Intersecting Oppressions: African Nova Scotians with Disabilities and Possibilities Arising

from the United Nations Convention on the Rights of Persons with Disabilities

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Abstract

Incorporating a social and critical model of disability with an eye to the important intersections of race, gender, income, and disability, we use the existing literature both on disability and on chronic disease[1] and health within the African Nova Scotian community to argue that a human rights-based approach to disability, exemplified by the United Nations Convention on the Rights of Persons with Disabilities (CRPD), provides the most promise for improving the lives of black Nova Scotians with disabilities.

Keywords

Disability; Chronic disease; Nova Scotia; Human-rights; Race; African; CRPD

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[1] "Chronic disease/conditions" are broadly defined in the literature as a continuous or persistent condition that can be communicable or non-communicable, can be physical or mental, and is not easily resolved (Hayward and Colman 2003, 1). Some examples that overlap with disability (depending on the definition used) include cancer, diabetes, respiratory illnesses, anxiety, depression, and schizophrenia.

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The United Nations Convention on the Rights of Persons with Disabilities (CRPD) has been lauded for its progressive rights-based approach and its potential to help achieve human rights for marginalized populations of people with disabilities. In this article we evaluate the potential of the CRPD to address the needs of African Nova Scotians, who have historically been underserved in terms of health care provision and disability resources and who comprise almost one-half of the province's racialized population (Nova Scotia (Code 12) (table) 2013).[2]

Incorporating a social and critical model of disability with an eye to the important intersections of race, gender, income, and disability, we use the existing literature both on disability and on chronic disease[3] and health within the African Nova Scotian community to argue that a human-rights based approach to disability, exemplified by the CRPD, provides the most promise for improving the lives of black Nova Scotians with disabilities. Agencies such as the Nova Scotia Human Rights Commission (NSHRC) have an important role to play in bridging

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[2] According to the latest data (from the 2011 National Household Survey) those identifying as black constitute approximately 44% of the province's "visible minority" population. (Nova Scotia (Code 12) (table) 2013).
[3] "Chronic disease/conditions" are broadly defined in the literature as a continuous or persistent condition that can be communicable or non-communicable, can be physical or mental, and is not easily resolved (Hayward and Colman 2003, 1). Some examples that overlap with disability (depending on the definition used) include cancer, diabetes, respiratory illnesses, anxiety, depression, and schizophrenia.

the perceived and material gaps between this human-rights focused legislation and the African

Nova Scotian communities.

We discuss our theoretical and methodological approach and our method. Second, we

discuss the history of the settlement of African-descended peoples in Nova Scotia, allowing a

glimpse into the roots of some of the inequalities with which community members contend.

Bearing in mind the negative social and psychological toll that historic and present-day

discrimination takes on physical and emotional health, we explore the current research on health

and chronic disease within the black Nova Scotian community while discussing implications for

those living with intersectional oppressions. From there, we discuss the formulation of the

CRPD, highlighting the paradigmatic shift from the biomedical model of disability to the social

model of disability. We consider the CRPD's potential for improving the lives of all Nova

Scotians with disabilities—particularly the lives of those already marginalized on socio-

economic, racial, and other levels.

We conducted an extensive survey of the academic literature as well as health and social

service providers and non-governmental organizations' reports on the topic of disability and/or

health, and race within Nova Scotia. Most of these documents were publicly available online.

We sought documents that articulated interconnections among these characteristics and other

sources of marginalization such as gender and income, but few were found. Predictably, many of

the documents espouse a public health or social determinants of health paradigm; we utilized

these sources carefully and primarily for illustrative statistics, recognizing that this approach may

not acknowledge the socially constructed nature of race, disability, gender, and other aspects of

identity, nor emphasize the systemic nature of racism and social inequality and the influence of

class structure on health outcomes (Coburn et al. 2003). These shortcomings have not gone

unnoticed from within and without the field (Frohlich and Potvin 2008), and we sought to

supplement the public health/social determinants of health-based literature with perspectives that

emphasize the highly personal experience of disability and that bring the voices of those living

with multiple sources of oppression to the fore. This approach could be termed a "*critical*

population health" perspective (Cohen 2006) grounded in an understanding of disability as

socially-mediated and as one of many intersecting social identities.

Although scant data exist – qualitatively or quantitatively – on African Nova Scotians

living with a disability[4], we make use of incisive reports on access to health care and other social

services that allow us to draw broader critiques and recommendations about the CRPD's

implementation. Health services, while essential to creating social inclusion, are not a clear

indicator of independent living; however, given the dearth of literature related to disability in the

African Nova Scotian community, we utilize data related to health services in order to create

understanding of why full realization of rights for black Nova Scotians with a disability falls

short.

While some governments and societies have adopted a social inclusion and rights-based

approach to disability issues, many still rely on a charity model or on a biomedical model that

spotlights medical "solutions" without addressing the socio-economic realities of disability. The

biomedical framework views disability as a type of pathology best treated through services that

allow the individual to approximate the lives of those considered "normal" (Rioux and Daly

2006, 349). The medical model's aims are to identify what makes a person "abnormal" and to set

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[4] An exhaustive literature review pointed to the dearth of scholarship on African Nova Scotians with disabilities
(with the exception of Wright 2012). Many resources exist that consider the two groups as discrete populations but
failed to note the intersecting vulnerabilities of those who are racialized as well as have a disability. In contrast,
many scholars did note the "multiple barriers" or "interlocking systems of oppression" facing racialized women in
the region, even if attention was not explicitly given to disability (Waldron 2010; Etowa et. al. 2007; Bernard 2005;
Bernard 2001).

out to maximize an individual's function through treatment or rehabilitation (Stienstra 2012, 3). Fundamentally, the medical model fails to acknowledge that one may lead a fulfilling life while also having a disability (Harpur 2012). It also fails to recognize the full range to which disability is socially constructed so that the degree to which one is "disabled" needs to be understood as both a normative condition and a condition created by social opportunities, services, and political will.

By contrast, the social approach that we advocate locates disability squarely within society. Disability is viewed as *difference,* and the political, social, and physical structures of society are all considered elements that can render a person "disabled" (Rioux and Daly 2006, 350). The social model treats disability not as a deficit – which is characteristic of the medical model – but as a "culturally and historically specific phenomenon, not a universal and unchanging essence" (Shakespeare 2006, 198). Rioux and Daly highlight two frameworks of disability that fall into the social model: the environmental model and the "rights outcome" approach. The environmental model focuses on how the ordinary physical environment can construct disability, while the rights outcome approach, which has been enshrined in the CRPD, emphasizes human rights principles. Intersectionality has also been heralded as a productive approach to tackling complex human rights issues due to its natural relationship to social justice and because it provides a conceptualization of the multiple dimensions of discrimination that could be brought to human rights' advocacy bodies.

