

Title: Putting a Finger on Pulse of African Nova Scotians

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What will it take for us to know the rate of chronic diseases such as high blood pressure in African Descended/Black communities in Nova Scotia?

As a healthcare provider it is very disheartening to see a member of the Black community admitted to hospital with end-stage kidney disease or other complications related to high blood pressure (hypertension) or diabetes. Often this progression could be prevented by earlier detection and management of this condition.

The recent news release from the Department of Health and Wellness highlights the significant association between high blood pressure and people of African descent! Data from the United States (US) shows that there is a higher rate of high blood pressure (up to 47%) in adult non-Hispanic Black Americans compared to adult non-Hispanic White Americans (33.4%).

African Americans develop high blood pressure at a younger age than other racial and ethnic groups in the US. They are also more likely to develop complications such as a stroke, kidney disease, and heart disease. In addition African Americans respond differently to high blood pressure drugs than do other racial and ethnic groups.

In the US it is estimated that one of three people with diabetes, and one of five people with high blood pressure will go on to develop chronic kidney disease.

We believe that the health disparities in African Nova Scotians are a mirror image of those in African Americans. Unfortunately we can only speculate and project from the statistical data provided by the US. We are not yet systematically collecting data on the burden of chronic diseases, such as high blood pressure, in African Nova Scotians.

We know that there are health disparities or gaps, in the quality of health and health care in Nova Scotian Black communities. We know that socioeconomic status, level of education, and other factors also play a major role.

A retrospective population-based analysis published in 2008 demonstrated quite clearly that African Nova Scotians in one specific community had higher levels of morbidity associated with specific diseases compared with the White population in similar communities. These diseases included the categories of circulatory disease (including hypertension), and diabetes mellitus.

How do we address health inequities in the local Nova Scotian context? Do we simply ignore them and hope that they will fade away? Or do we face them head-on and develop strategies to “even the playing field”?

Are we providing optimal health care to African Nova Scotians at this time of limited resources? Surely our healthcare dollars would be more efficiently used to prevent hospitalization, and progressive complications from chronic diseases such as a high blood pressure.

Addressing health disparities in Nova Scotia must begin with identifying the nature of these disparities, and the groups at risk, by collecting healthcare information stratified by diversity factors such as race, ethnicity and language.

Analysis of this data would be essential for evidence-based decisions, health promotion and prevention activities, and management of chronic diseases.

Interestingly the US, after extensive documentation of the health disparities among racial and ethnic minorities, chose to create the “Office of Minority Health (OMH)” in 1986. The mission of the OMH is “to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities”. The OMH has a number of strategic priorities including improving data collection and reporting standards.

So how best do we undertake the task of documenting the burden of chronic diseases in African Nova Scotians? What about the cost to the system and do we have the capacity to collect this data in a cost efficient manner?

The Health Association of African Canadians (HAAC) feels that this would require a collaborative effort between the Province, and all levels of the health care system. We feel that one cost-effective method of collecting this data would be to modify the MSI data collection system and request that all Nova Scotians are given the opportunity to self-identify by race and ethnicity.

We feel that all African Nova Scotians need to be aware of their health risks. They should be active participants in health care decision-making including policy, planning, and programs. Providing information on the burden of chronic diseases, such as high blood pressure, in African Nova Scotians would be essential in that regard.

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