are Black women who have lived in Canada for over ten years and are now Canadian citizens. The women are from diverse backgrounds, different age groups and marital status. Five of them are single with no children and have never been married, three of the women are single parents with adult children and have also been married, two of the women are single parents who have never been married, and one woman is

currently married with adult children. All of the women are professionals with expertise in the following areas: four Social Workers with MSW and BSW degrees, respectively two Teachers, one Lawyer, three Civil Servants and one Project Manager. The women are aged from thirty to sixty- five. All the women live in the Ottawa area and have been living here for a period of eight years or more.

Research Design

Due to the dearth of relevant literature on the issue of Black women's health experiences data was gathered using a qualitative approach, with in-depth face -to -face and focus group interviews. These data gathering methods offered the necessary flexibility in exploring the Black women's knowledge of their health experiences. The interviews were open-ended using appropriate questions as probes that provided participants with the opportunity to discuss the issues of their health without fear of reprisals and in an open honest manner. One of the main contributions of this type of research is to inform and hopefully, lay a foundation for social work practice about the issue of Black women's health in Canada.

Sampling

The purpose of a sampling design according to Patton is as follows: "qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit. Therefore, the purpose of interviewing the women is to allow us to enter into the other person's perspective" (Patton, 1990:12). The participants were selected from Black women currently living in the Ottawa for over eight years who are members of Black institutions and organizations such as Black

churches, immigrant support groups, settlement agencies, women's organizations as well as the community at large.

A snowball sampling technique (Patton, 1990) was used to recruit participants through contacts within the above named organizations and groups as well as through personal contacts with friends and colleagues. The aim was to recruit participants, who not only met the selection criteria, but also had a wealth of experience in the subject area on which data was being collected. Interviews were conducted in Canadian English, Caribbean and African dialects, according to the preference of the women. All of the women who participated in the focus group came originally from the Caribbean.

Limitations

The study was limited by lack of adequate Canadian literature specifically relevant to Black women's health. The intent of this study was to capture the experiences of the women's health and to hear their stories of how their health affected their families and community. However, this process limited my ability to draw generalizable conclusions about the issue under investigation. Another limitation of the research design was the limited time frame in which the study had to be completed. The lack of available funding was also problematic. In spite of these limitations I was determined to complete the study as a contribution to new knowledge in the field of Social Work and a contribution to the Black community.

Data Collection

In-depth face-to-face and focus group interviews were conducted and lasted approximately two hours each. During the interviews, an interview guide (Appendix A) was used to probe participants, when they needed encouragement. The questions were

open-ended to ensure that the main topics were covered without restricting interviewees to a pre-determined sequence of questions. With the permission of the participants, each interview was taped and later transcribed. One advantage of the interviewing method was the naturalness, spontaneity, and flexibility, in gathering the data. Also, the participants were in control of the environment throughout the process.

Data Analysis

In order to effectively understand and interpret the collected data on Black women's health experiences a content analysis was used Grinnell, (1997) indicates, that content analysis involves searching for and counting words, phrases, themes or concepts. I have avoided the quantitative elements of this data analysis; instead, I have used the qualitative aspect of content analysis. According to Grinnell, (1997) the qualitative approach provides access to difficult-to-obtain phenomenon such as life experiences, personal beliefs, values, and cultural realities.

After gathering the data, I searched for common themes and patterns that emerged. I did this in accordance with the model "from the margins" set forth by Kirby and McKenna, (1992). First, several analysis files were created, an analysis file for content and an analysis file for process. The content file contained all materials relating to substance, my reflections on this, and any "conceptual baggage" related to content (Kirby and McKenna 1992). The process file contained all matters relating to the plans and data gathering, my reflections on this and any "conceptual baggage" related to process. After these files were established, an analysis of the data within file and category was interpreted and supported by the literature and my personal experience. One of the advantages of this model, from the margin, was that it supported the Black

feminist approach by revealing and linking the forms of oppression experienced by Black women in regards to their health experiences.

Transcripts of focus group discussions, flip charts and face- to- face interviews were made from the originally taped recordings. As transcripts were read repeatedly, major themes and sub-themes were identified and coded. Once this process was completed all statements within the sub-theme categories were filed. This process also allowed the women to feel more comfortable telling their stories often using their own language and dialects (including patois), which enabled me to understand the dialects. Although, I understood the African dialect (Pigein English) I did ask the women for help in the correct translation.

Ethical Considerations

This study involved research with human subjects: therefore, strict ethical considerations were exercised throughout the entire data collection process. The primary ethical guidelines for this study are: The Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (1998); The Canadian Institute for the Advancement of Women (CRIA W) Feminist Research Ethics (1996); and the Social Work Code of Ethics (1994). The proposal for this study also received approval from Carleton University Ethics Committee. The following issues are highlighted based on the relevance to the research completed.

Informed Consent

This study recognized and respected the rights and dignity of all participants. The researcher understands that in order for research involving human subjects to be considered, the consent given by participants must be informed and entirely voluntary. Consent is/was considered informed when the participants are/were made aware of: a) the

identity of the researcher and her personal goals and intentions in conducting the research; b) the general purpose and nature of the research; c) any foreseeable risks and/or benefits that may be involved in participation, are identified; and d) the option to withdraw from the research at any time without penalty with an opportunity to reengage the project at any time, are/were clear to the participants.

To achieve this goal, first I arranged meetings with each potential participant to discuss the study. A letter of introduction was presented at this first meeting. The letter of introduction outlined the purpose of the study, time commitment required, confidentiality arrangements, and how the information was to be collected and used in the study (Appendix B). I discussed the content of the letter with potential participants, and encouraged them to ask questions.

Once a verbal commitment to participate in the study was received, the letter of consent was presented for signature. This letter included the agreement that participants could: withdraw at any time if the situation became too difficult; choose not to answer any question; and have tapes and transcripts either destroyed or returned to them after the analysis was completed. The letter of consent also acknowledged that participants had agreed to the taping of the interviews (Appendix C). The researcher and each participant reviewed the contents of the letter, and implications, before the letter was signed.

Confidentiality and Anonymity

Given that some of the data was gathered in a group setting, there was no way for me to guarantee that discussions from the focus group would remain entirely confidential, or that participants would remain anonymous. I made this clear to group members from the beginning. As with any focus group, there was a risk that participants would later

repeat things heard during meetings or reveal the identity of other participants to outsiders. I explained that if participants were not comfortable discussing something within the group setting they could speak with me in private. Participants were also advised that they should avoid revealing any information about themselves or others that they felt should remain confidential.

I did not reveal the names of any participant in my research to any third party. All identifying information was removed from transcripts and written reports. All recordings and transcriptions were kept locked in a secure place throughout the research process and was destroyed once the thesis was successfully completed.

Risk and Safety Issues

The protection of participants from emotional and spiritual harm took priority in this study. The research acknowledged and appreciated that the discussion of personal issues related to Black women's health experiences and its impact on their families might be painful to some participants. Therefore, participants were informed that they were free to withdraw from the study at any time. I did not reveal any personal medical and family information given to me by the women to others. None of the participants appeared to be emotionally upset during the interview or at any time and thereafter. However, I had access to a counsellor for support in case any emotional distress was indicated.

Before the process of recruitment of the participants began, I obtained written commitment for provision of counselling support from experienced counsellors.

(Appendix D) I made arrangements with one counsellor to ensure that support would be

provided free of cost to participants. The professionals providing the support were made aware that I would not be able to share any information about the participants with them.

Deception

No deception was used at any time. Potential participants were informed, through the letter of introduction, and discussions, of the purpose of the study, and how information was going to be collected and used. I encouraged the women to ask questions about the research. Those who participated were offered a copy of the final draft of the discussion. Most of the women from the focus group accepted the offer some also requested copies of the transcripts. One woman requested the return of her recording following completion of the study.

Factors that Impacted on the Study

As I indicated earlier in the study, I am a professional social worker whose experience includes working with women in the health care field. I am a Black Afro-Caribbean heterosexual, immigrant Canadian woman. I have also been one of the only Black women working in a mainstream health and social service agency and have had personal experiences with the difficulty Black women face in accessing appropriate and culturally sensitive health care. It is worth repeating that because all six women who participated in the focus group discussion came originally from the Caribbean it made the process much easier. This starting place of shared language; culture, experience and meanings did actually assist in the development of my relationship with the women in the study. This also allowed me to have a better understanding of the women's health experiences that helped me to tune in to some of the significant issues identified and therefore to ask questions that elicited useful information. A number of the women in the

focus group already knew each other, which allowed them to feel more comfortable in telling their stories often using Caribbean dialects.

My particular location did have an impact in terms of the women's expectations of my understanding of their experiences. There were moments when I found myself starting to participate by sharing information, and had to stop myself without finishing my sentence. I developed a strategy for responding by asking probing questions in order to stop myself from saying anything, though this did not always work. In any case, I felt that some of this interaction and mutual sharing facilitated the group process. I also feel that my experience in obtaining information as a social worker helped me to quickly regain the listening focus when it was necessary to do so.

Procedures to help me recognize biases included the use of field notes during the data collection process to document my observations, perceptions and reactions to events and situations, as well as my thoughts, feelings and general physical and emotional disposition. Efforts were made during group discussion, to avoid leading questions, statements and non-verbal behaviours. Self control and monitoring was a constant that I believe helped me to maintain the integrity of the data.

An important element that I should note is the fact that I deliberately did not add a question about spirituality to the interview guide because I wanted it to come from the women directly without coaching. However, once it was identified as an issue I was interested in how this was connected to their health experiences. All of the women without exception talked about how they were influenced by their spirituality. They made a clear distinction between organized religion and spirituality and the fact that it was directly related to their health. As well, some of the younger women felt that there

was a definite difference in how their mothers viewed their spirituality from the way the younger generation viewed it. This is consistent with my perception of Caribbean culture being strongly influenced by a sense of the reality and presence of God.

Finally, in my discussion of the findings some of the issues identified in the field notes are included. Participants' preview of quotes, and how their words were used in the report also helped in clarifying the extent to which descriptions and interpretations accurately reflected the reality of the women's experiences as they relayed it. I believe these methods also helped to protect the integrity of the data.

CHAPTER FOUR

A BRIEF REVIEW OF CANADIAN WOMEN'S HEALTH

Introduction

A study of the history of Canadian women's health is not only a recent phenomenon, but also one that deals more with health programs than actual people's health. Based on the available literature, one of the most destructive features of health programs, are that they are disease oriented as opposed to prescribing prevention or healthy lifestyles. Consequently, most health programs for women project certain rigidity in policy and procedures and a strict adherence to treating the illness. Social and individual problems are isolated and separated so that they have no common history. There is no recognition of a person's individual differences such as race, gender, class, culture and how these factors intersect in everyday experiences of women's health. This "illness" or medical model, that is used in most health programs and services, offers no acknowledgement of the potential and ability of people to change the context within these services.

As a result, data reflecting the health of Black Canadian women have been neglected in studies of health care. Due to the lack of available Canadian literature on the issue of Black Afro-Caribbean women's health experiences, it was necessary for me to review all available literature on the topic for this study. These include; local community based research reports, anecdotal and traditional knowledge, limited Canadian literature, and Caribbean research on Black women's health. Many themes were identified from the general health literature on women's health of which are the following: Access to Health

Care Services; Preventive Health; Behaviour and Lifestyles; Lack of Research; Lack of Information and Education; Cultural Insensitivity; Under-representation of diverse groups at all levels of workforce including health care; and Racism/Differential treatment.

This absence reflects the alienation that marginalizes us Black Canadian women in health care services. It was almost impossible to find useful and reliable literature that addressed issues specifically related to Black Afro-Caribbean women per se. No serious studies have been done to inform us how race and gender affect health patterns of women who are Black immigrants. However, there are many articles describing and comparing the health patterns of different “ethnic,” “cultural” and national groups (for example, The National Forum on Health, 1997; Canada Health Action: Building on the Legacy, 1997; Women’s Health Care Delivery in Canada, 2001). Among these articles are some interesting insights and findings available within the feminist and gender-oriented literature about women and health care. An example of one of these insights was: Tudiver and Hall (2001) who suggest that “women from diverse cultural and ethnic minority groups, including aboriginal and Inuit women, have raised profound issues about how other non-Western conceptions of health and wellness, causes of disease and different healing practices should be acknowledged and valued by the dominant Western medical system” (Tudiver and Hall, 2001:12). A second example is the recognition by Health Canada that “Health Canada is sensitive to ethno cultural heritage, sexual orientation, level of ability and demographic characteristics that alter women’s experience of health and their interactions with the health system” (Women’s Health Strategy, 2001:19). I find this statement by Health Canada very interesting since most of their written literature indicates the opposite. I was unable to find relevant and useful

information in the Women's Division of Health Canada on Black African, Caribbean, Canadian women. Furthermore, some of the community-based literature that offers ethnic profiling does not appear to be based on careful research because it underestimates or ignores issues such as class, gender, language, race, and culture that impact differently on members of the same "national" or "ethnic group".

Women's Health: A Brief History In Canada

This section presents a brief discussion on the history of Canadian women and their role in the health care profession in the early sixteen hundreds (1600s). According to Tudiver and Hall (2001).

An early history of women healers and midwives who derived their knowledge from apprenticeship and oral tradition characterized Native communities as well as settlements in the French and English Canada. In many areas of Canada, the mother or grandmother served as doctor, nurse and apothecary for the whole family. An under publicized fact of Canadian health history is that the first hospital in Canada, the Hotel Dieu in Quebec City, was founded by a group of women, in this case, the Augustine nuns of Dieppe, France, in 1639. In 1641, Jeanne Mance founded the Hotel Dieu in Montreal (Tudiver and Hall 2001:20).

Furthermore, the authors state that the institutionalization of health care and its scientific focus of medicine in the 18th century had a negative impact on the more holistic role that women played in the health of the community. As a result, it lost its importance. An example of this was in 1795, "a group of physicians persuaded the legislative Assembly of Upper Canada to include midwifery, once the sole domain of lay women into the definition of medical arts that could be legally performed by licensed physicians" (Tudiver and Hall, 2001:1).

