

**Health Perspectives | Undergraduate Health Studies Journal**

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[www.uc.utoronto.ca/uhsj](http://www.uc.utoronto.ca/uhsj)

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University of Toronto

ISSN 2292-1311



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## Foreword

As the Director of the Health Studies Program at UC, it is my pleasure to once again introduce this year's volume of *Health Perspectives*, the interdisciplinary journal of the Health Studies undergraduate program at the University of Toronto. This marks the sixth year that the journal has been produced – starting in 2009, students in the Health Studies program have created a high quality, peer-reviewed journal every year, giving undergraduate students a place to publish their academic work.

This year's edition of *Health Perspectives* has seven original articles that have been written, edited, and published by student contributors. Articles cover health issues across the life course, and explore health issues in Canada and internationally, showcasing the range of interests of our students in approaching the study of health. The articles are united in their careful attention to cultural and structural factors in the production of health and wellness, and in the high quality of their scholarship.

Since the inaugural edition of the journal, many Health Studies students have played important roles in keeping this student-run initiative alive and thriving. This year I want to say a special thanks to Rowena Symss, Editor-in-Chief, and the entire *Health Perspectives* team who have all worked extremely hard to get this year's edition of the journal to press.

I sincerely hope you enjoy reading this issue of *Health Perspectives*!



**SARAH WAKEFIELD**

*Director | Health Studies Program  
University of Toronto*

## A Note from the Editor

It is with great pride and gratitude that I introduce the 2015 issue of *Health Perspectives*. The diverse analyses represented in these pieces reflect the critical nature of the Health Studies program and, correspondingly, the broad manner in which "health" should be conceptualized.

Each of the selected seven authors, drawn from varying disciplines, uniquely convey the relation between current issues and their respective implications at the individual level. Engaging with topics such as Bill C-51, Canadian extractivism, Indigenous Food Sovereignty, and more, these works collectively paint an extensive network of interactions that we aim to bring to light through the journal. I would like to thank these authors, and all those who sent their submissions, for sharing their work with the *Health Perspectives Journal* and for contributing to the expanding analytical discourse on "traditional" definitions and treatments toward well-being.

I would also like to extend my sincerest thanks to the *Health Perspectives* Executive and the Health Studies Program Coordinators, without whom this publication would not have been possible. Alongside our talented authors, their invaluable contributions have made this a truly rewarding experience.

I hope that all of our readers similarly enjoy their experiences with these pieces. I hope each essay encourages further critical analyses to appreciate the significance of their content. Most importantly, however, it is our aspiration in publishing this volume of *Health Perspectives* to inspire readers to refine and share their own perspectives on the broad spectrum of issues pertaining to health.

**ROWENA SYMSS**

*Editor-in-Chief | Health Perspectives 2015*



# **“Coming Out”, Stigma and Support: Distress and Health Consequences Among Sexual Minorities within a Stress Process Model Framework**

**ANSON AU**

The stress process model, first conceptualized by Leonard Pearlin, constitutes a framework in the sociology of mental health through which mental health can be examined in terms of stress. As to categorical disorders, the dominant approach in psychiatry where individuals are broadly classified as disordered or non-disordered, stress comprises a continuous mental health process, but whose effects on mental health are often dismissed as “normal”. Much research in the area, however, has identified the significance of stress in its potential to map disorders. This is not to disregard the importance of disorders, but to appreciate the crucial role of stress in shaping disorders, among other mental health consequences.

The stress process model interprets stress through three fundamental processes: stressors, coping resources and social support, and mental and multiple health consequences. It has been used to explain mental health in terms of its effects in different contexts, including family (Aneshensel, 1992) and the workplace (Glavin, Schieman, & Reid, 2011), and to frame stress as a consequence of various factors such as life events (Wheaton, 1994), daily hassles (Aneshensel, 1992), chronic stressors such as structural entrapment in unfavourable positions (Aneshensel, 1996; Dressler, 1988; Wheaton, 1997), traumatic events (Wheaton et al., 2013), and non-events in which stress is accrued through just the anticipation of possible future events such as the recurrence of rape (Gersten et al., 1974; Thoits, 1983; Wheaton, 1994; Wheaton et al., 2013).

