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Black-African People, Diet, and Hypertension: It's Time We Speak with Nuance.

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Hypertension is a common condition in African-descent[1] communities in the West, as it is in those from the Caribbean. It is well known that, overall, Black people are collectively suffering from disproportionately high rates of high blood pressure, including pregnancy-induced high blood pressure (pre-eclampsia), pre-hypertension, and the chronic condition of hypertension itself. In the UK, 1-4 adults have high blood pressure (British Heart Foundation, 2021), yet Black people are 3-4x more likely to suffer from hypertension than their white British counterparts (Action on Salt, 2010)[2]. This disparity has been the case for far too long and, despite hypertension being often labelled as an 'avoidable condition', public health bodies have not adequately identified and targeted reduction and eradication of this disparity. If anything, I believe that they have held onto racial biases and colonial misinformation about our genetics and cultures, and have heightened the significance of individual and group behaviours over that of structural violence and psychosocial stressors, reducing (and even overlooking) their significance completely. Moreover, in the cases where individual choices are the most significant risk factors, there is a grave lack of nuance; for example, health professionals isolate health behaviours from the influence of employment, discrimination, mental health, and other socio-structural factors that *intersect* to strongly impact one's ability to live out a healthy lifestyle. In medical anthropology/ the social sciences, the intersectionality between the social, structural, and individual/ group health is understood via the theories of 'syndemics'[3] and biopsychosociality[4].

One belief the public health system has pushed, and one which we have internalised, is the idea that African foods are **inherently** unhealthy and that our cooking practices **centre** using excessive amounts of salt. Growing up, I would always hear my parents warn us not to add "too much salt" to our food so that we wouldn't predispose ourselves to hypertension. I would also hear much talk about 'Black food' and how it is so ridiculously unhealthy- full of salt and oil- from public health campaigns, but *zero* mention of any other risk factors that are significant for us, such as psychosocial stress. Growing up, all I ever heard from both Black and white adults was how our foods, our diets, and our lifestyle choices were to blame for the mass crisis of hypertension. However, I never *quite* believed them because I never felt that the food at home or at African gatherings was any saltier (or fattier) than the foods I ate at school or in white spaces; so, to me, this discrepancy made me question the legitimacy of the claims that my cultural and indigenous foods were "bad" and "unhealthy". If anything, I thought the opposite: every main meal that was consumed in my parents' house, and I mean every, was made from scratch. We were an African, migrant, working class household but, despite the financial obstacles that pervaded my childhood and teenage years, my parents somehow (and mostly) managed to ensure that we ate three times a day and that foods we did eat were homecooked and nutritious.

For us, processed snacks and sugar-sweetened drinks were a seldom-afforded luxury outside of the lunches we bought at school when we became teenagers. And even then, lots of fruit and water was included. Moreover, our diet in the house was still largely indigenous. As Zambian migrants, my parents

[1] African, in this article, refers to those from sub-Saharan Africa.
[2] This source is from the Action of Salt campaign from 2010, so it's old, Nevertheless, I've used it as I've been unable to find specific risk statistics for Black/ African people in the UK in more recent publications; the ones I've found simply state that we are at "higher" risk. Also, with the socio-political climate and public health environment over the past decade, I doubt that our risk has reduced from 3-4x.
[3] For further reading, see **Singer** (2003), **Singer,. et al** (2017), and **Mendenhall** (2019) as listed in the bibliography.
[4] For further reading, research the '**John Henry Hypothesis**' (theorised by Sherman James) and '**Sojourner Syndrome**' (theorised by Leith Mullings). The papers and books I've used from them can be found in the bibliography.

tried their best to ensure that we were raised never forgetting the tastes of home; thus, our main meals almost always included Zambian staples and lots of fresh vegetables. Fried and/ or super salty foods, like chips, were a treat that we'd only have if my Mum was too tired after work to cook a 'proper meal' (which was rare as she was a nurse and didn't compromise on our nutrition), or if it was a special occasion. Moreover, microwavable/ instant meals were a thing I'd only ever seen on TV adverts or in shops and, with the way my parents spoke about them (mainly regarding their severe lack of nutrition), I still don't touch them to this day. So, once again, knowing the dietary reality of my family- and several other African (and Caribbean) families- the heavily stigmatised rhetoric around our cultural foods, diets, and overall cultures just didn't make sense. Again, my diet was far healthier than the diets of my white friends and classmates all throughout school (although, this is not to say that no individuals or households have poor diets). It was only until I reached sixth form, and moved to a very middle-class school (where one of my peers was literally the child of a consultant my Mum worked under), that I began to think "oh okay, maybe I can be healthier". This was because my new, richer classmates had habits I had never been exposed to before; for example, some of them were vegetarian or vegan, some of them brought salads for lunch every day, and some of them bought fresh smoothies or drank water exclusively. For the first time, some of my white counterparts had a healthier diet than myself and my handful of fellow POC friends. However, this was only because they could afford to; they could afford to consume smoothies and salads every (other) day. And, for the first time, I began to see just how expensive eating clean in a Western diet was, and the ways in which my cultural diet was objectively healthy and the ways in which it wasn't. For the first time, I noticed the role of socio-economic status, and structural violence, in accessibility to healthy eating *according to Western standards*.