Since the beginning of the nineteenth century, the medical profession has played a dominant role in shaping the Canadian Health Care Services. This dominance has been

based primarily on the premise of exclusive jurisdiction for the rendering of many key services and control of boundaries for other health professions. Women who had acted as independent practitioners were now relegated to subordinate positions, denied access to medical training, and utilized as “inexpensive labour force” (Working Together for Women’s Health, 1990: 21).

The literature indicates that historically, Canadian women have been discriminated against based on their gender. They were denied entry into Canadian universities, access to resources and funding in the medical field as well as research funding. “Women’s current struggle to address their health needs emerged, in part, from a history of progressive exclusion and limited access to power in determining how health and illness would be defined and “treated ”(Hall, 2001: 2). Available literature on women’s health in general further indicates that, “women learned a variety of skills through apprenticeship from a mother, grandmother or other elders and they often served a wide community” (Women and Health Care Delivery in Canada, 1996).

The author found that by the mid-18th century however, hospitals were used to segregate great numbers of immigrants, largely from England and Ireland suffering from epidemics of cholera, typhoid and smallpox. For the next century, hospitals housed the poor and dying, under unsanitary conditions and where practices might likely harm, as heal. Mostly poor women sought work in hospitals and given the conditions, their death rates were high (Coburn, 1994:29).

Coburn (1994) further states that, the advance in medical science in the late nineteenth century raised the prestige and political influence of the medical profession and revolutionized the way medicine was to be practiced. Women practitioners, serving the health needs of their families and local communities, had little political influence over these changes. The new practices of scientific medicine drew upon male-dominant, ...

European values and attitudes. The skills of midwives and herbalists, as well as homeopaths and aboriginal healers, were publicly discredited, although in some places these were privately practiced. The literature further indicate that as medicine became a profession of increasing influence and control over resources, women were actively excluded by associations of male practitioners and limited in their access to medical schools (Coburn, 1994). Sheinin further indicate that:

Queens University in Kingston and the University of Toronto permitted enrolment of women in 1870s and early 1880s, but hostility and lobbying against women led to a ban by 1883. By the early 1900s, American and Canadian universities had begun to admit women to co-ed programs, the University of Western Ontario, Dalhousie University and the University of Manitoba had women graduates in medicine. But there was a decline in the number of female doctors due to quotas on female enrolments, discrimination in admission criteria, lack of adequate financial support, the lack of positive reinforcement in careers, unpleasant and prejudicial attitudes in classes and restricted access to practical experience and teaching (Sheinin, 1990:20).

Tudiver and Hall state further that these negative attitudes left a mixed legacy of some important scientific discoveries combined with many ideological falsehoods applied to women's lives and bodies, which were claimed to be scientific truths. Within the hierarchies of hospitals, women took on a variety of care-giving roles as nurses, aides, laundry and kitchen staff, and cleaners, subservient to doctors and subject to hierarchies among their own ranks. "Many women worked as public health nurses in urban and rural areas, providing care and information about hygiene, birth control and disease prevention to new immigrants, especially mothers and children" (Tudiver and Hall, 2001:21).

Increasingly, over the past two decades in Canada, health care issues have been receiving more attention by both the general public and government sectors. Women are learning more about their health, and medical policies are changing to consider women's

needs. Policy makers in different government jurisdictions are considering the importance of incorporating women's health issues into overall health policies. Although more attention is being paid to the issues of women's health in general policy development only general lip service is paid to the issues of visible minority immigrant and Black women. For example, Black scholar, Glenda Simms acknowledge that, "immigrant and women of colour tend to experience barriers in receiving adequate health care due to lack of information in their language, discrimination against them, cultural insensitivity on the part of health care workers, and lack of services for those adjusting to a new culture" (Simms, 1996:8). However, there is a lack of recognition of how race, class and gender intersect as they relate to the health of Black women in Canada and more specifically Ottawa.

Women's Health Status in Canada

In assessing the health of Canadian women, there have been some notable improvements during the 20th century. At the same time, other problems have been identified, (such as the call for new approaches to health care delivery). Tudiver and Hall (2001) state that: Canadian women experience a wide range of pressures and stress, all of which carry health risks. Women must balance paid and unpaid work, obligations to family and friends, juggle limited resources and often have low self-esteem. Women are also the major victims of violence in Canada. Current statistics show that one half of all Canadian women over the age of 16 have experienced at least one incident of violence.

Canadian women have questioned some of the fundamental approaches to how health care services are delivered as well as many professionally accepted assumptions and definitions of "quality care." Women have identified differential in power and

authority between the roles of doctors (both male and female) and patients. Patients feel intimidated about questioning professional expertise or refusing treatment. They feel that sexist and paternalistic attitudes and behaviours may also influence the interactions between male doctors and female patients and may impact treatment, such as the unnecessary performance of hysterectomies. (Women and Health Service Delivery in Canada, 1996). "Women have identified severe time constraints on most medical encounters which limit communication between patient and caregiver" (Women and Health Service Delivery in Canada, 1996:6). Furthermore,

A trustworthy health report indicates that there is a lack of sufficient information and access to resources to make informed decisions about proposed treatment. Furthermore, there is fragmented care, so that a patient requiring coordinated care feels that she is no more than the sum of her body parts. The inappropriate use of technologies, drugs, and devices and the under-representation of women in senior positions as physicians, health administrators, or policy makers are serious health issues that need to be addressed in the Canadian health care system" (Women and Health Service Delivery in Canada 1996:6).

It is interesting to note that within this climate of more open discussions about women and health care, those women are generalized as one homogeneous group. Women from diverse social and cultural communities are not included in this process as the system creates added barriers to their accessing health care. Women from these communities have stressed the need to focus policy, programs, public education, and research on the social, economic and environmental determinants of health as they affect their well-being and that of their families. Therefore, it could be argued that when existing mainstream literature speak of women per se, immigrant, refugee, ethnic, racial minority, and Black women are excluded. Rorie and others found that:

Some immigrant and refugee women are unfamiliar with Western routines and encounter a system that does little to make them feel at ease. Clients may not feel comfortable talking about traditional health practices and beliefs, or about past experiences, such as torture and rape (Rorie et.al.1996: 10).

Similarly, Nyman (1991) found that, in many cases, health care providers make racist remarks and display undesirable attitudes toward clients who are different to their kind. This is supported by the data in my study where the women have identified the lack of understanding by health care professionals of the cultural backgrounds and the epidemiological risk factors of particular groups. Also identified, is the need for culturally appropriate health care services that is more holistic.

Women and Appropriate Health Care

Appropriate care involves a profound understanding of the social determinants of health and of the most appropriate ways to work with people, from a variety of cultures, in their circumstances, to improve their sense of self and well being. A woman with basic health information is unlikely to change her behaviour if the emotional barriers she faces are not addressed. For example, Erickson states that health professionals often wonder about the low levels of breast-feeding in some northern First Nations communities. As an Aboriginal practitioner in Northern Manitoba pointed out, many of her clients confided that they don't breast feed because they cannot bear to look at their babies without shame after years of being sexually and physically abused. Campaigns to promote breastfeeding will not succeed unless caregivers acknowledge the roots of such pain and allow appropriate opportunities for healing (Erickson, 1994). It is also important for health care professionals and policy makers to become aware of the impact

of current health care services on the lives of Black women; it is time for much more than lip services to be paid to these Canadian women.

According to Kushner appropriate care can be defined as “the right service, at the time, delivered by the right person, in the right place” (Kushner (1994). It is further stated by Lavis and Anderson that,

...Providers should be able to discuss options for treatment and care in ways that the client can understand in order to make informed choices. A client’s cultural practices and other related needs should be addressed. This ideal is time consuming and influenced by many factors. For example, reviewing the same research evidence leads to different definitions of inappropriate services among different experts in different countries. More often than not, health technologies are implemented either without having been evaluated at any phase of the process of technological diffusion, or before assessments are completed (Labvis and Anderson, 1996:).

Some technologies that have been evaluated and approved for specific purpose are utilized for reasons beyond the scope of the original assessment. An example, offered by Coutts is that, “technologies such as, ultrasound and fetal monitoring which have been applied routinely in North America have not been shown to improve outcomes for low risk births” (Coutts 1996: 15). Research have shown that women with blocked fallopian tubes may benefit from vitro fertilization, but many others are offered the procedure with no evidence of effectiveness (Proceed with Care: The Report on the Royal Commission on New Reproductive Technologies, 1993). This report shows further that mammography screening to be of benefit to women only over the age of fifty, but many health facilities in North America promote its use for all women over forty. Further, that manufacturers and practitioners benefit financially when they promote costly technologies for inappropriate uses. They often leave consumers confused about the risks and benefits of such technologies.

The women's critique about inappropriate treatments and insensitive approaches to care such as unnecessary hysterectomies for Black women, or ignoring symptoms of heart disease, must be considered as criteria for developing appropriate care. In addition, clinical qualitative studies should demonstrate whether particular groups perceive the technologies and treatments used as contributing to their overall health and well-being. Questions that need to be asked, in relation to Black women's health and the health care system include: Is care provided in a sensitive, and culturally appropriate way? Are complementary therapists and support networks also used, and how do these services contribute to health outcomes? For caregivers and clients, answers to these questions would offer information and sensitive guidelines to explore the risks and benefits of various options. At a policy level, the information gathered should help monitor new technologies and therapies and assess appropriate, cost effective approaches to care.

It is constantly pointed out that women are poorer than men. That may be so, however, I would argue that Black women are poorer than white women and that there is a link between poverty and poor health that is seldom taken seriously by health policy makers and providers. Ross and Shillington (1999) have noted that while lack of income cannot be proven to be the cause of ill health, there are certainly strong associations between the two. Adequate health is not only dependent on universal access to health care and social supports but on factors, such as nutrition and good housing, employment and isolation which are directly related to the low income of Black women. In general, women experience discrimination on the basis of their sex and gender. However, Black women experience discrimination based on their race, class, and gender. In a society where discrimination on the basis of race, class and gender still exists, Black women's

use of and role in the health care system must be considered from that perspective.

Provisions must be made in health care policies to counteract the negative consequences of living with discrimination based on race, class, gender, culture and historical background.

Women Centred Health Service Delivery

As a health care professional, I have observed that there is a move towards the utilization of herbs and more homeopathic and non-Western type of medicines by some physicians. Writers such as Immen, (1996); Demarco, (1995); Wooten, (1995) and others, indicate that many consumers and practitioners familiar with non-Western medicine in their country of origin, or who encounter limits to biomedical treatment, have turned to Complementary approaches, including Ayurvedic, Chinese and Aboriginal forms of healing. According to Statistics Canada, at least 3.3 million Canadians paid more than \$1 billion in 1995 for chiropractic, naturopathic, homeopathic services and Chinese therapies such as acupuncture (Immen, 1996). More women than men seek out such therapies. For example, many women with breast cancer use a variety of therapies to build their immune systems and counter the harsh effects of chemotherapy and radiation (Ontario Breast Cancer Support Group, 1994). Women use herbs and other complementary approaches for conditions such as Pre Menstrual Syndrome (PMS), endometriosis and symptoms of menopause (DeMarco 1995). Women with chronic illnesses and pain, such as chronic Fatigue Syndrome and fibromyalgia, often find that they benefit from approaches that emphasize the interrelationship of mind and body. I believe that, many women are able to reduce their dependency on painkillers through visualization, massage, therapeutic touch, acupuncture and herbs.

While some consumers welcome these developments, there are potential pitfalls. The sale of nutrition supplements, herbs and “natural therapies” are big business and subject to marketing practices and pricing of large parent companies. Guidelines and standards exist for quality products as well as safeguards against incompetent practitioners. Aboriginal or Chinese approaches to illness and healing are based on complex diagnostic theories and practices that evolved over several thousand years. Elements from these systems cannot and should not be appropriated merely for large financial profits into current Western models of care. Understanding other approaches to health presupposes rethinking one’s own scientific paradigm and the social and cultural contexts of how health and disease are understood. As part of this process, we need evidence-based research and evaluation, which include qualitative research on the effectiveness of complementary and biomedical approaches. This could provide governments with important data to assess appropriate cost-effective care. As health professionals we need to dialogue about a variety of scientific approaches, which are ideally, complementary with one another. (Women and Health Care Delivery, 2001)

Research can be used to critically evaluate and explore options for service delivery using the insights of front-line workers. Since the focus is to influence policy on women’s health, research can perhaps identify some of the political blocks to effective change (Women and Health Service Delivery in Canada 1996). While I agree with these suggestions I believe that Black women must be included in this process since women are not homogeneous and race must be considered as a determinant of health in order to provide adequate and appropriate health care for Afro-Caribbean women.

Profile of Immigrant and Refugee Women

The popular stereotype, reflected in the media and in many government programs, is that “immigrant and refugee women” comprise a homogeneous group with some superficial variations in language and dress. In fact, the immigrant and refugee women’s community in Canada is strikingly diverse. All immigrant and refugee women do not share the same history, nor do they live the Canadian reality in the same way. Race, class, culture and religion language intersect as significant factors to determine the specific quality of any immigrant woman’s life. “Immigration to Canada is a different experience for women who have come from Punjab, Poland, or Peru. Women who come as physicians may experience the process of settlement and adaptation differently than women who are hairdressers or farmers. Women who arrived to find a large and flourishing community of their compatriots may face a different reality than women from countries that have sent few people to Canada” (Estable, 1986: 5). It is also a serious mistake to underestimate the diversity of political beliefs and health practices among immigrant women. For example, despite similarities in race, religion and language, women from the same country may be located at opposite sides of the political spectrum and may understand health values very differently. These differences that arise in the country of origin can be carried over to the women’s new situation in Canada (Estable 1986:5).

Immigrant and Refugee Women’s Health Care

While there are some similarities between mainstream, immigrant, refugee, racial, ethnic minority and Black women there are some very complex differences that limit access to available health care services. Some of these are: difficulties in speaking

Canada's official languages; separation from family and social networks; traumatic experiences of refugee women prior to migration such as torture and stress related migration issues; lowering of socio-economic status after migration; and racial discrimination in society and within the health care system.