Drawing from a framework informed by the stress process model, this paper aims to examine the stressful experiences of sexual minorities. Its results draw attention to largely chronic and non-event stressors rooted in social norms and stigma, and link health consequences, including behavioural dysfunctions and habits of substance abuse, to the diminishment of coping

resources. I conclude by highlighting the limitations of this study and trajectories for future development in this nascent area of sexual minority stress as conceived by the stress process model.

### **Social Roots of Sexual Minority Stressors**

The most recent report by the Institute of Medicine (IOM, 2011) indicates that sexual minorities continue to face unique health disparities that lead to substance and alcohol use, and are more likely to be subject to violence and discrimination. Norms and societal reactions from outside the LGBTQ community constitute a salient stressor for the sexual minority.

Societal reaction is often perceived by “closeted” individuals (those who have not disclosed their sexual orientation) in a negative light, regardless of whether this is true or otherwise; those who have not disclosed their identities to people within their social networks are often concerned over the moment of and consequences of revelation to significant others. This perception translates into a form of non-event stressor, whereby a person anticipates backlash from others for disclosure, regardless of its actual probability (Bjorkman & Malterud, 2012). The person consequently lives in a state of continued fear and insecurity, eroding personal resources and possibly resulting in lowered self-confidence and sense of control. If a negative reaction from their social environment is indeed present, sexual minority individuals may be prompted to internalize the negative messages into self-stigma (Lewis et al, 2001; Meyer, 2003). Hence, sexual minority stressors include both external sources via discrimination and internal sources via self-stigma. This is reflected in evidence from Meyer (2003) and is in agreement with the IOM’s 1999 report on lesbian health, which discusses how lesbians experience stress (likely non-event) from everyday life in addition to living in a homophobic society.

However, within the sexual minority community itself, there may exist other subcultures that endorse value systems comprising alternate forms of discrimination, and therefore additional sources of stress. While its findings cannot be imposed on other communities, one study identifies physical appeal as a theme underlying interactions within the Toronto gay community, whereby success as an individual within this community is

construed to be determined by the number of sexual encounters an individual can acquire in anonymous contexts (Green, 2008). Green (2008) further investigates the underlying stratification within the sexual minority community based on physical appearances. His findings indicate that, within the study, this standard was commonly used in evaluating others and the self, and two prominent themes of evaluation emerged: attractiveness and race. For the former, the young and muscular (attributes required to be simultaneous) are favoured versus the old and/or non-muscular; for the latter, the white person is favoured over Asian, black, or any other race. In both cases, individuals with characteristics deemed unfavourable are vulnerable to ostracism in both virtual (profile descriptions, on apps and online dating media, that preclude them) and physical (being ignored or rejected) contexts.

The sustenance of this norm may be sourced to the economic interests of corporations associated with the topic, such as condom companies. Advertisements for condoms are usually placed in the vicinity of gay clubs or bars, in which young, muscular white men and multiple partners are depicted (Green, 2008). Muscular white men and multiple partners could thus be aligned with gay interactions by members of the gay community who frequent these clubs, potentially reinforcing the aforementioned hierarchy or norm of sexual appeal. Should this line of reasoning hold true, then the sexual minority who is also a race minority could be more likely to face discrimination (Eguchi, 2011) and accrue a large stress burden from four potential sources: the anticipatory fear of stigma from the public, actual negative reactions from the public for their sexual orientation, disparagement from the sexual minority community for their race or appearance, and self-stigma from internalization of any combination of the previous conditions or difficulties with negotiating multiple identities (Eguchi, 2011). Higher levels of discrimination and perceived stigma in turn, are associated with depressive symptoms and other negative mental health outcomes, including alcohol and substance use (Herek & Garnets, 2007; Szymanski, Kashubeck-West & Meyer, 2008; Hatzenbuehler, 2009).

Any structure of social stratification shapes social comparison processes that can be internalized when unfavourable, leading to self-deprecation (McLeod & Nonnemaker, 1999). Thus, if applied to the extant stratification structure based on physical attractiveness illustrated by Green (2008) in the Torontonion case, individuals with traits deemed unfavourable within this hierarchy (with “less appealing” physical appearances) can internalize disapproval from the communities within which they are located. This can damage a person’s sense of control and self-confidence, and in turn degrade their coping resources. Two possible consequences emerge from this. First, as Green (2008) notes, those who experience a lack of self-confidence or sense of control, in the event that they are chosen for a sexual activity, are more likely to submit to others even if the decision to be made is one against their principles (e.g. intercourse without a condom); furthermore, a lack of self-confidence could translate to poor decision making in other domains of life beyond the sexual, such as in work or family-related settings. Second, multiple health outcomes may surface in the form of alternative behavioural strategies such as substance and alcohol abuse, which may be used to compensate for low mastery and high powerlessness (Seeman et al., 1988).

