INFLECTION POINT

ASSESSING PROGRESS ON RACIAL HEALTH INEQUITIES IN CANADA DURING THE DECADE FOR PEOPLE OF AFRICAN DESCENT

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INTRODUCTION

As the midpoint of the United Nations Decade for People of African Descent, 2020 offers engaged citizens a useful inflection point to assess progress on key policy concerns for communities of African Descent across Canada. Despite the Government of Canada's early reluctance to acknowledge the Decade, and the belated acknowledgement by federal and provincial leaders of the persistence of anti-Black racism, we arrive into this new decade with the health and wellbeing of Black Canadians under more scrutiny than ever before.

BARRIERS TO REFORM

What we find when we peer into the microscope and focus on Canada's health systems is a work in progress: an uneven blend of institutions who acknowledge discrimination in health service provision and policymaking but that act with a lack of urgency in attempting to remedy systemic discrimination. We continue to hear stories like that of Matthew John Derrick-Huie, who was denied vital treatment for a spinal fluid leak for sixty days due to racist stereotyping, or that of former Lieutenant Governor of Nova Scotia Mayann Francis, who suffered stereotyping upon recovery from an operation (Amin, 2019; Devet, 2019). These individual experiences are paired with system-wide blind spots about the health status of Black Canadians, as Nnorom et al. (2019) show in their scoping review of breast and cervical cancer studies of Black women. This evidence is just a slice of the experiences that show that the rhetoric of recognition falls short in leading to tangible results for those who need it most.

Policymakers often still fall into the trap of reducing discussions of racism in health systems to a challenge of individual bad behaviour rather than confronting the larger issue: an uneven and unjust distribution of ill health along racial lines. Initiatives like cultural competency training and increased diversity among organizational leaders are important, but they only scratch the surface of the challenges that Black Canadians face with health inequities – and that is if health authorities even venture to take these initiatives seriously. What is needed is a complete overhaul of the processes that provincial governments use to develop and implement health policy.

Organizations like the Canadian Public Health Association are helping to raise awareness of the pressing need for change. The Association adopted a position statement in 2018 called which outlines key policy recommendations for all levels of government that include "organization-wide reviews of their systems, regulations, policies, processes and practices to identify and remove racist approaches", as well as the collection and analysis of race and ethnicity data (Canadian Public Health Association, 2018). Progress on these laudable goals, however, is slow going.

One of many reasons for the neglect of racial health inequities across the country has been the lack of disaggregated race-based health data that could further illustrate the extent to which racism affects the health and healthcare of Black Canadians. In Nova Scotia, the Health Association of African Canadians as an organization has been advocating for the use of disaggregated race-based health data for 20 years. The members of HAAC – members of the public, frontline workers, policymakers and others – have seen firsthand the challenges that a lack of disaggregated data presents to their work as an organization, and to their lives as community members.

LIVING WITHOUT DISAGGREGATED DATA

Without data to better describe the extent of health inequities for Black Canadians, policy progress is tenuous. Individual experiences of discrimination, similar to those highlighted above, are ignored or removed from their broader systemic context. System-wide challenges of low service utilization and increased rates of chronic disease including hypertension and diabetes among people of African descent can be explained away due to other contextual factors. The lack of urgency within governments about health inequities becomes, in this framing, understandable. It is indicative of the processes of social and economic exclusion that underpin racism as a "fundamental cause" of health inequities (Williams, Lawrence, & Davis, 2019).

A lack of disaggregated data also has an impact on organizations, like HAAC, who have stepped up to push for a better health system for people of African descent. Programs that HAAC has initiated or co-led, such as the Nova Scotia Brotherhood Initiative or the Matter of Black Health Coaches, can be framed as relying on anecdotal data despite their potential efficacy. They are often given piecemeal, contingent funding that does not support widespread impact. Yet when they are funded, they demonstrably improve experiences of the health system for people of African descent in the province.

MOVING FORWARD

To shift these barriers and move Nova Scotia's health system towards health equity, community advocates and engaged policymakers have decided to take a different approach. HAAC, in collaboration with the Decade for People of African Descent Coalition and community leaders from across the province, has entered into a community policy co-creation effort to transform the way that the Nova Scotia Health Authority develops and delivers healthcare. The African Nova Scotian Health Strategy emerged from years of dedicated advocacy from community members who could see the toll that health inequities were exacting on communities of African descent across the province.

The strategy emerged from a report written by Dr. Ingrid Waldron that engaged 18 communities of African descent across the province. While the report, and the strategy, are yet to be officially released, disaggregated data collection was one of the top priorities for community members across the province. It came up in every consultation. Members of the public perceive that the information policymakers are using to make decisions about service provision and planning and resources is flawed; that it does not include them or their experiences.

CONCLUSION

The importance of disaggregated data collection for African Canadian communities applies to contexts broader than health – policing, education, environmental policy and more are all affected by processes of aggregation too. We must be careful, however, to avoid the mistake of suggesting that the findings of this data may be more valid than the experiences and advocacy of community members. Doing so would simply reproduce the processes of exclusion that already exist. Moreover, the data that does exist largely confirms and doubles down upon the suspicions and lived experiences that community members have been discussing for years.

This data collection is, nonetheless, a vital step for governments that are ready to take the concerns and experiences of Black Canadians seriously. When paired with long-term, authentic processes of engagement and policy co-design, this step could mark a Decade of true reform. Recognition is not enough – the tools to dismantle health inequities already exist. It is high time that we begin to use them.

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