Immigrant, refugee, and ethnic minority women also face additional barriers in relation to health care issues that may impede their access to both "mainstream" and "alternative health care services and programs". These barriers include; denial that such problems exist, a lack of access to information and supportive counselling, systemic racism, lack of knowledge about their own rights and ability to use the system. Since providers lack of knowledge about the realities of immigrant women can also affect the quality of service that is provided. Therefore, knowing one's own personal biases, values and interests, which stem from one's culture, will greatly enhance a person's sensitivity towards other cultures. Service providers, awareness of their own culture is the first step to understanding the cultures of others which helps to limit sexism, racism, prejudices, stereotyping and so on.

Much of the available literature on women's health is, in reality, focused on white middle-class Canadian women (Hyde, 1996). However, difficulties such as balancing work and family are common among all women. When we consider women from diverse racial and ethnic backgrounds in Canada, it quickly becomes apparent that different and complex social forces may result in differences in gender roles and behaviours. Among these are higher rates of poverty, discrimination, differences in family structures and cultures. A second recurring theme in the literature is oppression and strength. Immigrant racial and ethnic minority women have a heritage of oppression and strength.

Most of these women have a heritage of oppression, including slavery, war torture and trauma from which they have survived and gained strength.

Immigrant and refugee women exist between a nexus of intersecting gender, race, ethnic, and class discriminations. They are often limited in their actions by linguistic and cultural barriers that serve to alienate them from the larger society and isolate them within the home. Existing predominantly at the lower end of the economic scale, immigrant populations have historically lived at the margins of Canadian settlement, on pioneer homesteads, and at its core, in urban communities often marked by overcrowding and poverty. Living in such environments has brought to the foreground matters of health and health care, particularly in meeting the needs of immigrant and refugee communities, to the forefront. Migration is an uprooting experience often undertaken by the most poor and impoverished populations. Migration is also a move with the hope for prosperity and a peaceful life. However, there is a recognized danger in creating a picture of a homogeneous immigrant and refugee population undergoing identical transition and settlement challenges (Women's Health Newsletter, 1999).

Immigrant/Refuge Women's Access to Health Care

According to a report produced by the Federal/Provincial/Territorial Working Group on Women's Health, (1999) immigrants who have most recently come to Canada tend to experience the most difficulties in receiving the quality health care enjoyed by other Canadians:

Immigrant, [refugee] and visible minority women are among the most disadvantaged segment of our population. They often face isolation, exploitation in the workforce, poverty, racial prejudice and ethnic discrimination, and impaired access to social services. All of which seriously compromises their mental health (Mental

Health Needs of Immigrant Women in Ottawa Carleton –OCISO, 1985).

The data for this study reveal that the predominant health problems suffered by immigrant and visible minority women are stress related illnesses and depression. One study *Immigrant and Refugee Women's Health*, (1999) indicated that immigrant and visible minority women face a series of structural barriers when accessing the health care system. Therefore, preventative steps must be taken to ensure that all immigrant, racial minority and refugee women have equal access to the type of quality health services available to most Canadians. Raising the awareness of community service providers about the structural barriers that prevent Black immigrant and visible minority women from accessing the health services and improving their knowledge of the various forms of traditional medicine may assist them in developing appropriate and effective models of service delivery.

Rochen Ford and *Working Together for Women's Health* (1990) inform us that over the past two decades in Canada, women's health issues have received more attention from both the general public and government sectors. This is motivating Policy makers, in different levels of government, to consider the importance of incorporating women's health needs into overall health policies (Rochen-Ford, 1990; *Working Together for Women's Health*, 1990). The health needs of all Canadian women are listed as being essentially the same. However, the current health system does not meet all the needs of immigrant, refugee and visible minority women. They also encounter additional stress because of the differences in cultural backgrounds and expectations of the system. For visible minority women, racial prejudice and discrimination create additional structural

barriers to their full integration into society and compound the level of stress they experience. The conditions under which many of these women work such as long and irregular hours, lack of security, isolation and poor pay, impact greatly on their general, physical, emotional and mental health (Ontario Immigrant and Visible Minority Women's Organization, 1993).

Immigrant and Refugee Women and Health Education

The Canadian Advisory Council on the Status of Women (1996) states that women are the guardians of health care for the family. Furthermore, the study states that 75% of the women surveyed felt that they shouldered full responsibility for their family's health care. It is the women, including immigrant, refugee and visible minority women, who set the standards for healthy living in the home. They are the ones who are responsible for supplying and maintaining the dietary needs of the family. They also fulfil the role of doctor and nurse when family members are ill. However, their role can be very distressing when they must access external health care due to the lack of official language facility, cultural and educational differences.

Within the immigrant, refugee and visible minority communities, it is recognized that knowledge is power, but they are very much dis-empowered because of their lack of knowledge of the health care system. The health knowledge acquired by these women from their mothers or elders in their communities may differ from what is accepted or practiced in Canadian society. These women, therefore, have to learn new ways of maintaining their health and the welfare of their families. The lack of information about the health care system along with all the other stressors associated with integrating into a new society can produce feelings of inferiority, frustration, and isolation. These stressful

life events contribute to the deterioration of the physical and mental health of immigrant, refugee and visible minority women. For some women, the terminologies used by the health professionals are unfamiliar and due to lack of information, language and cultural barriers, these women are more apt to make decisions that, in some ways may be detrimental to their own health and the well being of their families. I believe that health language education and political advocacy are key factors in ensuring the health and well-being of all immigrant, refugee, and visible minority women and their families in Ontario.

Furthermore, I argue that in order for immigrant, refugee, racial and ethnic minority women to become an integral part of Canadian society, we must be actively involved in the society itself. Therefore, we must become active participants in research, policy and program development, as well as implementation process around the issue of women's health. It is essential that we look at how we have been excluded from government programs. We need to challenge the reality of how we are expected to transfer our experiences into the concepts of the status quo. We are forced to assimilate and focus on the world from the standpoint of the margins as described by hooks (1984). As immigrant women, we need to recognize our experiences of marginalization and be able to use it as a 'stepping stone' to better health.

Due to the diversity of the Canadian society we must now develop a process for working together. We need to understand and utilize multicultural approaches in programs serving all women including immigrant women. I concur with Hooks (1993) when she asserts that ways in which a woman of colour and/or an immigrant woman continues to be devalued by the larger society affects her perception of herself, her

relationships, environment, and ability to maintain some semblance of order and balance in the midst of chaos as experienced by these women. The result is an overwhelming sense of powerlessness, which may generate an attitude of self-blame, mistrust, feelings of alienation and guilt; lack of control, economic vulnerability and, ultimately a sense of hopelessness (Hooks, 1993).

Black Women's Health a Tradition of Resistance

In attempting to address Black women's health in Canada from a Black feminist perspective, it is important for us to move beyond the confined sphere of white feminist discourse on the issue being studied. We need to look at the historical and ideological context of Black women's health, in order to set the record straight regarding Black women's adverse health experiences. Such a historical and ideological context will delineate the manner in which Black women in Canada have existed for centuries (1600s to 2000s) as eternal "outsiders" within (Savary, 1995).

By reflecting on Black women's health through a historical journey using a Black feminist approach means identifying fundamental players in this journey through time. These players include Black women, the white society, white feminists, and the white patriarchal state where policies and laws are constructed and implemented to ensure individualism. This makes for a poisonous mix that has historically destroyed Black women's health and continues to do so. Yet it was through our brutal experiences that many Black women, their families and communities found strength to endure and resist oppression (Savary, 1995; Moreau, 1996).

Devaluation of Black Women

Earlier in the study, I explained that slavery was a fundamental reality of Black people's history in the Western Hemisphere of which Canada is a part. However, it is worth repeating that the institution of slavery was more destructive physically and emotionally to Black women than men, by virtue of their gender. Stolen from Africa by white slave traders and sold as chattel slaves to white slave masters in the 'New world', Black women found themselves in a hostile, patriarchal, socio-economic slave society, which stripped them of their humanity, their femininity, status, families, community, and health thus rendering them beasts of burden in many instances. White European colonizers sexually raped and physically violated Black women's bodies to ensure economic gains, the destruction of the "prideful arrogant, and independent spirit of African people. Such methods forced Black Africans... including women to conform to the white colonizers notion of proper slave demeanour... for the slave market" (Hooks, 1987:19).

Although some historians have denied that slavery ever existed in Canada, Winks 1977; 1961; Walker 1980; Pachai 1987; Hamilton 1982; Taylor 1992 and others have informed us that without a shadow of doubt, Canada was a slave society. Officially, slavery began in 1628 in Montreal. In spite of this evidence, Black people have been largely excluded from Canadian history. For example, Winks states that,

Slaves were sold... often side by side with livestock, since no public market was set apart expressly for this sale... most slaves were purchased before they were twenty years old and remained

with one family to be willed to the next generation... (Winks, 1961:15).

The women identified historical connections of slavery to their current experiences this is supported by Taylor (1992) when he writes that:

Black history in Canada begins with slavery and one of the earliest records of this in Canada shows a slave servant of the French exploration team arriving in 1604. The slave presence in Canada was not large but it was there although it is not easy to find in our history books. It helped alleviate the shortage of labour in New France and in the 18th century many families coming to Nova Scotia and New Brunswick from the USA brought their slave with them... (Taylor, 1992:7).

This evidence reveals that, throughout slavery, Black women's health was of little concern. After slavery, Blacks experienced a horrible transition into the dominant society referred to as, segregation. They were free from physical slavery, but enslaved in every other way. During the period of segregation (1833-1953), they were denied formal education, economic opportunities and civil rights. As a result, Black women's health was of no consequence. When urbanization began in Canada and the United States, little changed for Black women, they remained alienated from Canadian society and its health system.

As a Black Canadian woman, I have chosen to explore the structural factors of Black women's health experiences, because it holds for me particular significance. Black women's experiences in Canada historically and today have been abstracted from the cultural and institutional process. Because there is a dire need to inform the Canadian society about the Black women who were here from the inception of this nation together with the fact that historical research on Black women's health is non-existent we need to

correct this through research. In one of the few books documenting historical experiences of a few Black women in Canada, the author Dionne Brand (1991), states that although Black women arrived on Canadian soil as slaves or forced immigrants since the 1600s, it is in the United States that an abundance of Black feminist writings in relation to industrial capitalist societies like Canada's have emerged. Black feminists like Davis (1984); Hooks (1989); Carby (1981); Patricia Hill-Collins (1990) among others, have written about experiences of Black women in the United States and challenged the various models of the white middle-class feminist status quo. This status quo involves various models of white feminists critique that includes all of the gender analysis on women's oppression in the welfare state. However, they focus on biology, class and the patriarchy and fail to take a historical look at Black women's experiences with racism as fundamental issues of feminist analysis. The historical role of the adverse impact of racism on Black women's health in industrial capitalist societies like Canada's is thus curiously abstracted from white feminist discourse on women's oppression. While this study is not meant to imply that all Black women's health concerns in Canada are homogenous, the historical realities of all Black women are rooted in slavery and Black-white racist relations of power.

Descriptive female slave narratives, Black women's fiction, and current discussions on the subject are used to make the links between their subjective experiences and the objective assessments of the correlative influences on the Black woman's perception of her choice, definition of her social relations, and her self image within the master-slave relationship. Moreover, every attempt is made to trace the presence of Black women's devaluation in her family relations. Jane Ollenburger (1993) suggests

that Black women's devaluation under the system of slavery further contributed to her devalued status. Black women's fertility was used as a means of controlling their lives, as well as the behaviours of enslaved men. Ollenburger (1993) cites the development of the Black women's devalued self in terms of their roles as producers and reproducers. Black women were forced through rape to reproduce for profit, and the perpetuation of slavery as an institution. Cruelty was used as a method of breaking the Black woman's will. It reinforced her feelings of 'learned helplessness,' powerlessness within the slave community, as she was unable to control the most intimate aspects of her life.

The devaluation of the slave woman was reinforced daily in the cruelty used to break her spirit which inadvertently threatened her health. In order to enable someone to devalue herself, a dominant ideological mechanism must make her believe that she is helpless to control even the most intimate aspects of her life. (Walker, 1999: 91-92).

Black Afro-Caribbean Women in Post Slavery

Although slavery officially ended in 1833-1834 in Canada, and the Caribbean most Black women continued to work in lifelong subservient positions due to systemic racism which excluded them from formal education, meaningful employment, and other civil opportunities. Black women were compelled to work as domestics, service labourers or as underpaid menial workers. Consequently, they remained poor, economically exploited and denied training for better paying jobs. Generally (Black people), Black women in particular, had no choice but to accept menial jobs, even if they were educated (Walker, 1980). According to Walker, throughout Canadian history whites have used Blacks, including women domestics, as a cheap source of labour while denying them access to institutional services of education, housing, health care and

justice. All combined to adversely affect the health of Black women and their families (Walker, 1980).

Black Afro-Caribbean women have grown up in environments filled with anger, silence, rejection, alienation, and the knowledge that when we survive, it is in spite of a world that takes for granted our humanness, and which hates our very existence outside its borders. For centuries, we have learned to struggle, cope, survive and resist despite the brutality of slavery, oppression, discrimination, racism and stereotypic behaviours of our white slave masters. In addition to being mother and wife, the post slave woman was a worker. She worked in the rice, sugar, cotton and tobacco fields from early morning to late evenings. After working in the fields all day, the Black woman returned to her cabin to cook the evening meal. She had to wash sew and clean up before retiring for the evening. In addition to this heavy burden, she had to withstand the sexual abuses of the white master, employer his sons and overseer. During slavery Black women were forced to bear many children, in rapid succession, which resulted in a high maternal death rate because of the poor health care women received. (Rogers-Rose, 1986).

Early modern historians, who adopted a Euro- centric view of slavery, presented slaves as passive, ingrates who lied, stole, and were “suspicious, inefficient, irresponsible, lazy, superstitious, and loose in ... sexual relations” (Bush, 1990:4). Approaches such as this reflect the inherent racist bias of these writers, who adopted, without question, the perceptions of the planter class regarding the slave population. Examination of historical documents by Caribbean historians have resulted in the identification of contradictions between slaves’ presentations of themselves to their masters and overseers, and their work habits in their own environments (Bush, 1990;

Bailey, 1995 Shepherd, and others,). These indicate that the behaviours were therefore more likely, strategies consciously adopted to enable slaves to survive and resist the violation perpetuated against them (Bush, 1990:4). For example slaves, who were considered lazy, and stupid, were to their communities, valued, astute leaders and producers of food and other needed materials (Bush, 1990).