In her study of the limited "meaningful occupations" for African Nova Scotians and Aboriginals in Halifax's North End, Waldron uses narrative data to explore how "multiple identities converge to produce specific experiences for specific individuals and communities in different moments and contexts" (Waldron 2010, 36), drawing upon the much-articulated

contours of *intersectionality,* a theory that emerged from scholars of colour in the 1960s and

1970s (Samuels and Ross-Sheriff 2008). In this approach, both personal/individual factors (e.g.,

disability, age, gender, race, sexual orientation) and institutional/structural factors (e.g., socio-

economic status, availability of health and child care) are assumed to interact to co-produce

injustice for both individuals and groups. As Collins summarizes,

> the term intersectionality refers to the critical insight that race, class,
> gender, sexuality, ethnicity, nation, ability, and age operate not as
> unitary, mutually exclusive identities, but as reciprocally constructing
> phenomena that in turn shape complex social inequalities. (Collins
> 2015, 2)

Waldron offers this paradigm as a counterpoint to biomedical approaches that falsely

separate aspects of self into discrete categories (e.g., socio-economic status, race, gender) and to

research agendas that concentrate on individual-level, taken-for-granted "characteristics" that do

not properly acknowledge the level to which these differences are socially constructed and

embedded in hierarchical power relations. Certain parts of one's identity cannot be considered in

isolation but in different situations and different analyses particular aspects will be more or less

"salient." Samuels and Ross-Sherriff note that characteristics of identity can be advantageous in

certain contexts and disadvantageous in others; in their study of multi-racial adoptees with white

parents, they discovered that in white communities the adoptees' cultural capital and middle-

class socio-economic standing served to their advantage, whereas in black communities middle-

class upbringing seemed to distance them from their peers' "authentic black experience" of

poverty (Samuels and Ross-Sheriff 2008). As important as individual attributes are, socio-

cultural context can be critically important to an intersectional analysis:

> An intersectional analysis requires attendance to the historical, material and
> structural contexts and conditions that produce social inequality and the
> meanings assigned to it, as well as an interrogation of white privilege and power,
> and their accompanying ideological rationales for dominance. (36)

Recently, disability studies scholars have advocated for a much overdue discussion of race issues within the field. In the American context, even though blacks constitute only 12 percent of the general population but 18 percent of those with disabilities, whiteness has been the field's presumed default category (Lukin 2013, 308). For racialized people with a disability, issues of race cannot be divorced from their everyday experiences. As intersectionality transformed feminism, disability scholarship is ripe for a similar transformation; this new intersectional paradigm can accommodate these diverse components of identity to understand how they intersect to create heightened social injustice. The concept of simultaneous oppression "enables individuals to see how all their identities intersect and overlap in structuring their oppression and privileges" (Pearson 2012, 35)

Further, an intersectional approach can greatly enrich the field of disability studies as it helps to counter "disability essentialism," in which a static, single-dimensional identity for people with disabilities is assumed (Lukin 2013, 313). Relying on the insights of Omansky Gordon and Rosenblum (2001), Pearson notes that there is increasing recognition that one's disability cannot be divorced from other social identities and that, indeed, other identities might be more prominent in particular interactions or contexts (Pearson 2012, 32). Pearson's research on the intersections of disability, race, and gender on a college campus discovered that in different contexts disability is more or less prominent. For one white, blond female participant, her appearance invited the assumption that she was flighty. Her distractedness and hyperactivity were attributed to presumed character traits – not to the disability that was causing these tendencies. For a male interviewee of colour, his experiences as a racialized person were by far the most salient; he felt that he faced little discrimination based on his disability but noted numerous instances of racism he experienced within his academic department. Considering

disability and other social identities in an *intersecting* instead of additive sense allows movement away from a hierarchical ranking of marginalities – or a false compartmentalization of oppressions – towards recognizing the complexity of experiences of a person facing oppression on numerous grounds.

In Canada, 14.3 percent of the population – 4.4 million people – lives with a disability (Stienstra 2012). Data from the newly released 2012 Canadian Survey on Disability show that, at 18.8 percent, Nova Scotia has the highest rate of disability in the nation (the Canadian average is 13.7 percent) (Arim 2015, 6). Nova Scotia provides a much-needed case study illustrating how human rights focused legislation can help improve its citizens' quality of life. Although there is a telling lack of data specifically linking disability and minority communities in Nova Scotia, recent studies on health, poverty, and chronic disease reveal that the province's black and Aboriginal citizens, among other vulnerable persons, suffer disproportionately negative health outcomes (Etowa, Bernard, et al. 2007; Hayward and Colman 2003; Saulnier 2009).

Black Nova Scotians are over 90 percent Canadian-born and comprise the largest indigenous black population in the country (Mensah 2002, 90; Canada's Ethnocultural Mosaic 2008, 18). They have been dubbed the "forgotten population" of Atlantic Canada in terms of emotional and physical health circumstances (Enang 2001, 1). Scholars agree that designing comprehensive and culturally appropriate policies and instituting effective delivery of health services for this group are urgently needed; we echo those arguments and draw attention to the pressing need for disability-focused initiatives that recognize marginalization in interlocking spheres, invigorated by Canada's recent commitment to the CPRD.

Disability Among African Nova Scotians: Intersections of Disadvantage

African Nova Scotians represent an oft-dismissed yet crucial part of Maritime and Canadian history. Canada is home to a heterogeneous black population hailing from the Caribbean and Africa, thanks primarily to the "points system" introduced in 1967 that sought to redress past discriminatory immigration policies and paved the way for immigration of non-Europeans (Mensah 2002, 3). Today, the majority of black Canadians live in metropolitan areas such as Toronto, Ottawa-Hull, Montreal, Halifax, and Vancouver, and boast an array of educational and cultural backgrounds (Mensah 2002). Despite this current geographical and social diversity, few Canadians are aware that African-descended peoples have a long and storied history of settlement within Canada. Indeed, in Nova Scotia 84 percent of blacks are at least third-generation Canadian; they have abiding ties to both the province and the country (James 2010, 35). People of African descent arrived in Nova Scotia in the 1600s and are considered to be among its founders; Matthew Decosta, a former slave of the Portuguese, was the first to arrive – some time before 1603 – and he served a vital role as a navigator for French colonists and as a translator of Mi'kmaq (Enang 2001).