Aging is another consideration when mapping the stresses experienced by members of sexual minorities – and more broadly, within any person’s life. When a person with a high sense of control encounters a stressor beyond the scope of their expectations, the impact of it can be more cataclysmic than if someone with a lower sense of control experienced it. For instance, in the Torontonion example, an individual with high status in the gay community who loses this status may experience a disproportionately large impact on his personal coping resources, and would require more adaptation to this loss than a person who had a low status from the start. This parallel is strictly intended to illustrate the potential effects of aging on the individual sense of mastery in the context of mental health, as might be identified in Green’s study (2008), not to underscore generalizations nor inflict them onto broader sexual minority communities.

## **Sexual Status Stigma, Personal Coping Resources, and Mental Health Problems**

Social support can play a pivotal role in mitigating stress for members of sexual minorities and in improving their personal resources. For example, social networks buffer stress within minorities (Kuyper & Fokkema, 2010), where social support from friends and partners indicate higher levels of psychological adjustment (Kurdek, 1988). Given the nature of issues that a member of a sexual minority faces, the form of the social support an individual seeks out must be considered when measuring its effect on stress. For instance, Wayment and Peplau (1995) claim that worth support (the reassurance of one's identity being respectable) is more helpful to such individuals than other forms of support, such as guidance.

The widespread LGBTQ community in the United States offers an alternative, accessible avenue to attaining symbolic or social support (Bonet, Wells, & Parsons, 2007). Nevertheless, this community structure contrasts with those in nations where more progressive steps have been taken in terms of acceptance. For example, in Norway, same-sex marriage is legal, but there also exists no such well-established network from which support can be drawn – a condition amplified by low population density and large cities (Bjorkman & Malterud, 2012). Bjorkman and Malterud (2012) posit that, in this situation, sexual minorities experience a personal legitimizing effect from the official recognition and approval of their sexual identity. Here, the primary source of empowerment for members of sexual minorities is the support of an authority higher than any one of their personal relationships, and this empowerment can expedite disclosure and strengthen resolve when they are defending themselves against social stigma.

Disclosure of sexual identity or orientation to others, while it constitutes a stressor, can also fulfill a support function for sexual minorities (Bjorkman & Malterud, 2012). It directly addresses the chronic absence of sense of control and insecurity from a feeling of dishonesty that a person concealing their sexual identity may often experience. “Coming out”, regardless of whether directly (e.g. confessing to having a partner of the same sex) or indirectly (e.g. referring to a partner with pronouns of the same sex), is hence a process that alleviates the need for the individual to dwell

on the opinions of others, as well as the need for others to fill in perceived gaps with rumours (Bjorkman & Malterud, 2012), thereby eliminating two forms of non-event, chronic stressors. Bjorkman and Malterud's (2012) discuss how the process of defending one's sexual identity maintains a sense of dignity for the defender. It creates a domino effect by inspiring others in similar situations to do the same, thereby addressing the chronic frustration with oneself that can develop when one allows the unilateral condemnation of minority communities to continue by keeping silent. Being acknowledged by one's social environment and by oneself provides a sense of control that feeds healthy self-esteem and positive response expectations, and that is critical for shaping good mental health (Lazarus, 1984).

Meyer's (2003) minority stress model recognizes that positive coping resources and social support may moderate the relationship between perceived stress and mental health. In support of this, multiple studies have confirmed the positive impact of strong coping skills and self-esteem on mitigating distress and depressive symptoms accrued from heterosexist events and discrimination (Harrell, 2000; Szymanski, 2009; Wei et al., 2008). Self-esteem is therefore an important predictor of sexual minorities' mental health (Chen & Tryon, 2012). Therefore, anti-gay discrimination and violence, expectations of rejection, and internalized homophobia associated with sexual minority status (Meyer, 1995; 2003) often leads to elevated risk for psychiatric disorders, including anxiety, depression, substance abuse disorders and suicidal behaviour (Gilman et al., 2001). In particular, internalized homophobia has been found to be related to other psychological distresses, such as demoralization (depression, anxiety, helplessness, hopelessness, low self-esteem), feelings of guilt, feelings of uncertainty regarding issues of sexuality and sexual orientation, contemplation of suicide, and AIDS-related distress that may include fear of contraction or distress from stigma following its contraction (Meyer, 2003; Rosser et al., 2008). It has also been identified as a determinant of the quality and satisfaction of same-sex couples' relationships (Balsam & Szymanski, 2005; Mohr & Daly, 2008).