Open resistance was not the only response made by slave women to an untenable situation designed to erode their integrity as persons. For one thing, open resistance was not always possible. A major survival strategy used by slave women was their spirituality.

Spirituality: A Health Tradition

For most Black women spirituality refers to an individual's way of thinking, believing, acting and living with a deep sense of the presence of divine spirit. During slavery, Black people used spirituality as a way of sustaining themselves when their native religion was forbidden. They adopted, the religion of their captors (slave masters) in some instances, the African gods were blended with Christian faith and saints in order to preserve some aspects of their own faith. Similar combinations of African and European faiths were observed (such as pocomaina from Jamaica and spiritual and religious rites found in the other Caribbean islands such as obeah) which is also a belief in the power of good and bad spirits. These religious rites and practices gave the slaves and ex -slave a sense of their own power to seek deliverance, survival, or vengeance against their oppressors (Bush, 1990).

Similarly, people of African descent in Canada may be found in all denominations (Christianity, Islam, Rastafarianism, Voodoo). Strong spiritual beliefs served as an

integral part of life in Africa and during slavery and after in the new world. Spiritual, and religious services conducted by slaves during slavery were of great importance in helping slaves to deal with their oppression. Spirituality was also used as a signal of the time and place for slaves to meet before an escape from the plantation. These spiritual activities contained hidden messages, and a language of resistance. Messages such as “wade in the water” “steal away” or “know body knows the trouble I’ve seen” are part of the resistance language expressed in songs known as Negro spirituals. (Bush, 1990). The promise of God’s gift of salvation provided Black slaves with outlets for expressing their feelings for dealing with the pain, humiliation, and anger when they were treated worse than animals. The history of Blacks in North America and the Caribbean has revealed that religion and spirituality have played a significant role in the survival of Black people in the diaspora. First, it gave the slaves and their descendants the courage and strength to continue their laborious toils under barbaric conditions and helped to keep them together. Following slavery the Black church, which emerged from the religion of the slaves, was for a long time the most effective institution in re-establishing the Black communities. The church provided and continues to provide the communities with a sense of identity, and the courage to face the world with pride and confidence and, most of all it, served to develop agencies for Blacks. This legacy continues in modern day Canada as an important aspect of Black women’s historical lives (Bush, 1990; Field Notes, 2001).

As a consequence, Black women’s historical background of slavery and their reliance on spirituality for survival, and in some cases life itself, are of great significance to the preservation of Black women’s health practices. Health care providers and professionals working with Black women and their families must be sensitive to the role

that spirituality plays in many of our lives as our belief systems and experiences contain important meanings about our past. It is my contention that our spirituality may be able to provide different intervention strategies to meet our health care needs.

Africans' traditional ways of practicing their spirituality was forbidden by law at the beginning of slavery. Needless to say Christianity was also forbidden. When it was perceived that Christianity would aid in indoctrination and increase wealth and profit, slaves were encouraged to pursue a more Judeo-Christian religion. They were taught by an oppressive structure that their masters "were brothers in Christ" (Genovese, 1976). Genovese contends that a twisted interpretation of the Bible by white slave masters encouraged their slaves to accept without question their master's decisions. Judgement was reserved as the sole responsibility of "God and the white man". This kind of spirituality dictated that the slaves be submissive and obedient in their subjugation (Genovese, 1976). I believe that these issues of submissiveness present in Black women and their current internalization of these feelings have their origins in the oppressive slave experience and have impacted on their health experiences today as well as their relationships with their families.

Although, slaves were forbidden to practice their own spirituality, ceremonies and rituals, their indoctrination within Christianity was also their source of resistance. They were able to sing hymns to get through the monotonous tasks and the brutality of slave life on a daily basis. It was their devotion to these beliefs, and convictions in a Superior Being that gave them hope to endure the conditions they were forced to bear. The church, which held and still holds a predominant place in Black people's lives, offered a deep abiding faith in a "greater good" and a "higher power" that gave slave and ex slaves

their spiritual, emotional, mental, and physical strength. The Black church for some of these women was also the only place where their identity wasn't obscured by racist and sexist imagery (White, 1994).

Family

Another site of resistance in the context of slavery and post slavery was the survival of the extended family. Issues of importance such as single mothers, and out-of-wedlock children were not stigmatized in the slave and Black communities. For the slave owners, these social phenomena were welcomed because it was seen as increasing their wealth. For slave communities, the continued tradition of African extended-family system, even with "fictive" or chosen kin, became a matter of survival for the Black race and culture. Relations, friendships, 'psuedo-familial' bonds were created despite the separation of families by the dominant class. These extended family relations provided a community regardless of country or cultural origin (Amott, 1996). The unavailability of Canadian or Caribbean literature on the conditions of Black women after the Emancipation (1834) prompted the utilization of American materials. "I can only infer that the issues and conditions, although different, were similar in ways that the oppressive construction of race, class, and gender relations was perpetuated against Black women (Walker, 1999: 70). Family relations, spirituality, and faith are some of the themes that have been identified by the women in the study that show the linkages between their history and their present health situation are discussed further in chapters five and six.

CHAPTER FIVE

BARRIERS TO BLACK WOMEN'S HEALTH

Introduction

This chapter discusses the significant themes that emerged from the data, gathered from the eleven Black women about their health experiences in Ottawa that they have identified as barriers to healthy lives and their accessing positive health care in Ottawa. According to the women, these barriers affect them systemically at the individual, institutional, structural and societal levels. I have found that for the women, access is not simply their ability or inability to participate in the health care system, but includes some of their most intimate health issues (micro) that prevent them from enjoying 'good' health holistically. For example, the women talked about, "living under enormous stress; expensive medication; multiple responsibilities; poor mental health from under-employment; chronic fatigue; worry about poverty; fear of the impersonal way that they are treated by doctors and health care providers; objectification of their bodies; paternalism; lack of acceptance by society; the absence of professionals who are of African and Caribbean descent, and so forth" (Group Interview, 2001).

Also, several participants in the study felt that there was a lack of recognition and knowledge by health care professionals of their historical, cultural, racial experience. The women in the focus group expressed it this way: "We don't trust the medical system," "our voices are not being heard" "why would we assume that we would trust the medical system if other institutions are not trustworthy" "we cannot trust a system

that deals with the symptoms of our health problems and not the problems that affect the whole person” (Group Interviews, 2001). Needless to say, the data also reveals a number of other interrelated issues that influence the women’s access to holistic health care.

However, in this chapter I have discussed the women’s perception of the major barriers to their health. These include: fear of medical professionals; living and coping with stress; the interrelatedness of gender, class and race, class when accessing health services; systemic racism in all its manifestations; and coping with health care practices in Ottawa. It is worthy of note, that the women also discussed briefly about some of the diseases that are prevalent specifically among Black women (especially sickle cell anemia). However, the issue of Black women’s diseases was not dealt with since none of the women in the study shared their experience with any such disease. The participants spent more time discussing societal barriers that they face in their search for healthy existence.

Fear of Medical Professionals

In the Caribbean and some Black African countries we are taught to respect those in authority and especially those who are our elders. However, because of our history of slavery and colonialism, in many cases, this respect for authority or those in power over us can be translated into fear. For example, children are taught to fear the police representatives of colonialism; as a result, the natural tendency for them when they encounter such an authority figure is to run away. Also, in most European colonized countries those in authority were/are whites and they ruled with fear. Similarly, the few natives who were chosen by the whites to rule are/were placed in positions of authority by the colonizers were given the power to severely punish the natives who transgress

against the commands of those in authority. Although things have changed politically and culturally and more of our own people are professionals in our countries of origins, the tendency is still to fear white professionals and those they put in power under them in any capacity when racism is evident.

In light of this, it is not difficult to understand the plight of Black immigrant women who have to deal with a health system that is completely controlled by the dominant sector of the society who are of the colonizers' cultural background. One woman expressed her fear this way, "for me health care in general is very frightening the experience of being there is not always pleasant" (Interview March 2001). Then she continued rather sadly:

...When I go to the doctor I'm terrified of what I'm going to experience. If I don't go to my own doctor I'm terrified of what will happen there. The way I'm treated, the way I'm not believed, the way I'm touched in a different way, it's as if I am an object with a number, it is very patronizing. It's that feeling of "nothingness." I am made to feel as if I am nothing, so those kinds of experiences makes me fearful of going for example for a pap smear, I mean why would I want to put myself through that additional stress. It is always an added stress to be able to go and see my doctor for a medical check-up, it's that fear of the paternalistic attitude, and of being treated like my body is not worth touching it's a scary ordeal. There exist that objectification of this is a thing not a real person...(Interview March, 2001).

The women's stories of fear, stress and frustration indicate the suppression of our feelings because they are painful, unpleasant, and frightening, or because we have been taught to hold them in by a culture that imposes passivity on the Black female psyche. As a result, we experience mental distortions that interfere with our thinking, feeling, and ability to take effective actions in caring for our health. For example, hopelessness, and powerlessness are feelings reinforced by the socio-economic power structures that have pervaded Black women's lives imposing on them poverty or great financial deprivation.

One of the most prevalent feelings expressed by all the women was that, health care professionals need to be taught cross-cultural communication skills as well as cultural sensitivity training. These should be developed with input from the Black community.

One of the women expressed it this way:

Health care providers need regular in-service and educational programs promoting culturally competent and sensitive approaches to health care. Nurses and educators must develop culturally sensitive approaches in doctors' clinics that include both doctors and their receptionists. I think it really comes back to the training that health professionals and doctors receive because I'm sorry, but we have a diverse population in Canada yet we are still not getting exposure to what that means. Doctors are not going to become aware through training processes. There has to be more effective dialogue between the Black community and the health community because I don't see it being pursued. There needs to be more dialogue and integration of official training for health care professionals (Interview March, 2001).

It is clear from the women in the study that for them to improve their health condition serious structural changes must take place in the health care system as it relates to Black women. In addition to the above, the participants expressed fear of accessing service when they claim that:

This fear prevents us from seeking help. Some of us experience intimidation at a level of discomfort when having to discuss sensitive issues with the doctor. Many of us do not understand what was said during our visit to the doctor, due to lack of time the doctor could spend with us, or the medical terminology that was used to make diagnosis. A lot of Black women don't speak English so there is a language barrier, but there is also a language barrier understanding what the doctor says (Group Interview March, 2001).

One woman gave a striking example of the fear we Black women face when accessing the health system. She explained that she is a Black professional worker assisting a Black woman whose first language is not English, and because of the woman's fear

needed assistance to have an informed appointment with her doctor. The worker explained to her client:

What we are going to do is to write the questions that you have down. Then give them to him (the doctor) and I would appreciate it if he writes his response down, that way I can translate for the client. What we are trying to do in every possible way is to understand the concerns of the client and what are the responses of the doctor. The other thing I find very difficult is that the health terminologies are not in our language and even if you know English not everyone went to medical school, so the doctors assume that you understand what they are talking about and most of these clients are too shy to say, excuse me I don't understand what you mean, as they are not perceptive enough even though they are assumed to be assertive. Because they respect authority, a doctor is very important in our Culture and we don't want to seem stupid and the doctors don't have the time all they have is fifteen to twenty minutes (Group Interview, 2001).

Based on this woman's story, in order to get adequate service from the doctor the women need to be able to organize their thoughts and write them down. This could be very difficult, as the women do not always know what questions they would like to ask the doctor in advance. Even if they do know, by the time they get to the doctor's office, if their English is not adequate, the questions become very difficult to write down. They might feel that they are taking too much of the doctor's time as he appears to be so busy and they just want to get out of his office because the whole environment is so uncomfortable. One of the women indicated that: "Most services are designed and delivered as if everyone speaks English fluently, is of same western European cultural values, education, orientation, middle-class, and socio-economic status, and knows where to find what is needed and is able to access the health services they need" (Interview March, 2001).

Most of the women agree that, as a result of this lack of sensitivity Black women no longer desire to go to see their doctors because there is a lack of trust. According to

one woman, “one of the biggest problem I find is when women arrive at medical reception in doctor’s offices the receptionists are very disrespectful to the clients they are also quite racist. Another professional in the group who worked with a Black client gave one example of this. She reported:

The client said to me they are so racist at this place. Always I’m the last one to be served so I said to her let’s find out today. We will ask how many people are ahead of us and then we will see how soon we are called. We asked and was told that there were only two people before us we sat and waited and there were five people before us I wanted to believe the client so I went with her so when we were finished seeing the doctor I asked him about it and he promised he would do something about it. I think the people who are hired in these doctors’ offices are racist, and they are stressed and they are not getting much attention paid to them or their work is not valued and they are under a lot of pressure so they take it out on the clients (Interview April, 2001).

It would appear that even before these women get to their doctor’s office they are so fearful that they become even more ill, so they decide not to put up with the fear of the racist attitudes of receptionists so they go home and take care of themselves with alternative medical care. Finally, another participant of the study concluded by saying “one of the most compelling reasons I believe that women are fearful of going to see their doctors is that there is no one there who they can relate their experiences. There are insufficient Black doctors to meet the health needs of Black Afro-Caribbean and African women. We need to see doctors who look like us; there is a need for doctors who are a reflection of us (Black doctors). Black doctors have a familiarity who we can relate to” (Interview March, 2001).

Women Living Under Stress

Stress was identified as one of the most common health problems among the Black women in the study. It is ironic that while the women agree that there is a very

good medical system in Canada, at the same time they found that in most cases in Ottawa it meets the needs of certain people, those being mainstream and English speakers.

One of the women emphasized that:

...This medical system that is so good has not tuned in, nor has it followed suite in dealing with stress. What the doctors recommend is rest, or medication, and when they do clue in on stress they will ask the kind of work I do and when I tell them they will say, I guess its stress take it easy... It's very difficult to take it easy when you are a single mother who does a manual labour type of a job. Where if you don't work you don't get paid, or if you are a student who is living on a tight budget, so it's not realistic to ask me to take it easy. Although the doctors can recognize that I am stressed physically they don't have alternative ways of treating this stress except with medication that cost money. And if I am living on a low-income budget I cannot afford to fill that prescription. This is why, as Black women, we turn to alternative forms of medicine. However, as an unemployed Black woman I cannot afford to pay for the cost of holistic care so what I am saying is that I am also very sick. How ironic! There are two systems alternative or holistic care and the institutional medical care system and I need to be able to balance the two to put some balance into my life... (Interview March 2001).