From that time, the African diasporic arrival continued in three waves. The first migration in 1776 brought to the province more than 3,000 American blacks, who had been guaranteed freedom and land grants in return for their loyalty to the British during the American Revolution (Kelly 2003, 3). Additionally, 1,232 slaves were transported to the colony as the property of white Loyalists, and were made to chop wood, clear fields, and build ships. When Nova Scotia was hit by famine in 1789, African Canadians were not permitted cold-weather supplies or food rations unless they continued their mandated road work (Christensen 1998, 42). Much of the land and rations promised to the free black Loyalists never materialized because the

priority system that was established to organize the massive influx of settlers favoured white officers and other white settlers. The black immigrants who did receive their promised land allocations found them to be small, isolated from the white settlements, and of poor quality, the reverberations of which are still felt today as many Nova Scotian blacks struggle with isolation and limited access to public resources.

The second influx of migration in 1795 brought exiled Jamaican Maroons to Nova Scotia's shores; the 500 settlers were frustrated by the unfamiliar and unforgiving climate and resented that white residents only viewed them as a source of cheap labour (Whitfield 2005, 2). In 1800 most of the Maroons re-located to Sierra Leone, joining as many as half of the black Loyalists from the first migration who had also re-settled in West Africa (Kelly 2003, 4).

The final major wave of settlement occurred during the British−American War of 1812 that brought African-American refugees to the then-British colony. The majority of these newcomers were former slaves from two distinct slave cultures: the Chesapeake and the Georgia Sea Islands. The settlers themselves were also highly diverse; some were highly skilled, others had a background in farming or labouring, some came in family units, and others escaped independently. Their ages ranged from five to eighty. Indeed, historians have emphasized these distinctions: "if the Refugees can be understood as monolithic in any terms, the desire for freedom comes to the forefront" (Whitfield 2005, 27). They also had other commonalities: each "wave" that arrived came to occupy the lowest strata of society and they had to learn to "live and cope with the shame and stigma attached to legacy of slavery" (Bernard 2005, 54). Some returned to the United States after the war while others emigrated to the Caribbean or West Africa. Still others stayed in the colony and worked with the original settlers and remaining Maroons to forge the province's black communities and settlements.

Many black Nova Scotians (particularly rural dwellers) lived in substandard housing for generations and lacked large-scale electrification and sewerage (Kelly 2003). Nova Scotian society remained officially segregated into the 1940s – a legal and social status that white citizens occasionally resorted to violence to maintain (Whitfield 2005, 6). As Christensen points out, Canadian engagement with race usually focuses on Canada's role as a "haven" from slavery as the terminus of the Underground Railroad without acknowledging the widespread racism and discrimination that blacks face. The case of Africville is a particularly poignant example of the domination of white business and government interests over the desires and wellbeing of black residents. Settled in the 1840s by black refugees, Loyalists, and their descendants, this settlement – located on the shores of the Bedford Basin in Halifax – became a self-sufficient community. It was also, however, a highly sought-after location for development. In 1947, the city rezoned the area and prepared it for industrial use, against the wishes of most residents. By the end of the 1960s, the city of Halifax had expropriated the land, resulting in the forced removal of residents. All of these actions had been taken under the guise of "slum" clearance, without recognition of the role that the city itself had played in creating poor living conditions by refusing services such as sewerage, garbage collection, and police services, and by locating a city dump, a prison, and railway expansion adjacent to the residential community (Nelson 2001, 13-14). In the 1980s, a public park was established on the site of the former community and it continues to be a locus of both commemoration and public protest. In 2010, the city government offered a formal apology for the destruction of the Africville community and a compensation package that included $5 million and a parcel of land (Nelson 2011, 137), which was used to build a replica of the community's church. Despite this apology, former residents' struggles are far from over. Usage of the park as an off-leash dog park has been a particular point of contention, with the

chairperson of the Africville Heritage Trust noting, "It just does not jive that a national historic site is also a site for dogs to be able to relieve themselves" (Africville dog park upsets black community 2014). At the beginning of 2015 the park officially became designated as an on-leash park only after concerns were raised by the Africville Genealogy Society and visitors to the historic site (Africville Park becomes on-leash for dogs as new park opens 2015).

All told, racism, geographic isolation, low quality housing, limited educational opportunities, and poor health "have had a cumulative and devastating impact on peoples' lives" (Enang 2001, 2). Those coping with discrimination are more likely to report mental and physical health problems, constant stress, feelings of depression, and feelings of anger. Disadvantaged groups, such as racialized minorities and single mothers, are more likely to experience chronic and relentless stress (Hayward and Colman 2003, 59). Racism "saps dreams and leads to despair about the future" (Hayward and Colman 2003, 29).

Furthermore, despite the perception that virulent racism is a relic of the past, black Nova Scotians attest that their lives continue to be affected by discrimination and attendant constraints upon life opportunities (Kelly 2003; Bruhier 2009). The 2013 Nova Scotia Human Rights Commission's report on consumer racial profiling confirmed what African Nova Scotians had been reporting anecdotally for years, that they continue to encounter suspicion and hostility in the public arena and as consumers. Furthermore, focus group participants explicitly linked their experiences of consumer racial profiling (e.g., being followed while shopping or questioned about ability to pay) with overall negative health consequences due to the stress, depression, and fear that profiling causes; as one middle-aged respondent said, "I feel defeated" "(Working Together to Better Serve All Nova Scotians: A Report on Consumer Racial Profiling in Nova Scotia 2013, 85).

The structural nature of racism within Nova Scotian society has antecedents in centuries-old historical processes such as the siting of the black newcomers in environmentally-undesirable areas, the provision of unsafe housing, and the lack of sufficient education and employment access and resources (Kelly 2003; Whitfield 2005). As a result of the process of unequal and undesirable land allotments, African Canadians in Nova Scotia today often face the additional burden of residing in areas disproportionately exposed to hazards such as low-lying land or dump sites (Borden et al. 1999; Kelly 2003), with potentially disastrous consequences for health and human development. There are strong similarities between the siting of African-Canadian communities in undesirable or unsafe locations and the experiences of other communities of colour, such as Aboriginal groups and black Americans. Researchers have explored these relationships under the rubric of environmental justice scholarship (Bullard 1994; McGurty 2007; Bolaria and Bolaria 1994). Scholars allege that these communities are taken advantage of because of low socio-economic standing and limited resources with which to contest unfair practices (Kelly 2003).