Fast forward to university, where I took a real interest in racial health disparities in cardiovascular diseases; I found evidence to back my perception of the relationship between 'African culture', health behaviours, and cardiovascular risk. One particularly relevant research finding I came across was the theory of ***dietary acculturation***. In sum, it investigates how (im)migrants[5] assimilate into Western culture through changes in diet, and the politics and health consequences of it (Satia-Abouta, 2003; Satia, 2010). Unsurprisingly, research has found that traditional African diets (and general dietary habits, such as low-level snacking (Satia-Abouta, 2003; Osei-Kwasi et al., 2017)) are quite healthy in comparison to Western diets- which tend to be high in fat, low in fruits and vegetables, and include frequent snacking- and that the greater the dietary acculturation, the poorer African (im)migrants' health becomes (Okafor et al., 2014). I say that this finding is unsurprising because I have certainly witnessed its evidence in my own life and in the African spaces I occupy, but also because, globally, entire communities didn't begin to suffer from salty/ fatty diet-related chronic illnesses until the '***nutrition transition***'- a nutritional shift towards the increased consumption of processed foods, edible oils, sugar-sweetened beverages, and non-home cooked foods, that began in the West in the late 1900s (Reddy & Katan, 2003; Popkin et al., 2012; Banda, 2020b). The nutrition transition is believed to be the consequence of neo-colonial forced cultural assimilation, capitalist economies and economic principles, neoliberal business values and freedoms, globalisation, and a general global increase in poverty (de Vogli et al., 2014; Guardian, 2018; Legge, 2018; Monaghan, 2018; Lolas et al., 2019; Banda, 2020b). In addition to this, the nutrition transition is marked by a simultaneous reduction in physical activity and an increase in sedentary behaviour, as well as the obesity epidemic, made possible by a culture that promotes obesity. This is theoretically known as the '***obesogenic environment***'/ '***globesity'*** (Satia, 2010; Costa-Font & Mas, 2016, Banda, 2020b). Therefore, it's unsurprising that African people's traditional/ indigenous diets are healthier than Western diets, and that their health becomes poorer after dietary acculturation here in the West, when the West is known for cultivating the obesogenic environment and obesity crisis, and has been for decades. What is unfortunate, however, is how structural unhealth is seldom ever acknowledged when it comes to the context of- and and risk factors

[5] By (im)migrants, research means those in the first generation; i.e. they were not born in the UK but now reside here.

in- the relationship between African people's diets and hypertension/ disease risk; our behaviours, cultures, and other expressions of Blackness are problematised and demonised whilst expressions of white culture and legacies of forced colonial assimilation are wholly overlooked.

What I also found was worthy of noting is the fact that, despite African diets being blamed as the primary reason for our disposition to hypertension and other non-communicable diseases, our counterparts back in our home-countries have lower rates and risks of the diseases than we do here (Okonkwo, 2002; Okafor et al., 2014). Given the stigmatising rhetoric surrounding our traditional/ indigenous diets, this difference is shocking- scandalous, even- because it strongly challenges the argument that traditional African foods, diets, and cooking methods are the *primary* reason for our risk. By stating this, I'm not suggesting that our diets are completely 'green' or 'clean', nor am I arguing that our none of our traditional foods are high in salt and/ or saturated fats. What I *am* stating is that the belief that the consumption of "African foods" is the underlying reason for African Western populations' disposition to hypertension is reductive, piecemeal, and inaccurate. Moreover, it erases the distinctions between our various cultural and national foods; as a southern African, I was disappointed to find that public health research and narratives reduce 'African foods' to West African foods, basically reinforcing the racist notion that Africans are homogenous. If the reductive diet argument wasn't these things, then the majority of our counterparts back in our indigenous lands would show similar rates for risk and prevalence. But they don't. This, to me (and several other social scientists) suggests two things: a) our collective and cultural diets are not as significant in risk as white health experts have argued them to be (although they certainly still matter), and 2) there are other factors- specific to existing while Black in the West- that play a more significant role than is being acknowledged, researched, and discussed.

A few critical perspectives have been applied to public health, by mostly Black academics, in attempts to expand knowledge and explore nuance in the health disparities that affect us. Included in these are the '***John Henry Hypothesis***' (pioneered by Sherman James, 1987; 1994), the '***Weathering Hypothesis'*** (theorised by Arline Geronimus, 1992), and the '***Sojourner Syndrome***' (first argued by Leith Mullings, 2001; 2002). However, these aren't really known outside of Black academic spaces, nor are they actively applied in medical education, theory, or practice. I believe that this needs to change. But, change must start with us: we *need* to begin speaking about our risk, diets, and cultures with nuance, and reject the colonial, anti-Black language and ignorance that is ingrained into Black health narratives if we want our medical practitioners and healthcare system to.

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