Dr. Glenda Simms, a member of The National Forum on Health, identifies the following issues as being of concern to immigrant, racial minority, who are also Black women in Canada. According to Dr. Simms, Black women's isolation from mainstream society caused by differing cultural values, belief systems and practices, create serious barriers for them in understanding, gaining access to, and integrating with, the health care system. In addition to these external pressures, she discusses internal problems that create stress that cause Black women some concern for their mental health. She further states that Black women's mental health are compromised due to the stigmatization of their immigrant and socio-economic status, racism and general marginalization. This situation says Dr. Simms leads to alienation, frustration, isolation, and ultimately to stress, crisis, which result in poor mental health (Simms, 1996). "As a result, it is not

easy to see the full picture and the multiple factors of marginalization that result in stress-related illnesses such as arthritis, rheumatic conditions, immune deficiency illnesses, chronic fatigue syndrome, and serious mental health problems, such as anxiety and depression” (Canadian Advisory Council on the Status of Women, 1995:12). According to the women in the study:

These are some of the issues that must be addressed in prevention, intervention and treatment services that must be designed and operated for and by Black women if they are to be culturally sensitive. In developing a comprehensive model of care for Black women the first step is self-awareness and cultural sensitivity. As well as a diversity of staff to show that people on staff are like the people who are coming in for service. We all know that race, like language, is a barrier for some women, and health service providers need to be aware of their own cultural biases and racist assumptions about Black women’s health (Group Interview 2001).

A 1995 report from a National Symposium on women’s health, convened by the Canadian Advisory Council on the Status of Women (CACSW), looked at some of the health issues facing racial and visible minority women in Canada. The report argues that the combined impacts of sexism, racism homophobia, and other forms of systemic discrimination have serious health consequences for large groups of women. In addition, it states that most statistics are not aggregated by variables such as race or sexual orientation (CACSW, 1995). This is not surprising since Black women have emerged from a history of oppression (such as. slavery) and systemic racism that has continued into the twenty first century. As a result of living in this white dominated society the struggle for Black, and other immigrant women, includes having to cope with sexism, racism, poverty, and single parenthood. Consequently, it may be difficult for Black women to deal with health-related issues when they are interrelated with gender, class

and race issues. I have found also, that the health of Black women, are conditioned by their status as workers, as members of a visible minority group, and as women.

Gender, Class Race and Black Women's Health

The data reveal that current health care service providers do not recognize or consider the importance and differences in the lives and experiences of Black in contrast to white women and what this means for their health care. For example, the women have found that there are tremendous differences between the ways Black and white women deal with their bodies. One woman summarized it this way:

Black women and white women think differently. How we define who we are is different. We have a stronger sense of self, but we get sicker because we put up with more issues on a daily basis I think that when it comes to Black women and their health I don't know what it is if it's an African Cultural thing, or it's a West Indian culture thing, but we don't tend to talk about our bodies in the open. We don't like to talk about our feelings out in the open or in public at all we hardly talk about it within our families none the less to a stranger. I don't see too many Black women cancer survivors getting together and talking about living with cancer; but I see a lot of my white friends sitting around talking about living with cancer but Black women won't necessarily do that (Interview March 2001).

This seclusion of our bodies is linked to that of our African slave foremothers. During slavery their bodies were so violently violated by their slave masters, physically, sexually mentally, and emotionally, that they developed a cultural practice of not exposing their nakedness, illness or discomforts to others even other members of their own families. This has been passed down from one generation to another among Black women of the diaspora. Mainstream health professionals cannot understand this historical connection that affects Black women's health today. The women, of the study who are also knowledgeable about their history state that:

There were definite links and connections between Black women's health experiences historically and today some of these links are the lack of trust

of health professionals that has been a common thread throughout the study. In some cases the ideology of Black inferiority versus white superiority influences our health care. Although as Black women we may not feel inferior to the white doctor this is what society says; he is superior therefore, although we may not feel inferior and he may not feel superior to us we are in an environment that produces that kind of view, and because of that there exists a superior kind of situation that evolved from slavery. Mistrust is also a product of slavery. Another issue is that as Black women and coming from the slavery mentality we are viewed as being strong like horses. The prevalent feeling by these professionals is that there is nothing wrong with us. This too comes from slavery. As a result of that, Black women have a tendency not to tell people when they are suffering because it could get to the “mass” (slave-master) and he might separate us from our families so it has become a kind of tradition for Black women to suffer in silence (Group Interview March, 2001).

This lack of trust that these Black women spoke about in the study can also be interpreted as social class. Social class, in reality, is a subtle way of saying that because of the social bracket that health care professionals are assigned by society, they have the authority over their clients. Especially when the latter are Black, it creates lack of trust between Black women and those given power over their bodies. As indicated earlier, in some cases mistrust is experienced even in the family when it relates to the exposure of the Black woman’s body. In support of the discussion of this issue one of the women said, “... even as a child I would never tell my mother that I had a prickle in my foot because I knew what she will do, so I didn’t tell her until she noticed. The Black woman seldom runs to a person in authority saying “I’m a sick.” Black women carry on until they can’t carry on any more. This is an attitude inherited from slavery. Furthermore, “most Black women look to God to heal all their diseases. They externalize their faith in that way; for some of them it works, for others if doesn’t that again comes from slavery” (Interview March, 2001).

In my experience, as one of the few health care professionals of my race, I have found that Black women will try all of the other available health remedies first, for example traditional medicines, and if nothing works then they would go to the doctor. But the underlying factor is the fear of exposing ourselves to the doctor, as we don't want him/her knowing everything about us. This is one of the practices that we are not comfortable with because as slaves our foremothers were always examined, they had no privacy or choice over their bodies, because they were like animals being bought and sold. Slavery has taught us to hide our bodies from the master class, those being white. Even though we are no longer actual slaves we feel enslaved by doctors when they have to impersonal examine our bodies. One of the women stated that:

...It is only recently as recent as the sixties after the civil rights movement that things began to change for Black women so even after slavery which was about four hundred years our culture is built and transmitted and sent down from generation to generation and because of that we can't just change overnight it will take time...(Interview, March 2001).

This historical legacy of slavery, later replaced by racism, has affected Black women's ability to access the Canadian mainstream health care system. Appropriate and culturally sensitive health care services are needed to correct this serious health situation for Black women. Doctors and/or health care professionals need to take the time to understand the cultural history of the different oppressed groups in our diverse society. For example, telling a white woman to go and undress does not cause the same fear as it does for a Black woman. The latter doesn't even undressing in front of her children, or even her husband therefore cultural sensitivity is essential for Black women if they are to access health care services.

Black women from the Caribbean and Africa are also accustomed to having a female nurse in the room at all times when they go to see the doctor. She gives them a sense of security, but here in Canada Black women must face the white doctor. That does not work well for Black women. Also, in most of the Caribbean and some of the African countries, health care is usually provided by women (nurses and midwives). We also have more Black doctors and health care providers in our countries of origin so when we have to visit a male doctor he/she and the nurse are Black and have the same culture so they understand. Also, the women in the study are not used to taking pills and or prescribed medication. We rely heavily on holistic and alternative care where most medicine are from herbs and are in liquid form. Reader's Digest researchers capture it well when they found that "... Many African descendents keep alive a holistic perception of health that stems from age-old concepts of being and spirituality found in their ancestral homelands... An African-based holistic view holds that one stays well by avoiding extremes of temperature, eating properly, keeping clean (both inside and out), and exercising. Proper behaviour is also essential to health." (Reader's Digest North American Folk Healing, 1998:175).

Black Women and Systemic Racism

It is the view of the women in the study that systemic racism, in its various manifestations, is a barrier to their accessing appropriate health care in Ottawa. As I have indicated earlier participants from the study agreed that there is a lack of trust and confidence in health care professionals and the medical system. Furthermore, there is a lack of acceptance for holistic medicine, and a lack of training for health care professionals when providing sensitive and appropriate health care to Black women. Of

major concern to the women was the way that these missing elements were expressed racially when they sought to meet their health care needs. Different women in the focus group expressed their opinions about the issue, but two of them stated that:

Racism is about exclusion, issues such as cultural sensitivity, language, history and so on, are not integrated into the wider society and this adds to the issue of 'unwell ness.' Inclusion is a double-edged sword and North American culture sees differences as being abnormal...In the medical system there are too many white people and no Blacks to understand who we are, racism has a lot to do with it, also sexism that has an impact on "me" as a Black woman. What we are measured against is whiteness that says that white is normal. It says psychologically we will never measure up. We suffer in silence and we are silenced, therefore, we have to change the language and stop going to someone else for the answers to our health problems. Instead we need to go within ourselves for the answers. As this causes a sense of powerlessness a feeling that we have no control and that leads to depression and crisis in our lives (Group, Interview 2001).

Elliott and Fleras state in their discussion of racism that at the institutional or societal level racism can be regarded as impersonal, unconscious, unintentional, and covert. Systemic racism is the name given to this subtle, yet a powerful form of discrimination that is entrenched within the institutional framework of society. With systemic racism, it is not the intent that counts, but rather the consequence. Policies, rules and priorities might not be inherently racist or discriminatory in intent. However, they have discriminatory effect in that they exclude certain groups from access to equality in all areas of our lives (Elliott and Fleras, 1992:64).

The prevalent feeling among the women was that there is no recognized standard for holistic medicine, or level of acceptance. Further, one woman claims that "until it is accepted and practiced universally people will still be hesitant to accept it" (Interview March, 2001). As I have stated earlier in the study, Black women view health from a holistic perspective. "However, because holistic medicine is not accepted as a part of the

Canadian medical system Black women cannot access this service.” Another issue discussed by the women that impacts on their access to services was the fact that, “there was a lack of recognition for the health care training and experiences of Black women from countries other than Canada” (Group Interview March, 2001).

As one of the interviewees observed, “it is ironic that in the year 2001, with all of the technological advances the human race has made, basic humanitarian needs, tolerance of one another are still light years away. Although both federal and provincial governments, theoretically have implemented various forms of legislation to stem systemic racism, discrimination by race, continues to be a major factor in accessing all institutions and systems, our health system is no exception” (Interview March 2001). Most of the women agreed that, “there is a lack of respect, understanding and acceptance of the different cultures, values and experiences of Black women, and that there is discrimination that is based upon socio-economic status” (Group Interview 2001).

Black women face what is often referred to as a “double whammy”. These women experience discrimination on the basis of their gender, race, ethnicity, language, culture, and age. These social and biological factors influence all systems within society that the women must access for survival. These factors are used to discriminate in places of employment, access to professions, education and the Canadian health care system. Although there are large numbers of Black women employed in the health care system, the majority are menial workers and are not in influential positions to make change. This, sometimes blatant, but more often subtle discrimination experienced by Black women, affect how they view themselves and their environments. It is my experience that racism has even more adverse effects on Black women’s health and self-esteem than most other

factors. Through its racist social structures and health care employees, the health care system discriminates against Black women and is generally insensitive to their needs.

Participants in the study have all agreed that the existing health care systems with the legislated policies, administrative negative attitudes and subtle program barriers to health care services for Black women. This is evident in the refusal of those in authority to recognize and deal with the racial and cultural discrimination which impacts on Black women individually and as a distinct group. The lack of representation of diverse groups within health care systems, especially in positions that are responsible and accountable for the decision making process and the definition of service delivery; the lack of recognition of and/or capacity to address language needs and inequality of funding of health programs/research between communities are manifestations of the inequality in the health care system

The Lack of Information

Another very important health barrier discussed by the women was the lack of information and education on the part of Black women. "There is a definite need for us Black women to take more initiative in finding out about the health care services that are available to us." "We must become more involved in our respective communities and voice our concerns. As Black women we must become more self-empowered in order to gain some control and accept accountability for our own health needs". The need for self-empowerment perpetuates the cycle of vulnerability and feelings of powerlessness over one's self. These feelings lead to stress which leads to depression that manifests themselves into serious illnesses" (Group Interviews 2001). One of the women expressed her view this way:

I think it's about us taking responsibility for taking our education to that level as well. Because I've certainly worked enough in many of these health organizations to know that we end up being a paragraph and as you have said we are lumped in with other immigrant women from all across the spectrum and I think that we have to take responsibility for that and no body else can do it but we ourselves. We also have to take responsibility for our health. Our stories will have to be told it's not just economic. The training process has to be more effective between the Black communities and the health care community. We have to think realistically, we have to take steps to take care of ourselves, and we have to take time out to listen to ourselves and to our bodies (Group Interview, 2001).

The idea of self-empowerment is new to most of us since we are from cultures where sisterhood is significant. Where solidarity goes hand in hand with our spirituality and with our self-esteem, our education and our culture. We are a holistic people and we think not in individualistic ways but as a group, a family as a community. Now we must learn to get together and to work together to educate ourselves and assist one another in positive ways if we are going to remain healthy in an unhealthy society.

Health Practices and Coping

When I asked the women how they cope with their pain, sicknesses, crisis, and helplessness as Black women their response was instantaneous:

We get sick and we die, unless we are prepared to talk to each other about it; and unless of course we are able to find a doctor who has made a concrete effort to get to know Black women's health issues, to do their research. It is all well and good to have a female doctor, but you also have to make sure that you know what type of female health provider we are dealing with and the issues that compound our whole reality, not just the fact that we are female biologically, but the fact that we are Black female and we have a lot of issues to deal with on a daily basis that other females don't have to deal with. So if the doctor/practitioner can tap into those resources and find out what are the issues that are particular to Black women then we can sort of start to trust them and we will be able to talk to them and they will be better able to understand us, about who we are and where we are emotionally, spiritually and physically. That will help us to be more healthy (Group Interview, 2001).

Black women's spirituality is one of the major ways through which they are able to cope with our health issues. Through our spirituality we are able to bond with each other in a community of sisterhood and solidarity. Hooks states that, "through our history in this country, Black women have relied on spirituality to sustain us, to renew our hope, to strengthen our faith" in life, in one another and in a Higher Spirit (Hooks, 1993:184).