For African Nova Scotian community members with disabilities, the challenges are manifold; they face a forms of multi-layered and intersecting discrimination based on their racialized background and on their disability, as well as gender, socio-economic standing, citizenship status, sexual orientation, or place of residence (Wright 2012). Scholars have noted the difficulties that members of minority groups who live at the juncture of racial discrimination and disability face(Blanchett, Klingner, and Harry 2009, 392). Institutional racism, grinding poverty, and limited access to early intervention services compound these health-related challenges for African-descended communities (Enang 2001; Etowa, Bernard, et al. 2007).

Indeed, a 2009 Organization for Economic Development (OECD) report revealed a large disparity between poverty rates for Canadians with and without disabilities. Canada ranked fifth out of the OECD countries for poverty rate by disability status: greater than thirty percent of those with a disability live in poverty, compared to between 15 percent and 20 percent of non-disabled individuals (Sickness, Disability and Work: Keeping on Track in the Economic Downturn- Background Paper 2009, 35). Data on poverty and disability within Nova Scotia bear out this trend: In 2006 Nova Scotians with a disability earned $7,364 less than persons without a disability (Income Statistics for Persons with Disabilities in Nova Scotia, Part A: A Statistical Report 2009-10, 3). Further, the poverty rate of Canada's racialized groups is nearly double that of other poverty groups (Hayward and Colman 2003, 30).

Health services infrastructure has been and remains particularly difficult to access for the black Nova Scotian community. Enang and Etowa outline the barriers that many black community members encounter trying to obtain health resources, including long-distance travel to access services such as breast exams, dental care, and prenatal appointments (Enang 2001; Etowa, Wiens, et al. 2007). High levels of unemployment and low socio-economic status make it difficult to afford private transportation and associated costs, and public transportation in rural areas is extremely limited.

Historically, as a result of these inadequate resources, family members – primarily women – became the main caregivers, with their medicinal treatments often consisting of herbal remedies (Enang 2001). This traditional role has echoes in today's cultural norm of the "strong black woman," with which many African women in Halifax identify (Bruhier 2009). It is expected that women of African ancestry will take care of the needs of their immediate and extended families and possibly other community members, often to the detriment of their own

mental and physical well-being. The ideology of the "strong black woman" can place conscious or unconscious pressure on black women, with adverse impacts for their health status. One workshop participant noted this stereotype's impact on the provision of certain health services: "black women are not often offered an epidural during childbirth as they are perceived as stoic and strong and able to withstand the pain without medical assistance" (Enang 2001, 6).

Qualitative research into chronic disease within the black Nova Scotian context reveals that among those with type 2 diabetes, the greatest stressor they experience is family expectations of support (Bruhier 2009). Relatedly, black American women indicated that caregiving-related stress makes their diabetes difficult to control: "the diagnosis of diabetes did not seem to translate into reduced expectations from family members in terms of performing physical tasks related to caregiving or an increased amount of emotional support from family members" (Samuel-Hodge et al. 2000, 931). Shambley-Ebron and Boyle noted that, in the African-American context, broader societal stereotypes that label black women as "strong" or as "survivors" result in the perception that they would not need the help of social programs. Such labeling can create a hostile health care environment (Shambley-Ebron and Boyle 2004). In the African Nova Scotian setting, research indicates that black women fear the unwelcoming environment of a mainly white healthcare system, causing them to rely on friends and family for advice rather than seeking the support of professionals (Enang 2001, 6).

One speakers' comments about aging, caregiving, and disability at the 2012 Nova Scotia Disability Symposium elaborate on the cultural context of health services: "Black people take care of their own … from the cradle to the grave. This folklore is built on the idea that African Nova Scotians have large and supportive extended families that are socialized to look after all of our possible needs across the life span" (Wright 2012, 1). As Wright hints, the perception that

this extended support system will serve as a buffer against life's challenges can be more "folklore" than reality. For those facing intersecting oppressions, gender inequalities can interact with racial inequalities to create a situation of simultaneous oppressions. Take the case of unattached African Nova Scotian women: 57 percent of this population lives below the low-income cutoff, compared to only 13 percent of the Nova Scotian population at large ("Cost of Poverty in Canada," 11). Far beyond the individual level, the history and legacy of oppression and racism have resulted in the lowered social status of black Canadians as a group; for female black Nova Scotians, socio-economic, political, legal, and occupational disadvantages can be doubly so (Waldron 2010, 26).

Despite their shared racialized status, it is overly simplistic to assume that community members have a uniform experience across genders. A study of prostate and breast cancer experiences within African Nova Scotian communities found that the men highlighted their experiences as racialized individuals and expressed resentment about the racism they experienced from health care providers. On the other hand, female participants emphasized that their experiences with breast cancer linked them to women of all races: "We are all women and cancer is cancer" (Evans et al. 2005, 267). Nevertheless, women reported discouragement and feelings of "invisibility" when trying, unsuccessfully, to find a breast prosthesis to match their skin tone. Men emphasized the frustrating emasculation they felt in the face of prostate cancer treatments, whereas women focused on their ability to fulfill their community and family roles. These differences within the experiences of having cancer demonstrate that gender inescapably plays a role in the very personal experiences of health care service and treatment. As the authors note, "what appear to be contradictions in the findings between men's and women's experiences

and perceptions are actually affirmations of the overlapping and contextualized nature of gender, class, and race" (Evans et al. 2005, 269).

Black Nova Scotians' lack of participation in the health care system also relates to historical exclusion from resources, under-representation of African Canadians in the health professions, and cultural insensitivity on the part of non-black health care providers (Enang 2001). An overarching theme of the existing scholarship on health service provision to black Nova Scotian communities is the necessity for culturally competent and culturally sensitive policies and practitioners. Workshop and focus group participants emphasized this need, stating that Afrocentric and traditional healing practices must be valued as complements to mainstream medical approaches. Relatedly, culturally competent approaches require different understandings of disability; for instance, in a community where low literacy is the norm, a learning disability that renders reading difficult may not be recognized (Wright 2012).

Participants also emphasized the importance of having people of colour in the medical profession, who they felt could better relate to their daily struggles and challenges as well as to black health issues such dark skin and hair care (Enang 2001, 7). In one study about the experiences of black Nova Scotian women with crack cocaine addictions, participants pinpointed the lack of culturally relevant services as a major barrier to their recovery and a factor that contributed to hesitation to access treatment options. One respondent's comments on her experiences at an addiction-treatment centre vividly illustrate this point: "I am sick and tired of telling workers and counselors what it's like to be (b)lack" (Thomas Bernard 2001, 14). Waldron cautions, however, against single-minded cultural competency or cultural sensitivity approaches that obscure the structures of power that affect various social groups' experiences of health care. Writing from the perspective of occupational therapists, she notes that "the focus on culture at

the expense of other factors such as race in discussions on diversity … demonstrates a curious

reluctance to grapple with the discrimination, inequalities, exclusion and marginalization

racialized communities experience" (Waldron 2010, 21).

The Road to the CRPD

The CRPD, adopted by the United Nations in 2006, aims to ensure persons with disabilities are

able to enjoy their human rights fully and equally, and to promote and to respect their inherent

dignity (*Convention on the Rights of Persons with a Disability* 2006). The signing of the CRPD

is generally agreed to have both reflected and solidified the paradigm shift from the medical to

the social model of disability (Harpur 2012; Kayess and French 2008; Mégret 2008). The

CRPD's eight general principles include a) respect for the inherent dignity of each person,

including his or her ability to make autonomous decisions; b) non-discrimination; c) full

participation in society; d) respect for difference and equality for people with disabilities,

recognizing them as a part of humanity's diversity; e) equality of opportunity; f) accessibility; g)

equality between genders; h) respect for the capacities of children with disabilities and

recognition of their right to preserve their identities (*Convention on the Rights of Persons with a

Disability* 2006, 5).

The CRPD combines the protection of individual and group rights while creating a

framework for positive policy and public perception changes. It differs from previous human

rights treaties in that it provides practical steps and substantial detail about how each right should

be implemented and monitored. The scope of interpretation is limited and reduces uncertainty

about how a specific right should be enacted. For instance, the "right to work" is guaranteed in

Article 23 of the Universal Declaration of Human Rights (1948), but its ambiguous nature made

reforms difficult to achieve and maintain. Under the CRPD, the right is refashioned and concretized to include freedom from harassment, the redress of grievances, access to technical and vocational programs, the promotion of entrepreneurship and of employment in the public and private sectors, and the right to a safe and healthy work environment (Harpur 2012, 6-7).

Canada's signing of the CRPD was applauded by the Council of Canadians with Disabilities (CCD), the Canadian Association for Community Living, and a host of other associations that advocate for persons with disabilities. Steve Etsey, the Chair of the CCD's International Committee, praised its symbolic importance, stating "Today ushers in a new era where people with disabilities are viewed as full citizens with exactly the same rights and responsibilities as other citizens of Canada" (*Canada Ratifies United Nations Convention on the Rights of Persons with Disabilities* 2010). The CCD's National Chairperson, Marie White, spoke to the CRPD's practical applications for implementation and enforcement within Canada: "The CRPD is not simply another well-intentioned declaration without any teeth. It requires the Government of Canada to act and monitor progress in achieving the commitments of the treaty. Canada's actions to create a more accessible and inclusive society will be the subject of both domestic and international scrutiny" (*Canada Ratifies United Nations Convention on the Rights of Persons with Disabilities* 2010).

The CRPD further aims to guarantee and promote civil and political rights such as equality, life, liberty, and security of the person, as well as the aspirational goals of accessibility, independent living, health care, and full political participation. The broad range of rights identified provides the following:

- An acknowledgement and concrete international legitimization of a rights based approach to disability;
- A framework for governments and NGOs to follow when adopting disability law and policy;

- A commitment by state signatories to create greater awareness of the goals and guiding principles of the CRPD;
- A commitment by state signatories to advance research into the technology and environmental design that promotes greater social inclusion for persons with disabilities; and
- A commitment by state signatories to advance laws toward the realization of the CRPD principles, and remove legislation that creates discriminatory barriers (*Convention on the Rights of Persons with a Disability* 2006).

The CRPD has the potential to have a profound impact on the status of persons with a disability across Canada. The potential advancement of rights within the CRPD framework may be realized particularly in Atlantic Canada, which is characterized by socio-economic and health inequities at higher rates than the rest of Canada (Hayward and Colman 2003, 31). Furthermore, chronic disease affects already-marginalized groups at disproportionate rates. Low-income groups such as Aboriginal peoples, racialized minorities, single mothers and their children have worse health than the rest of the population of Atlantic Canada. Nova Scotia's diabetes rate is the second highest in the region at 5.2 percent (Hayward and Colman 2003, 11) and it has the highest rate of diabetes-related disability.

Even in the absence of precise statistics, it is clear that disability affects a significant number of the province's black citizens; further, scholars have definitively shown that low-income groups, racialized minorities, and single mothers have worse health than the rest of the region's population (Hayward and Colman 2003, 11). Articles of the CRPD addressing the links between poverty, discrimination, and disability provide a compelling call to rectify these entrenched issues in the province.

Article 19(b) explicitly refers to community inclusion and the "prevention of isolation or segregation from the community" (*Convention on the Rights of Persons with a Disability* 2006, 14), while Article 28(1) addresses the rights of persons with disabilities to adequate food, clothing, and shelter. Kelly has noted that African Nova Scotians are affected by persistent and

unacceptable levels of poor housing, physical isolation, and residence in neighbourhoods located adjacent to industrial sites (Kelly 2003). One of Etowa et al.'s focus group members recounts the substandard accommodations present in community: "You know, the doors are thin … holes in the walls are terrible, the floor hasn't been changed. It's [a] health concern. It's unsanitary. But it's cheap—they can afford it" (Etowa, Wiens, et al. 2007, 66).

The difficulties that black Nova Scotians, particularly rural-dwellers, encounter when attempting to obtain health services is also a topic of concern within the CRPD; Article 25 charges States Parties with the duty to "provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons" (*Convention on the Rights of Persons with a Disability* 2006, 18). Questions of access to health care strike at the heart of the intersecting factors that result in negative health outcomes for rural black Nova Scotians, which include poverty (and consequent inability to afford healthful foods and prescription medications), lack of transportation, and physician shortages (Etowa, Wiens, et al. 2007). Further, Article 25(c) explicitly calls upon signatories to provide health services in close proximity to the communities they serve, including rural regions, bearing strong implications for the resource access improvements needed by African Nova Scotian communities (*Convention on the Rights of Persons with a Disability* 2006, 18)

Beyond the realm of health, the CRPD also calls for equal access to education (Article 24) and to employment (Article 27), two further areas of concern for advocates of black Nova Scotians (Kelly 2003). In both these domains and the aforementioned, NSHRC has the potential to effect much-needed change for the status of African Nova Scotians with disabilities.