The issue of sharing is very important because when we speak about issues affecting Black women from a health approach, we find that Black women are ten times more likely to die from heart condition, high blood pressure, diabetes, and from all the illnesses that white women survive. When we come to the North American countries we get in our little corners and suffer alone. We need to develop a system whereby we find each other, like the other visible minority groups do, and share as we are culturally taught. It is interesting to note that while there are Black women who have survived cancer, there many have died deaths that are unnecessary because their white counterparts are not dying from the same illnesses. Why? In most cases, they die alone without the support of the community. "It is interesting because no one is researching this phenomenon. Because these common diseases are killing us at a much higher rate than white women we need to find out the cause" (Interview April, 2001).

There are some similarities between Black and mainstream women in terms of biology, however there are some distinct differences as well. For example, our perspective on and how we access health care services. As well within the Black communities there are also similarities and differences. One of the women summarizes this way:

Within Black Afro-Caribbean women's grouping there are similarities and differences as well, and what is important to one woman may not

necessarily be important for all Black women, and it may not be important for white women, therefore in order to treat a Black person there needs to be an understanding of the living conditions the environment in which this individual lives. For example, when a doctor says that you need to live on a balance diet and exercise, this means that the doctor does not have a good understanding of the type of environment in which we must live, how many hours we must work, whether we are single parents. The type of pressures and struggles we must undergo. The white doctor is tailored to serving a white population, and he is doing it because that is what he/she understands. However, if he/she is to continue to serve a diverse population then he/she must be willing to educate him/herself about that population in order to provide appropriate and culturally sensitive care to that clientele (Interview April, 2001)

While we are right in expecting mainstream society to cater to a diversity of community Black African, Caribbean, Canadian women to take some responsibility for their own health care. We have not been involved in studies about our own health, and have not acknowledged ourselves as resources for, our own health care. All of the women interviewed for this study believed that our physical, mental and spiritual health is closely related that health in one area affects health in the other two areas. All of the women agreed, “when they are physically healthy our psychological state is more positive, we able to think about the future and make plans and we feel more relaxed.” They further indicated “when we are physically and spiritually healthy we feel capable and are inspired to engage in social and leisure activities. Our self- esteem is high, we feel full of energy and are more motivated to care for ourselves and our families.” (Group Interview March, 2001)

One of the women shared, “when I feel tired, stressed and unmotivated I force myself to go to work or to school, and continue to take care and support my family even when I felt sick” (Interview March, 2001). This underscores the need not only for health care professionals to create environments that support the physical, mental, and spiritual

well being of Black Afro-Caribbean women, but their community as well. The Black community needs to recognize the many health barriers that Black women face and do all it can to assist those women to realize themselves as resources for their own health, and to help to empower them through appropriate support systems so that they can gain control over their own health and that of their families.

The issue of family relations was identified in the data as one of the key themes and will be discussed further in chapter six. All the women recognized the health barriers and the importance of pursuing 'good' health so that they will be able to take care of themselves and their families as healthy women.

CHAPTER SIX

TRADITIONAL HEALERS AND ALTERNATIVE MEDICINE

Introduction

In the previous chapter I began a discussion about the barriers the eleven Black women in the study experienced in their lives, by exploring their internal health problems; the issue of their access to health care services and their ways of coping within the system. In this chapter, the emphasis is on the women's experiences as they tell their stories about the health approaches they have found useful to the health. These include: traditional and alternative medicine; and holistic approach to health care; spirituality; faith; empowerment; and family relations.

All the participants contributed to a definition of health as "a Black woman's lifestyle; her everyday living, how she feels and thinks of her physical self, her spirituality, as well as her physical, emotional, mental and psychological well being. Health is not purely a physical thing. It involves having a good peace of mind as well as a good physical body because our health affects every aspect of our lives. Our wellness and how we cope with our wellness is part of how we cope with life in general (Group Interview February, 2001). One woman asserts: "Where I come from, health is a concept that I don't think we separated it from, the general day- to- day activities. We use traditional ways that are preventative medicine" (Interview March, 2001).

Historically, older African and Caribbean family members were the first to be called on for medical needs in the family. If their treatment failed to heal the sick, an herbalist from the community was called in to deal with the case. These women and men were well versed in herbal remedies for most common ailments. If the illness persisted a

spiritual healer with supernatural powers to heal may then be called. At this stage the faith of the sick is very important to his or her healing. Faith healers also used prayers and other rituals that might successfully address the problem. These traditional healers used holistic approaches to health and were very important persons in the African and Black communities.

Traditional Healers

Our concern for our health, the health of our families, and our communities is as ancient as ancient Africa and slavery. A healthy Black African and/or Caribbean community insured the continuation of the existence of the tribe or the group (Jacobs, 1987; Gray White 1985; Lorde 1980). An unhealthy community was under the threat of death and ultimately, extinction. In those ancient times traditional healers emerged from almost every community, and were trained by healers from the previous generation to continue to provide health care for the community. In most cases, they were grandmothers, or older female relatives who were taught the herbs and how to perform healing acts by their mothers and grandmothers by experience and by trial and error. (Wade-Gayles, 1995; Jones, 1986).

These traditional healers were revered for their healing knowledge that was entrusted to them. They were usually successful in providing relief for the ill in body, soul and spirit. However, today traditional healers are regarded not so positively because they use faith, prayer, fasting, and spiritual practices, with healing herbs, to procure good health. They are sometimes ridiculed as being useless. For generations, in the African culture, women have informed us “that good health is perceived as a blessing from God for living right, and poor health was seen as punishment from the Almighty for careless

living and/or a lack of faith in God" (Interview April, 2001). However, today traditional healers are not always accepted as being progressive because of our total dependence on western medicine and methods of treatment. With the failure of modern health care systems to deal with the tremendous health issues that our societies in general and Black women in particular, are facing, we are slowly returning to traditional medicines that are being redeemed and referred to as alternative medicines.

Alternative medicine is the term being used in our contemporary society to denote medical or health care that is different from the western medical model once it is controlled by doctors, large pharmaceutical and health insurance companies and government. It is interesting to note that when alternative medicine is practised by a non-western medically trained doctor that person becomes a suspect of fraud. Health care is big business. As a result, the administering of health care in our contemporary society is individualistic, impersonal, costly and exclusionary. In most instances, Black women, who view health care holistically, find it difficult to seek help from a system that deals with the physical separately from the mental, the social, the emotional, the spiritual, the financial and the personal. "We are of the opinion that, for women to enjoy good health, we must be healthy in all areas of life. Also, it is our belief that a healthy woman influences or most likely will contribute to healthy family relations" (Group Interview February, 2001). Whether we receive healing from a traditional healer or a modern day health provider the important thing is that we are able to enjoy healthy living.

Traditional Health Care

I have discussed the role of traditional healers in the various communities of origin of the women and the holistic nature of healing. All of the women agreed that,

health was defined in a less intellectual way by their communities of origin. “Health was never really defined formally rather, was a normal part of day-to day life. We went to the doctor when we were ill, what was more common was the application of were different forms of traditional medicine” (Interview, April 2001).

The women talked about mothers who always ensured that they had regular check ups at the doctor and the dentist once a year. However, other things like cuts, bruises, burns, fevers and other ailments were treated with herbs and other forms of traditional medicines depending on the geographical location. One of the women summarized it this way:

Herbs was used all the time, we didn't take much of doctors' medicine. When my mother took us to the dentist she would have already used herbs. We had to use salt and charcoal and rub our gums and the teeth. We used the charcoal to brush our teeth after using the salt. We also had a stem which was used as a toothbrush this was called a chew stick. We just bite the end into a brush and we brushed with soda power and salt. We rubbed the gums and cleaned our tongues with the stick brush. We would have a new one every day (Interview April, 2001).

The prevalent view of the women was that they used traditional medicines much more than western medicine although some participants also indicated a strong preference for both traditional and modern medicines. A number of the women indicated that they received most of their health care while in school because the doctors and nurses paid regular visits to their schools. One of the reasons for this occurrence is that hospitals and other medical facilities were always far away from the villages where most people lived. And it was easier for the government to provide medical care through the schools. For example, in Trinidad, a laxative called “chinaponium,” commonly known in Jamaica as ‘worm medicine,’ and Epson salt were always given at school by the nurse and the children were sent home for the afternoon. This remedy was usually given at the

beginning of each school year in order to clean out the intestines (the belly) of additional germs so that no germs would be brought back to school following a long holiday (Field Notes February, 2001).

One woman explained the process as follows: “It was assumed that the nurse needed to clear both our bodies and our minds for healthier and better learning in school” (Interview April, 2001). Other types of traditional treatment that were used by the traditional healers are:

“Punching rum” for high fever, “soft candle” for swellings, “lemon tea” or “bush tea” for good night sleep, “scultimultion” shark oil, cod liver oil, and ferrol for supplement “sanapods” for a healthy stomach, and we drank lots of water; ate lots of fresh fruits, vegetables and sea foods. Fresh foods were cooked daily. A balanced diet was a part of the community daily routine. Children took well-prepared lunches to school or the school provided hot meals for the children who lived too far to walk home from the school for lunch (Interview April, 2001).

Schools were considered an extension of the community, because the community as well as professionals were involved in instilling good healthy habits, and well-being in the young children. Health care was not seen as belonging to one domain with a specific expert who was so skilled that people were unable to challenge or devise his or her own process treatment plans. One woman describes the process as follows:

The primary school was an extension of the community. There, traditional medicines were kept in the school and were used by older school teachers to treat bruises, cuts snake, scorpions, wasps and other kinds of health incidents that took place at school. We were well taken care of at school. When we were naughty our teachers punished us, we prayed, sang, and played at school. We were safe with our teachers at school. With the intervention of western education and medicine by missionaries and colonialists things have changed. Now children are sent to the clinic where the one nurse who is on duty is over worked and under paid. Lots of health information is sent to the school with no western doctors to administer health care to the schools. In most cases children are still being treated with traditional medicines by the community healers (Interview April, 2001).

Most of the women grew up in these communities where preventative traditional medicines were administered in a more holistic way. They have left their countries of origin to settle in large urban cities in Canada and are now faced with differences in their health care practices. They are no longer encouraged to use preventive medicine rather they are given prescriptions for medication which does little to change their health situations. One woman shared her frustration into the changes of the health care system upon migration as follows:

In a lifetime we move from one culture to the other. In an urban setting in the new society at the infirmary with nurses who are qualified in western medicine. From age eleven on I lived in a different social setting but I keep going back to the traditional one and that essentially is where I think I belong, because this was my health base, my beginning (Interview April, 2001).

The women whose countries of origin was Africa described having the traditional medicine until aged nine or eleven, then moving to the urban centres where western health care approaches are practiced. They were provided with both the traditional health care that was more holistic as well as the modern/western medical system prior to coming to Canada. One woman described it this way: “With that kind of lifestyle we are modern and then we are traditional, but it is the balancing of those two cultures that is important for me. Most people have grown up like that in this part of Africa so they have both the rural and the urban settings as children” (Interview March, 2001).

She further explains about the process of accessing traditional health care as well as the fact that the location of western hospitals made traditional medicine essential to the village. Even in Canada the reliance on what’s available also becomes paramount because of Black women’s busy lives it makes a visit to the doctor for simple ailments a

major incontinence. One of the women, who is originally from Africa, explained about a village community, the distance of health care, and the availability of traditional village healers.

A village community is almost self-sufficient. For example, if a snake bit someone, another person who knows an older person a healer, who lives in the back of the house, will be able to treat the bite in traditional ways and with herbal medicine. Even malaria was treated with herbs as an emergency. If it got very bad then the family and the sick person would be taken to the western hospital for western treatment. Hospitals are always so far away from the village community that the people go to the hospital only with major illness. The village has all kinds of medical professionals even though they do not call themselves that, but people knew who was who, and if anything happened they would just arrive, they did not have to be invited. The healers were always ready to help and they always knew that they were needed someplace. These healers were also close by where the villagers could have easy access to them. In most cases these healers were older women who had received their healing powers (knowledge) from their grandmothers or other elders in the village and they were very reliable as health care providers (Interview April 2001).

Some of the women from the focus group agreed that traditional medicine was very effective and traditional healers were highly respected and trusted by the people. As a result, when they got ill they consulted with the traditional healers who were not far away. One woman summarized it this way:

For me as a child illness was not an issue, if I had a toothache I was taken to the dentist, and he took the tooth out. If any child had an earache, the woman healer who was sometimes our mothers treated it with hot oil and bacano leaf. So my memory of childhood and health has always been a history of preventative medicine because keeping us healthy was always on our mother's minds and it was considered less of a hassle, plus there were too many children to look after so they could not be allowed to get sick. As a result of these different types of preventative health care practices that we receive as children, most of us are now immune to a lot of the western diseases. We can conclude that traditional medicine was/is an essential component of our health care and we are more accustomed to holistic health care than western health care with its heavy reliance on drugs (Interview April, 2001).

Earlier I indicated that, Black women traditionally, viewed health from a holistic perspective (mental, emotional, spiritual and cultural). Therefore, their ways of seeing and accessing health care are different from western treatment and illness model that dominate the Canadian society.

Black Women's Health and Family Relations

Most of the women agreed that those of us Black women who grew up in the Caribbean and Africa had wonderful health habits because we were taken care of, not only by our parents and grandparents, but also by our extended families, as well as our village where we grew up. One woman described it this way:

We ate very balanced diets made from fresh fruits and vegetables we also shopped and cooked everyday. Food was purchased, as you needed it. We were also a community where we had extended families relatives, friends so they made sure that we had the right things to eat, we were very healthy. There was also lots of exercise. It wasn't like ok, you have to exercise, but you ended up doing it anyway because you had to walk everywhere since there was not the luxury of having a car so if you needed to go some place you had to walk to school, to church, to the market, to visit a friend, etc. In one day you could have walked up to five miles or more (Interview April, 2001).