NSHRC and the CRPD: Pathways for the Future

The rights enshrined in the Convention have direct concern for areas of provincial jurisdiction, ranging from ensuring the accessibility of the province's physical spaces, to eliminating barriers to employment and educational opportunities, and to protecting the right of persons with disabilities to live independently and to make decisions affecting their own lives (Canada and the UN Convention on the Rights of Persons with Disabilities 2011). The NSHRC had been vigorously involved in advocacy for a holistic commitment to the rights of persons with disabilities as outlined by the CRPD. This commitment was shown in a CRPD "Lunch and Learn" in March 2012 (Nova Scotia Human Rights Commission Lunch and Learn Unknown Year), the hosting of a CRPD educational session at Dalhousie Schulich School of Law (Exploring Implementation of the Convention on the Rights of Persons with Disabilities in Nova Scotia 2013), and several plenaries when NSHRC held the annual conference of the Canadian Association of Statutory Human Rights Agencies (CASHRA) in Halifax in May 2013 (Nova Scotia Human Rights Commission- A Year of Firsts 2013) .

Considering that NSHRC was established in 1967 explicitly to combat racial, religious, and ethnic discrimination (later expanded to include other forms of discrimination such as age, gender, sexual orientation, and ability) it is logical that the struggles of disabled racialized minorities would be a priority for this body (Moving Forward with Human Rights in Nova Scotia, A Discussion Paper Presenting Issues and Options Identified in Phase I of the Organizational Review of the Nova Scotia Human Rights Commission 2001). This commitment to countering racial discrimination is also evident in NSHRC's partnership with the Canadian Race Relations Foundation in hosting the annual Award of Excellence and Symposium in

Halifax, featuring panel discussions and workshops on strategies to eliminate racism and to promote equality, multiculturalism, and treaty rights (*Symposium to Eliminate Racism* 2012).

This article has stressed that much remains to be achieved. We have shown that members of underrepresented communities with disabilities have specific unmet needs rooted in historical circumstances of racialization. Recent events sponsored by the NSHRC have sparked conversations that will foster greater awareness and commitment to implementing the CRPD to the benefit of black Nova Scotians and others. They are only a starting point, however, toward the development of practical ways of achieving these ends, and a variety of players, including researchers, health care experts and providers, and the general public need to work together. More research is required, but if limited data exist on disability in the African Nova Scotian community, this lack should not preclude the development of strategies targeting the particular need of these citizens. It is futile, however, to expect communities to reach out to service providers who do not reflect the same cultural understandings of disability or of family and community dynamics.

As acknowledged by the aspirational components of the CRPD and social conceptualization of disability from which it draws, disability exists (and is created) within specific socio-economic contexts. Efforts to remove discrimination and ableist policies will be undermined by poverty and barriers to adequate housing, transportation, health, education, and employment. Therefore, we suggest that any disability strategy for black Nova Scotians primarily must recognize the convergence of oppressions facing group members and how hierarchies of power affect both their daily lives and their interactions with health care and social service providers. We also suggest that the health and social service sector workforce be enhanced with professionals of colour, that targeted services are developed for conditions that

disproportionately affect the black community (diabetes, sickle cell disease, etc.), and that

cultural networking and health forum opportunities are provided (Bruhier 2009; Enang 2001;

Etowa, Wiens, et al. 2007). Critically, all of these recommendations should be undertaken in

collaboration with the African Canadian community and with sensitivity to the historic and

ongoing racism that community members face. The next steps forward should reflect and

promote the ideal "nothing about us without us," which figured prominently in the development

of the CRPD (Nikias 2012).

"Nothing about us without us" will conceivably ring all the more true as further supports

are implemented and the layers of discrimination peeled away so that the individuals with

disabilities become more assertive about their rights and advocate for inclusive services. Greater

awareness will improve the capacity of persons with disabilities to navigate the systems and

agencies available to them, thus diminishing learned subordination and facilitating a rise in self-

determination and empowerment.

Correspondingly, the NSHRC must invigorate its own obligations under the CRPD

regarding implementation and monitoring; regretfully, the federal government has declined to

designate a national-level CRPD monitoring body, such as CASHRA (Statement by the

Canadian Association of Statutory Human Rights Agencies on Canada's First Report Under the

Convention on the Rights of Persons with Disabilities 2014). We recommend that NSHRC

provide ongoing opportunities for the public to learn about the CRPD, ensuring that persons with

disabilities and their advocates in Nova Scotia know what their rights are and what methods of

self-advocacy are available to them. Public education also provides an opportunity for employers

and government representatives to learn what these rights mean for the ways in which they

conduct business and deliver services. From here, NSHRC can build on the priorities

communicated by communities and stakeholders, bearing in mind that other human rights-focused commissions will also devise parallel strategies. Individuals and organizations can draw on the NSHRC and its commitment to the CRPD to achieve a version of citizenship that reflects inclusion of socio-political and civil rights, ensuring that the CRPD is more than just a "paper pledge."

There is also strong potential for collaboration with organizations that advocate for the cultural rights and social well-being of black Nova Scotians, such as African Nova Scotian Affairs, which includes improvement to health status of community members as one of its primary goals (*What We Do* 2014). Additionally, it is promising that NSHRC has recently announced a "multi-year engagement strategy" focusing on the needs of African Nova Scotian communities (2014- 2015 Statement of Mandate 2014, 7-8).

States Parties will provide reports to the Committee every two years in accordance with articles 35 and 36 of the CRPD. The reports will provide a comprehensive explanation of the progress each state has made towards implementation of the Convention; in fact, Canada just completed its first report. Unfortunately, Nova Scotia's submission to the current report did not mention the specific needs of the African Nova Scotian community (Convention on the Rights of Persons with Disabilities: First Report of Canada 2014).

We have aptly demonstrated the need for improvement in awareness of and service provision to African Nova Scotians with disabilities, with critical importance given to an intersectional approach that addresses the interlocking sources of vulnerability that community members experience. It is not enough to consider disability as the only site of oppression for black Nova Scotians; many members of this community are simultaneously marginalized by self-identified and ascribed social identities such as race, gender, age, and sexuality. Further, these

identities converge with hierarchical power relations informed by centuries of discrimination as well as are impacted by institutional shortcomings such as limited educational or vocational opportunities.

This paper was not conceived to serve merely as an academic exercise, but as a call to action. Nova Scotia, and Canada more broadly, have received their orders from the United Nations. As Petricone explains, "As a ratifying state, Canada has undertaken and committed to ensuring and promoting the full realization of all human rights and fundamental freedoms for persons with disabilities … and to implement the rights recognized in the CRPD" (Petricone 2013, 22). The human rights conventions that purported to protect disabled persons in the past have been supplanted by the CRPD, since it not only has a specific disability focus but also provides considerable detail on how these rights should be executed. Indeed, Canada's ratification of the CRPD represents an unprecedented commitment by the state to disability rights. With every day that slips away, Canadians' rights are denied and their vulnerabilities are exacerbated; however, with action, tangible improvements are achievable. The CRPD has provided a long-sought-after framework for measurable improvement of quality of life for people with disabilities; it is up to us to transform these obligations from the abstract into reality.

References

2014- 2015 Statement of Mandate. 2014. Nova Scotian Human Rights Commission.

Africville dog park upsets black community. 2014. *The Canadian Press*.

Africville Park becomes on-leash for dogs as new park opens. 2015. *CBC News*.

Arim, Rubab. 2015. A profile of persons with disabilities among Canadians aged 15 years and
older, 2012. In *Canadian Survey on Disability, 2012*: Statistics Canada.

Bernard, Wanda Thomas. 2005. Black women's health in Nova Scotia: One woman's story. In
*Surviving in the hour of darkness: The health and wellness of women of colour and
indigenous women*, edited by G. S. Harding. Calgary: University of Calgary Press.

Blanchett, Wanda J, Janette K Klingner, and Beth Harry. 2009. The Intersection of Race,
Culture, Language, and Disability Implications for Urban Education. *Urban Education*
44 (4): 389-409.

Bolaria, B. Singh, and Rosemary Bolaria. 1994. Inequality and Differential Health Risks of
Environmental Degradation. In *Racial minorities, medicine, and health*, edited by B. S.
Bolaria and R. Bolaria. Halifax, N.S.: Fernwood Pub.

Borden, Chester, John Desmond, Ardith Jordan-Simmonds, Ray Merriam, Shay Paris, and
Geraldine Wright. 1999. "Looking Black," Past, Present & Future: Analysis of
Community Enhancement Association. In *We Can't Walk Alone 1999: A Path to
Community Capacity Building in Nova Scotia*. Truro, Nova Scotia: Atlantic Community
Economic Development Institute.

Bruhier, Deborah O. 2009. A Voice to be Heard. Social Barriers Impacting on Dietary
Modification: The Experiences of Women of African Descent with Type 2 Diabetes,
Applied Human Nutrition, Mount Saint Vincent University, Halifax.

Bullard, Robert D. 1994. *Dumping in Dixie: race, class, and environmental quality*. 2nd ed. Boulder: Westview Press.

Canada and the UN Convention on the Rights of Persons with Disabilities. 2011. edited by N. S. H. R. Commission: Canadian Association of Statutory Human Rights Agencies.

Canada Ratifies United Nations Convention on the Rights of Persons with Disabilities. Council of Canadians With Disabilities 2010. Available from http://www.ccdonline.ca/en/international/un/canada/crpd-pressrelease-11March2010.

Canada's Ethnocultural Mosaic. 2008. Ottawa: Statistics Canada, Minister of Industry.

Christensen, Carole P. 1998. Social welfare and social work in Canada: Aspects of the black experience. In *Re/visioning: Canadian perspectives on the education of Africans in the late 20th Century*, edited by V. D'Oyley and C. James. North York: Captus Press.

Coburn, David, Keith Denny, Eric Mykhalovskiy, Peggy McDonough, Ann Robertson, and Rhonda Love. 2003. Population health in Canada: a brief critique. *American Journal of Public Health* 93 (3):392-396.

Cohen, Benita E. 2006. Population Health as a Framework for Public Health Practice: A Canadian Perspective. *American Journal of Public Health* 96 (9):1574-1576.

Collins, Patricia Hill. 2015. Intersectionality's Definitional Dilemmas. *Annual Review of Sociology*.

Convention on the Rights of Persons with a Disability. Secretariat for the Convention on the Rights of Persons with Disabilities 2006. Available from http://www.un.org/disabilities/default.asp?navid=14&pid=150.

Convention on the Rights of Persons with Disabilities: First Report of Canada. 2014. Government of Canada.

Enang, Josephine. 2001. Black Women's Health: A Synthesis of Health Research Relevant to

Black Nova Scotians. Halifax: Maritime Centre of Excellence for Women's Health.

Etowa, Josephine B, Wanda Thomas Bernard, Bunmi Oyinsan, and Barbara Clow. 2007.

Participatory action research (PAR): An approach for improving black women's health in

rural and remote communities. *Journal of Transcultural Nursing* 18 (4):349-357.

Etowa, Josephine, Juliana Wiens, Wanda Thomas Bernard, and Barbara Clow. 2007.

Determinants of black women's health in rural and remote communities. *CJNR*

(Canadian Journal of Nursing Research) 39 (3):56-76.

Evans, Joan, Lorna Butler, Josephine Etowa, Iona Crawley, Daniel Rayson, and David G Bell.

2005. Gendered and cultured relations: exploring African Nova Scotians' perceptions and

experiences of breast and prostate cancer. *Research and theory for nursing practice* 19

(3):257-273.

Exploring Implementation of the Convention on the Rights of Persons with Disabilities in Nova

Scotia. 2013. Halifax, Nova Scotia: Nova Scotia Human Rights Commission and the

Disabled Persons Commission.

Frohlich, Katherine L, and Louise Potvin. 2008. Transcending the known in public health

practice: the inequality paradox: the population approach and vulnerable populations.

American Journal of Public Health 98 (2):216-221.

Harpur, Paul. 2012. Embracing the new disability rights paradigm: the importance of the

Convention on the Rights of Persons with Disabilities. *Disability & Society* 27 (1):1-14.

Hayward, Karen, and Ronald Colman. 2003. The Tides of Change: Addressing Inequity and

Chronic Disease in Atlantic Canada. Halifax: Population and Public Health Branch.

Income Statistics for Persons with Disabilities in Nova Scotia, Part A: A Statistical Report. 2009-
10. Dartmouth, Nova Scotia: Disabled Persons Commission.

James, Carl. 2010. *Race & well-being : the lives, hopes, and activism of African Canadians*.
Halifax: Fernwood Pub.