It was very important that we stayed as healthy as possible. Life was not always easy and our parents were concerned that we made it to become adults with healthy bodies to be able to bear our children in a healthy way. The women expressed their frustration about "the lack of control that we feel as Black women because we are not able to influence the kind of health care that was available to us, for our families." (Group Interview March 2001). For Black women, the Black family social support from friends and family is an essential element of our health. One woman describes her situation with sadness.

I was very healthy as a child and I think that I am healthy now because I had the right nutrition, nurturing, emotional support and love, I had everything that I needed to grow up as a healthy child. But if I were to contrast that with my own child growing up in Canada she is not getting all the good things that I had, for one thing, she is missing out on the extended family connection, and that emotional support and love that I had. She has no aunts, uncles, grandparents and no community. Her community is the daycare where the majority of the people are white she is a minority in that community, where she is also exposed to all that junk food and as hard as I try as a parent she is influenced by her environment and wants the food that the other children are able to have, (i.e. MacDonald's) all the other fast foods (Interview April, 2001).

One of the most prevalent issues identified by the women is the important role of the extended family in theirs and in the lives of their children. The lack of that form of maintained-connectedness to healthy well-being has resulted in some instances where good friends and the Black church have provided surrogates and/or substitutes as one of the women explained:

When you have a family, partner, husband, child's father you have someone to lean on so the whole responsibility of parenting doesn't fall on you, but when it falls entirely on you it's a different story and this has an impact on the child. As a Black immigrant woman with no family, for me, that is where the church became my extended family. I remembered once we had no food we just prayed and some members of the church brought us food I suppose that was because I relied on my faith and my spirituality I would say that my positive health and well being had a positive impact on my son. I have been blessed to have good health because I practice holistic health (Interview March, 2001).

Another woman in support of the influence of Black women especially our mothers' on their family relations says: "Black women's health knowledge is being taken away from them, we don't necessarily do what our doctors say. Everyone calls mother first. She is our "mirror" she is who we always sees us as we are and seeks out our problems. There is a direct relationship between my health and my mother she is the one who I want to talk to when I am sick" (Group Interview, 2001). Material and emotional

support from family members in the forms of money, encouragement and someone to talk with, or in drawing on the experiences of older family members, are very important to the Black family. Older women especially have an important place in the family as they impart wisdom to the younger generation and they are valued and respected for their experiences, knowledge and wisdom.

Language was identified as one factor that influenced Black women's health. Although all the women spoke English, their understanding and interpretation of health service provider are not always understood. They may have "free" health care, but these women still face the complexities of understanding how to access health care services and face the barriers of interpreting the body and linguistic language of the dominant society. They claim that they are not obtaining the kind of health care they value (i.e. holistic assessments); instead they receive inappropriate or culturally insensitive care. Many of them are turning to alternative health care. One of the women who used acupuncture as an alternative form of health care stated:

I think for the alternative medicine we tend to feel that it is working and it works because we believe it is working, we tend to believe that the western medicine does not work for us because we sometimes do not follow the instructions or we do not fill the prescription for prescribed medication so this idea of one pill fix all does not work for us. Even when I was very sick I resisted the white doctors treating me because I did not trust them getting into my head so we decided to try the acupuncture. If you are lucky to have a family, you will have emotional support but if you have no family support it becomes very difficult because for me, even if my family was not physically there I knew that spiritually they were here, and even though they could not make the pain go away, being there was important (Interview April, 2001).

One of the women made an interesting comment. She claimed that "while western medicines may help in the healing process, it can create more harm than good because I am not able to trust the white doctors, since they know so little about Black

women's bodies. I am of the opinion that Black women's bodies react differently to these medicines than other women." She continued "I was ill for a long time... Black women and white women think differently, how we define who we are, is different. We have a stronger sense of self as within our community so that when we get sick we are worst off because we put up with more issues on a daily basis, and the Black community in Ottawa is much smaller than other places like Toronto or Montreal, so we have limited community support" (Interview March, 2001).

It is the opinion of another woman that " Black women's health has to be addressed through an integrated approach (socio-economic stability as a healing agent) the reality of what we are dealing with is important. Being Black in a white society is difficult, as a result we spend more time trying to achieve than taking care of ourselves" (Interview March, 2001). I have observed in my work as a health care provider that another problem that we face as Black women is the perception, in our communities and families, that we are pillars of health and strength. We are not supposed to get sick. The whole weight of an entire family health weighs down on us. This added pressure is not always visible to doctors who are not trained to ask these pertinent questions and as a result, we are often misunderstood and misdiagnosed. So when we become ill we might delay going to the doctor until we "are bleeding and puking".

Sometimes the frustration of trying to communicate our stresses of daily life to our doctors is more alienating, isolating and time consuming, especially when the doctor is white and we have issues with racism. These are real issues of living in a hostile world that barely tolerates us, denies us jobs, and forces us to work at more than one job to survive with young families. Then we must fight against the streaming of our children by

the school system and the killing of our sons by the police and each other. Life is too difficult sometimes to explain. Therefore, waiting until a medical crisis to see the doctor eliminates the need to communicate because we are all consumed with treating the crisis and not the underlying issues.

Another woman claims that her experiences in Canada have had a negative impact on her children as her health can go from extreme stress to a car accident “my experience is that I’m always on that spectrum between stress and major illness because I have a lot of stress in my life and that’s definitely affecting my children and the way I relate to them.” (Interview April 2001).

She claimed that she often finds herself living on the edge, worrying about where to live, providing food for her children, being unemployed, as well as the uncertainty of her life as a Black woman living in Canada. This is because she is first generation immigrant and she does not have extended family in the sense that you build networks with your family relations. As, a Black woman she explained:

I find living in Canada to be very difficult. This has a negative impact on my health as I am constantly stressed, doubtful, worried and even though I know that I am just as good as the next person that weight keeps weighing me down to the point of feeling inadequate, and when you start feeling inadequate your performance could sometimes show as if you are inadequate which is not always the case, and this becomes the cause of my unwell-being. I would say that there is a direct link between my health and how it impacts on my family, especially in day –to- day relationships which is the visible part and the invisible part... they also worry about my well-being because they can sense it even before I feel that I am not really well, my children are very tuned to my behaviour (Interview April, 2001).

From the women’s stories we can conclude that Black women’s health experiences in Canada have a direct link to their family relationships. Furthermore, for Black women who are single parents without extended family connections there are

additional struggles to maintain their health and that of their families because no one is available to alienate some of the stress. Therefore, how health services provide care for Black women and their families is very important. It is essential for health care providers to understand Black women health issues. It is equally important that these women are involved in research, as active participants in programs, policy development and implementation and to ensure that issues of concern to Black women are included. Therefore, questions must be asked of policy makers, doctors and other health professionals. The question is not whether services and policies are biased, but to what degree and in what way. Failure to admit these biases, disregards the values of Black women that could lead to health service providers 'blaming the victim'. As a result, service providers could be seen as agents of social oppression whose sole purpose is to ensure compliance to Western-European white male-based cultural values in health care.

The women's stories reveal that Black women see good health as incorporating healthy physical, mental, spiritual, emotional and social existence. However, it has been proven that there is no acceptable standard for holistic medicine as part of the Canadian health care system. Until it is universally accepted, people will still be hesitant to embrace it. As long as we continue to support the mentality that when we go to the doctor he will give us medication that will fix whatever is wrong with us and we develop the attitude (Western medicine model) that one pill will cure all our illnesses then we are doomed to ill health. One woman observed: "When we are sick we go to the doctor and we are expected to get well right away. We don't realize that healing takes time because we got sick over a period of time; we are impatient with the process. The health system

gives us this false idea that the doctors' drugs have the answers to all our health needs" (Interview April, 2001).

One important question for Black women regarding our health is the question of trust. Can we trust a system that deals with symptoms and does not treat the whole person? People are looking for a quick fix, which is very much, a part of an individualist culture where people tend to believe that this fix is the answer to all our problems and that things will work out just fine. However, in a Black culture, one woman shared this insight: "What is not taken into consideration is the fact that as Black people we come from a culture where we realize that sickness is something that we might have to deal with time and time again" (Interview March, 2001). We need to ask the question Do we trust health care providers who want us to believe that medicine can work magic while at the same time they condemn traditional and alternative medicine as unscientific? As one woman said, "Abnormal healing practices dictate to the whole body physically, mentally, emotionally socially and spiritually that all is not well" (Interview March, 2001).

Spirituality And Black Women's Health Today

All eleven women reported spirituality as an essential and necessary factor in their health and well - being. Spirituality was used as a method of survival and resistance depending on individual life experiences. The voice of one woman speaks for the group in her story.

She said:

I would tend to believe that spirituality is having that spiritual peace within yourself and having self love and believing that our purpose in life is not just strictly about what we can get out of it, but what we give and what is the purpose in our life. That is our way of looking at spirituality. We may have changed from what was our parent's reality and what is ours so what we are calling spirituality, has changed. I think though that while the whole issue of support is very important, I think that Black women try, for the most part, to network with one or two friends, but I think also for a

lot of people some kind of spiritual practice whether it is prayer, whether its meditation or something else that is done that says we can truly have something and its something else that they can do for themselves, and we can firmly see the results that no body else would probably see then our spiritual self need is met. We know that it is working somehow and that is what is carrying us. For me it is a feeling that the faith becomes stronger than the problems (Group Interview, 2001).

Every Black woman experiences her spirituality differently. We may have been trained to believe our parents and community specific type of religion that was ingrained in us as truth. But as we grew up we decided according to our faith, what Superior being controls our lives. That faith that we exercise in the God we serve, we believe, gives us the strength to overcome or endure our health problems. One of the women stated that:

Spirituality for me fills up the void; we all have voids in our lives. I have been lucky that I have been able to maintain the spiritual component of my life. I think that is why I don't drink excessively I don't gamble, or do drugs. How this is expressed in my life is that I am a traditional African woman. I have not changed to become sophisticated. I'm just whom that community produced in the sense that I value the things that I grew up with. For example, music and dancing it's almost heavenly. When I am feeling spiritual I dance, and I have taught my children to dance. It's amazing what I can do when I become spiritual it's like good sex. My spirituality has helped me to guide my children and it gives me something other than material things to believe in. It also helps me when I am stressed I go to church and I sing and dance and pray and that is how I give meaning to my life (Interview April 2001).

Another woman described how her spirituality relates to her health this way:

"Spirituality for me is a personal relationship with a spiritual being that interconnects my soul, my body, my spirit, my life. How I treat my body is important to my spiritual well being because my body is a temple of the Holy Spirit. My body is the only one I will have and if I put junk in it I get junk out of it. Spirituality and faith play a great role in my health because my health is so linked to my spirituality, and my spirituality to my

lifestyle so therefore, my health becomes my lifestyle. Freedom for me is based on my spirituality and, if I am free spiritually, I can enjoy my spiritual life then my health is impacted and as a result my family's relationship is impacted (Interview March, 2001).

For most Black, African, Caribbean women residing in Canada spirituality impacts their health. Their entire life style is influenced by their belief system. Some of the women stated that, one of the important things in our community that allows us to strive without the health care system is our spirituality. "I also believe that we do a very good job because when we believe in the creation and most of the entire Creator. Something happens to us we believe that its our faith that brought it to us and we don't have to ask "why me" "why me," and we settle for what comes our way and we pray we celebrate and we deal with our lot" (Group Interview, 2001).

One of the women related spirituality to her work and her clients this way: "I have found that some of the clients that I work with who have psychiatric illnesses, I've noticed that they feel much better when relying on their spirituality. Studies have shown that people who suffer from chronic depression who have relied on their spirituality have been proven effective. As well, I have noticed in my own clients that the one's who have used their spirituality, are better able to deal with their issues as opposed to the people who ask, "why me", when you ask, "why me," its as if you are not supposed to be sick and that show's a lack of faith. I believe that there is a direct link and connection between, our health, spirituality and faith" (Interview March, 2001).

Faith and Black Women's Health

Some of the women reported the Christian aspect of spirituality being used as methods of survival and coping. They reported belief in God; they felt that God would

respond to cries for help and direction, God was described as being very near, in the sense of imminent. Moreover, the women presented a God who directly intervened in their everyday lives. Their belief in God is also connected to their faith which is another area identified by the women. The women described faith in the following ways:

Faith is believing what we cannot see, but we are working towards it. Faith is that we expect something to happen and we are working towards it. The same applies with our health. We know that we have good health, but we are working towards having better health. Faith without work is dead. The Bible tells us that if you have faith and you have no work your faith is dead, the same applies if you have work and you have no faith that's not too good either. You need a combination of faith and work, we must put them together then we will have the result of spirituality that will cover us and our whole lives become developed in a more holistic way (Group Interview, 2001).

According to Vanzant (1998) faith is the magnetic pull of the heart's desire, an inner knowing that brings spiritual and emotional assurance. The substance and foundation that, one believes. The writer goes on to explain that faith is the inner sense of knowing that with divine order working on the side of the believer, all things will come together for her good. She encourages that we must muster faith in order to take the right steps in the right direction. Faith is the only way to avoid fear of disease. Faith is like planting a seed of positive thinking and good health. She concludes by reminding us that in our deepest, darkest moments, when we need it the most, we lose faith. We lose faith in ourselves. We lose faith in our Creator. We want to blame others and ourselves for whatever health situation we find ourselves in.

Vanzant believes that Black women have lost the ability to attend to our spirituality and spirit. She reminds us that as Black women we are taught to doubt our abilities and capabilities we have been taught to doubt the small still voice that speaks to us, the voice of spirit. She further states that the key to mastering trust is "knowing" that

we are worthy of the best. When we know and trust there is goodness with our names on it, we become patient and peaceful. Those of us, says Vanzant, who have not mastered the ability to trust may have missed the lessons of stillness and patience. However, as Black women we must master each of these before we can understand or master the lesson of faith (Vanzant, 1995).

In conclusion, I believe that we sometimes feel that we have lost the ability to listen and trust our inner spirit. How then can we trust a system that we feel provides us with superficial, unreliable, insensitive, and inadequate health care services?