Kayess, Rosemary, and Phillip French. 2008. Out of darkness into light? Introducing the
Convention on the Rights of Persons with Disabilities. *Human Rights Law Review* 8
(1):1-34.

Kelly, Brynn. 2003. A Brief Overview of Policy Issues Related to Rural Nova Scotia's Black
Community. In *Rural Communities Impacting Policy*. Nova Scotia: Coastal Communities
Network; Atlantic Health Promotion Research Centre.

Lukin, Josh. 2013. Disability and blackness. In *The disability studies reader*, edited by L. J.
Davis. New York, NY: Routledge.

McGurty, Eileen Maura. 2007. *Transforming environmentalism: Warren county, PCBS, and the
origins of environmental justice*. New Brunswick, N.J.: Rutgers University Press.

Mégret, Frédéric. 2008. The disabilities convention: human rights of persons with disabilities or
disability rights? *Human Rights Quarterly* 30 (2):494-516.

Mensah, Joseph. 2002. *Black Canadians: history, experiences, social conditions*. Halifax, N.S.:
Fernwood Pub.

Moving Forward with Human Rights in Nova Scotia, A Discussion Paper Presenting Issues and
Options Identified in Phase I of the Organizational Review of the Nova Scotia Human
Rights Commission. 2001. Nova Scotia Human Rights Commission, Praxis Research &
Consulting Inc.

Nelson, Jennifer J. 2011. "Panthers or Thieves": Racialized Knowledge and the Regulation of

Africville. *Journal of Canadian Studies/Revue d'études canadiennes* 45 (1):121-142.

Nelson, Jennifer Jill. 2001. The Operation of Whiteness and Forgetting in Africville: A

Geography of Racism, Department of Sociology and Equity Studies in Education,

Ontario Institute for Studies in Education at the University of Toronto.

Nikias, Vangelis. *Convention on the Rights of Persons with Disabilities: Overview and Next

Steps for an Accessible and Inclusive Society* 2012. Available from

http://www.ccdonline.ca/en/international/un/canada/vangelis-nikias-June2012.

Nova Scotia (Code 12) (table). 2013. In *"National Household Survey (NHS) Profile." 2011

National Household Survey. Statistics Canada Catalogue no. 99-004-XWE.* Ottawa:

Statistics Canada.

Nova Scotia Human Rights Commission Lunch and Learn. Unknown Year. Nova Scotia Human

Rights Commission.

Nova Scotia Human Rights Commission- A Year of Firsts. 2013. Canadian Association of

Statutory Human Rights Agencies and the Nova Scotia Human Rights Commission.

Omansky Gordon, Beth, and Karen E Rosenblum. 2001. Bringing disability into the sociological

frame: A comparison of disability with race, sex, and sexual orientation statuses.

Disability & Society 16 (1):5-19.

Pearson, Holly Ellen. 2012. A methodological approach to examining racial and ethnic

minorities with disabilities: intersecting and interlocking race/ethnicity, disability, and

gender, Sociology, Iowa State University, Ames.

Petricone, Ivana. 2013. Disability Law Primer. ARCH Disability Law Centre.

Rioux, Marcia, and Tamara Daly. 2006. Constructing Disability and Illness. In *Staying Alive:*

Critical Perspectives on Health, Illness, and Health Care., edited by D. Raphael, M.

Rioux and T. Bryant. Toronto: Canadian Scholars' Press.

Samuel-Hodge, Carmen D, Sandra W Headen, Anne H Skelly, Allyson F Ingram, Thomas C

Keyserling, Ethel J Jackson, Alice S Ammerman, and Tom A Elasy. 2000. Influences on

day-to-day self-management of type 2 diabetes among African-American women:

spirituality, the multi-caregiver role, and other social context factors. *Diabetes Care* 23

(7):928-933.

Samuels, Gina Miranda, and Fariyal Ross-Sheriff. 2008. Identity, oppression, and power:

Feminisms and intersectionality theory. *Affilia: Journal of Women & Social Work* 23

(1):5-9.

Saulnier, Christine. 2009. Poverty Reduction Policies and Programs. The Causes and

Consequences of Poverty: Understanding Divisions and Disparities in Social and

Economic Development in Nova Scotia. In *Social Development Report*. Nova Scotia:

Canadian Council on Social Development, Canadian Centre for Policy Alternatives.

Shakespeare, Tom. 2006. The social model of disability. In *The disability studies reader*, edited

by L. J. Davis: Taylor & Francis.

Shambley-Ebron, Donna Z, and Joyceen S Boyle. 2004. New paradigms for transcultural

nursing: Frameworks for studying African American women. *Journal of Transcultural*

Nursing 15 (1):11-17.

Sickness, Disability and Work: Keeping on Track in the Economic Downturn - Background

Paper. 2009. Organisation for Economic Co-Operation and Development: Directorate for

Employment, Labour and Social Affairs.

Statement by the Canadian Association of Statutory Human Rights Agencies on Canada's First
Report Under the Convention on the Rights of Persons with Disabilities. 2014. Canada
Human Rights Commission.

Stienstra, Deborah. 2012. *Disability rights*, *About Canada series*. Halifax: Fernwood Pub.

Symposium to Eliminate Racism. Human Rights Commission 2012. Available from
http://novascotia.ca/news/release/?id=20121002002.

Thomas Bernard, Wanda. 2001. Including Black Women in Health and Social Policy
Development: Empowering Black Mothers with Addictions to Overcome Triple
Jeopardy. Maritime Centre of Excellence for Women's Health.

Waldron, Ingrid R.G. 2010. Challenges & opportunities: Identifying meaningful occupations in
lower income, racialized communities in North End Halifax. Halifax: North End
Community Health Center.

What We Do. African Nova Scotian Affairs 2014 [cited June 27, 2014]. Available from
https://ansa.novascotia.ca/work.

Whitfield, Harvey Amani. 2005. *From American Slaves to Nova Scotian Subjects: The Case of
the Black Refugees, 1813-1840*. Edited by B. D. Cummins and J. L. Steckley. Vol. 2,
Canadian Ethnography Series. Toronto: Pearson Education Canada Inc.

Working Together to Better Serve All Nova Scotians: A Report on Consumer Racial Profiling in
Nova Scotia. 2013. Halifax: Nova Scotia Human Rights Commission.

Wright, Robert S. 2012. Caregiving, Aging, and Disability within the Black Nova Scotian
Community Paper read at Nova Scotia Disability Symposium.