Empowerment of Black Women's Health

It is the view of the women that a legitimate use of power is empowering. Further, that the source of powerlessness are negative images that we have as oppressed people, the negative experiences that we encounter in this society, that systematically deny us opportunities to take positive actions towards our own well - being. One woman summarize it this way: "power is dominance and control, and it is embedded in the social structures and institutions in Canadian society including the health care system. She further states that, "knowledge is power, and power is the central component of oppression" (Interview April, 2001). As a health professionals and a Black woman, I believe that empowerment is the process of giving greater power to clients in whatever way possible, such as, education, political and self-awareness, the facilitation of self-sufficiency, independence, and the ability to challenge power hierarchies such as the Canadian health care system.

As many of us are aware, it is very difficult to get correct information and even harder to use it effectively in an environment of domination that promotes cures for

illness rather than preventive holistic health. It is often easier to get advice that destroys our health than the kind that would promote well-being. For example, if one is suffering from insomnia, pills are prescribed rather than advising one to look into the causes of the insomnia that is generally extreme worry and stress, inherent in competitive individualistic market societies. Hooks (1993) shares her belief in self-recovery when she explains:

I suffer a lot from insomnia. It causes me stress because often after a sleepless night I have to carry on with the activities of the day as though I am not tired. Meditating helped me learn to relax so that I could enhance the chances that I would sleep the night through or, if not, experience my wakefulness unstressfully (Hooks, 1993:64).

The women have recognized that knowledge is power and that Black women are very much disempowered because of their lack of access to the health care system. The health knowledge learned by Black women from their mothers or elders in their country of origin differ from what is acceptable or practiced in Canadian society. These women therefore, have to learn new ways of maintaining their health and the health of their families. Lack of information and barriers to the health care system along with all the other stressors identified by the women have produced feelings of inferiority, frustration, and isolation. These stressful life events have contributed to the physical and mental well-being of Black women. The women have identified barriers to their access to appropriate health care as a result they could make decisions that are detrimental to their health and well-being and that of their families. As Black women, we believe that education and political advocacy are key factors in ensuring the health and well-being of Black women in Ottawa and Canada. By the women in this study is supported by the call

from other immigrant, visible minority and refugee women in a report that was done in 1991 by the Ontario Ministry of Health.

The Health Care Needs of Immigrant Visible Minority and Refugee Women, (1991) report it found that these women have significant health care needs but appear to utilize health care services less than other mainstream white female client groups. This contradiction was largely due to the cultural, linguistic, racial, gender and class barriers embedded in the system. They demanded that health be located in a context of economic, social, and environmental realities, since all of these factors have a direct impact on the state of health and well-being of Black and other racial minority women. The report also noted that Canadian health care providers recognize and include the holistic nature of oppression in terms of gender, class, race, religion and cultural backgrounds of these women. The needs of these women, therefore, call for a recognition and emphasis on health education, promotion, and disease prevention as critical components of health care (Ministry of Health, 1991).

In conclusion, the women in all these studies are highly critical of the current health care system and advocate for a transformed system that would regard the individual client and community as equal partners with health care institutions (Ministry of Health 1991). In this manner the women articulated the need for current health care approaches to move away from the current expert versus client model of health care. Although, traditional healers were considered experts, the treatments they recommend tend to empower clients to engage in the process of healing themselves and gave them alternatives to medicine that were familiar to them. This sense of control is a long way towards empowering clients. Since "many areas of the health care delivery system are

simply inappropriate for and insensitive to the needs of minority women” (Ministry of Health 1991: iii).

Given the current health care system, Black women in the community have had to find alternative ways to resist the current model that both contradicts their needs and have an adverse effects on their health and well- being maintains an adverse effect on their health. Accordingly, given the fact that based on the data from this study, very little have changed for Black women and health care provision. Since the 1991 study was conducted, it has become essential for Black women to find alternative ways of meeting their health care needs and those of their families.

CHAPTER SEVEN

CONCLUSION, FURTHER RESEARCH AND RECOMMENDATIONS

Introduction

In this thesis, I have attempted to uncover the health experiences of eleven Black African, Caribbean, and Canadian Women residing in Ottawa, Ontario. It was my contention that these Black women's health is linked to their social, political, economic and historical position in Canadian society and that the interconnection of race, class, and gender create barriers that prevent them from accessing adequate health services. One of my major findings is that the issue of access to health care services is a serious concern for the women in the study. The Black feminist theoretical framework, from the standpoint of Black women, informed the study in a way that helped to reveal how the women in the study experience the Canadian health care system. Similarly, the utilization of a qualitative methodological approach made it possible for the women to voice their experiences without intimidation. I was able to gather relevant data from in-depth interviews and focus group discussions with the Black women that addressed the research questions posed by the study.

Information was collected from available books, studies that were done on health in Canada, reports, and other forms of literature. My own experience, as a Black Afro-Caribbean woman, as well as health professional, and the observations of other African, Caribbean, Canadian women in the community were useful in the analysing the women's health experiences in Ottawa.

My investigation of the health experiences of Black African, Caribbean, Canadian women in Ottawa revealed some interesting findings mentioned earlier in the study. I have found that barriers to Black women's health is directly linked to their historical position in Canadian society, and is influenced by their race, class, gender, and socio-economic position. A number of themes have been identified from the data. First, the data confirms that little is known about Black women's health experiences in Ottawa; second, that Black women are not accessing the health care system, as they should because of systemic and societal barriers. Third, that Black women's approach to health care is from a holistic perspective that is different from the Canadian medical model. The data further reveal that spirituality and faith are preventative ways of coping for these women. Further, immediate and extended families are essential components of Black women's health and well-being. Finally, Black women do not access the health care system mainly because of fear, and lack of trust for health professionals and the health care system that treats the symptoms rather than the illness utilizing a medical model rather than more preventative approaches.

Holistic Health

The women in the study defined health as a Black woman's lifestyle. Her everyday living, how she feels and thinks of her physical self, her spirituality, and her physical, emotional, mental and psychological well-being. It was the feeling of the women that health is not purely physical; health is having good peace of mind as well as a good physical body, and this affects all aspects of their lives. I have found that Black women's wellness and how they coped with that wellness is part of how they cope with life in general. As Black women we are used to a more traditional and preventative

approaches to medicine that is also more holistic. I have found from the women's stories that African and Caribbean communities rely on alternative forms of health historically and today. As a result, traditional healers and the utilization of herbs are important components of their health and well-being.

A Legacy of Spirituality

Another interesting finding is the women's report that they, like our mothers of old, view spirituality as being an essential component of their health care. Spiritual health was described as feeling comfortable, happy, and confident, safe. They further described spiritual health as feeling close to God. Being spiritually healthy can be transmitted to the mind and body that keeps us in touch with God. The women described a variety of ways of nurturing their spiritual health such as: listening to music, enjoying nature, reading and so on. All of the women in the study believed that physical, mental and spiritual health are inter-related. It was the feeling of the women that there is a direct link and connection between their health, spirituality, trust, and faith.

Family relations

The data revealed that social support from family and friends is an important element of the women's health. I have found that one of the prevalent issues from the women's stories is the important role of the extended family, especially maintaining a healthy lifestyle among those women who do not currently have extended family in Ottawa or Canada. The data reveals that Black women's health experiences are directly linked/connected to their family relationships. Therefore, how health services provide care for Black women and their families is very important. It is essential that these

women are involved in research, as active participants in programs, policy development and implementation, to ensure that issues of health concern to Black women are included.

Implications For Social Work Practice

This investigation of eleven Black women's experiences in Ottawa, reveal several implication for social work practice, both as an academic discipline as a field of practice. As social workers, who are health care providers, it is important that we be informed about the multi-cultural groups that we serve within the Canadian health care system. In order to address this need serious and decisive steps must be taken; by policy makers, health agency employers, educational systems, training institutions and the ethnic communities that are affected.

In addressing the health experiences of the Black women in the study a few suggestions have been made, which if implemented, may assist in eradicating the barriers they experience when accessing the health care system.

First, because of the large Black population in Canada, there is a urgency for government agencies to be correctly informed of the health needs of this population. As a result, policies and interventions that will be beneficial to the Black women and their community may be implemented. Second, health agency employers should increase the recruitment of this marginalized group in health care delivery and seek to address the retention of Black health care professionals. Third, the educational systems should be more consistent to encourage the pursuit of the careers in the areas of health care among visible minorities. Fourth, all health care professionals, such as doctor, nurses, and other health care providers must be given cross-cultural training in the areas of traditional and cultural health practices of the visible minorities groups. A critical examination of the

history of health of the group studied, will inform service providers of the interconnectedness of race, gender, and class oppression that affect Black women's health.

Finally, the Black community must seriously take responsibility for encouraging, supporting and assisting Black women in being empowered to access the health care system.

FUTURE RESEARCH

- Further research needs to be conducted on racism in the health care system as it affects the mental and physical health of Black women in Canada.
- An investigation of diseases that disproportionately affect the Black population, for example sickle cell anemia.
- Research is also needed in the area of family relations in Black women's health. An investigative research project should be initiated to analyse the forms of oppression experienced by Black women of the African Diaspora in their effort to access health and social services.

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APPENDICES

APPENDIX A

INTERVIEW GUIDE

Thank you for agreeing to participate, in my study. This will be an informal interview, and will last one to two hours. Also, the interview will be taped as we previously agreed. The issue that I would like to cover in the interview is your health experience as a Black. You can set your own pace for the discussion. You can refuse to answer any questions, and you can choose to end the discussion at any time. You are free to have a break anytime during the process. Do you have any questions you want to ask, before we begin?

- **When I say Black women's health experiences what comes to mind for you?**
- **How did your mother/community define health in the past?**
- **Please share with me some of your health experiences in Ottawa. Do you feel that this has impacted your family relations? Explain how this happened?**
- **Based on your experiences what do you feel are some of the major health concerns of Black women in Ottawa?**
- **What are some of the barriers that you face in gaining access to holistic health care in Ottawa?**
- **Do you feel that there are links and or connections between Black women's health experiences historically and today? If so, what are they?**

Thank you for taking the time to participate in the research. If you wish to have a transcript of the tape, let me know. When I have identified quotes that I wish to use, in the study I will give you the opportunity to look at them in the context that I intend to use them. I will remove any quotes that you wish me to withdraw, as we agreed. Do you have any other questions?

APPENDIX B

LETTER OF INTRODUCTION

I am currently enrolled in the Master of Social Work (MSW Program at Carleton University School of Social Work in Ottawa, Ontario. As a partial requirement to obtain this degree, I am required to complete a thesis.

For my thesis, I wish to interview Black women living in Ottawa to get their views and experiences on Black women's health issues and concerns. This study will help to inform social workers and service providers, as well as members of the Black community, about Black women's health experiences.

Through this study I hope to identify some barriers and issues affecting members of this community. I also hope that that this new knowledge created through this research will raise awareness and lay the foundation for future studies in this area.

Participation in this study involves an interview that will last between one and two hours. I will ask for your permission to tape the interview to facilitate accuracy in my analysis. Participants will have a choice of where the interview will take place. While I will be using your words and ideas, any aspect that will make you identifiable will be eliminated. I will also ensure confidentiality, and you can stop the interview or withdraw from the study whenever you want. At the end of the research all tapes will be destroyed or returned to you.

I will ask that you sign a letter of consent that outlines the process of the interview session. There are no anticipated risk to participants in this study, counselling support is available if and when you need one. Should you have any questions, please do not hesitate to contact me or my thesis supervisor.

I appreciate you taking the time to read this letter and look forward to your participation in the study. I believe the richness of your experience will greatly enhance this study, and the field of social work, as well as the Black community.

Sincerely

Melissa Rowe

APPENDIX C

LETTER OF CONSENT

I _____ agree to participate in the study being conducted by Melissa Rowe of Carleton University School of Social Work. I am aware that this study will involve discussions about my views and experiences about my health as a Black woman living in Ottawa. I agree to the following:

- Interview of approximately one to two hours.
- Audiotaping of this interview if permissible, and that these tapes will either be returned to me or be destroyed.
- There are no anticipated risks involved in this study. Participation is voluntary, and I may withdraw at any time.
- I understand that my name and any identifying detail will be kept confidential.
- I can have counselling services should I require them.
- I will have access to a draft of the paper and can ask for removal of any information that I find is inaccurate or harmful to me.

I understand that the results of the study may be published and will be deposited in the Carleton University Library for future reference. I understand that my name and all identifying information will remain confidential and not be disclosed under any circumstances whatever.

Interviewee _____

Researcher _____

Date _____

APPENDIX D

Letter. from Counselor.

Valerie J. Rowe, M.Sc.,
7-297 Sunnyside Avenue,
Ottawa ON K1S 0R9
Tel (613) 736-9539

November 28, 2000

To Whom It May Concern:

This letter is to confirm my agreement to provide therapeutic counselling, support and referral service for the women who are a part of the thesis research project entitled, **The Impact of Black Women's Experience on the Family: Reflections on Slavery**. Ms. Melissa Rowe, a Masters Level student in Social Work at Carleton University, is conducting the project.

As a Psychotherapist with over 5 years experience, I offer a safe and confidential environment in my practice. I have a varied background that includes a Bachelor of Science Degree in Special Education and a Masters of Science in Counselling. Some of my areas of focus in my counselling include: Sexual and Wife Abuse, Depression, Self Esteem issues, Cultural Adjustment issues, Suicide, and Anxiety and Panic Disorders.

My sessions are conducted in English, although I have access to use cultural language interpreters on an as needed basis.

I look forward to offer my service and to fully support the women of this project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valerie Rowe', written in a cursive style.

Valerie Rowe, M.Sc

APPENDIX E

Summary of Charts

Black African, Caribbean Canadian Women's Health: Their Lived Experiences

Black African, Caribbean, Canadian Women's Health: Their Lived Experiences

Barriers/Access to Health Care

- fear of medical professionals
- lack of trust of medical system
- silence, stress
- impersonal treatment
- objectification of their bodies
- paternalism
- lack of acceptance by society
- multiple responsibilities

Race, Class and Gender

- experiences different than mainstream women
- mind, body, spirit (holistic perspective)
- reliance on traditional herbs/practices
- guidance from elders/traditional healers
- community involvement
- medical model

Coping Mechanisms

- spirituality (practice)
 - resistance
 - survival
 - empowerment
- faith (belief)
 - method of avoiding fear
 - inner sense of knowing
 - obtaining peace

Family and Community Relations

- collective voice
- role of extended family
- role of extension of village
- Church
- strength of mothers