When examining the outcomes of stress on members of minority groups, it is informative to look at situations where

various broad sources of stress are compounded by each other. For instance, drawing links between visible minority immigrants and sexual minorities, two levels of stress appear for individuals belonging to both categories. First, social discrimination and structural disadvantages on account of race are relevant within both groups. Second, the stigma perceived from heteronormative and intolerant components of American culture could add to the insecurity that sexual minority immigrants feel, diminishing personal coping resources such as sense of control, self-esteem, and ability to handle stress. Drummond (2005) discusses how masculinized cultures, such as Confucian Asian cultures, attribute stigma to sexual minorities based on familial ideals grounded on heterosexuality (Drummond, 2005).

However, despite the consideration that sexual minority immigrants may experience greater psychological distress from difficulties with acculturation, as described by Bernstein (2007) with regard to Korean immigrants, studies investigating the causes of this distress reach different conclusions. While, upon first impressions, it may be surmised that an immigrant who is also a member of a sexual minority group experiences multiple discriminations (Szymanski & Gupta, 2009), others have failed to confirm this dynamic, observing instead that sexual minority status acts as the primary cause of psychological distress in contrast to racial minority status (Chen & Tryon, 2012). A possible explanation for this centers on perceived body image expectations among Asian immigrants (Eguchi, 2011), who, following immigration to America, claim to feel the infliction of a stereotype about gay Asian-Americans as feminine, passive, and subversive (Chesebro, 2001; Phua, 2007; Poon, 2006) that not only conflicts with their own personal identity, but originates from a desire to racially concentrate male privilege in White men by disadvantaging gay Asian-Americans (Eguchi, 2011). Critiquing this norm by drawing on critical race theory, Han (2008) posits that “because gay White men make an ‘investment in Whiteness,’ they eradicate whatever male privilege gay Asian men may have by relegating [them] to the feminine position” (p. 20). Thus, the conflict arisen from the imposition of such racialized and body image stereotypes may lead to harmful contrasts with an idealized

body image that diminishes the self-esteem of those who do not fit this ideal (Drummond, 2005; Eguchi, 2011).

It should be understood that this section aims to address the apparent intolerance toward sexual minorities contained in the familial ideals of Confucian Asian cultures as it affects the mental health of sexual minorities who immigrate from such cultures; this is not an attempt to generalize Asian cultures altogether nor to suggest they can be reduced to being defined as intolerant. Once more, this is intended to revisit this *singular* trait of intolerance in Confucian Asian cultures, as has been discussed in literature.

### **Multiple Health Problems**

Attending nightclubs and bars that cater to sexual minority communities can be interpreted as a form of providing and receiving social support. However, these locations typically provide exposure to the distribution and trade of addictive substances (Lea, Reynolds & de Wit, 2013). For sexual minorities, substance and alcohol abuse appear to be problems that are often underestimated (Lewis et al., 2012). McCabe et al. (2009) note that the prevalence rates for heavy drinking among a group of lesbians and bisexual women in 2004-2005 were 20% and 25% while rates of alcohol dependence were 13% and 16%. These women also met the criteria for alcohol dependence more often than their heterosexual counterparts in the study. Moreover, 26% of women in sexual minorities report lifetime alcohol abuse disorders, and 11% report lifetime alcohol dependence disorder (Meyer, Dietrich & Schwartz, 2008). The prevalence of substance abuse extends to youth (under 21 years old) in sexual minorities, where odds for substance use were found to be 400% higher than heterosexual youth (Marshal et al., 2008).

These trends of alcohol and substance abuse can easily be perceived to feed into another issue in the same way that they do for heterosexual, cisgender couples: partnership violence. The partners or ex-partners of people who abused alcohol have been shown to be at increased risk of physical violence or abuse (Glass et al., 2008). Additionally, Schilit, Lie and Montagne (1990) discovered that from a sample of 104 lesbians, 37% reported being in abusive relationships and 64% of batterers and victims also reported use of alcohol or substances before or during

incidents of abuse. However, this problem is perhaps more pronounced for sexual minorities than heterosexuals in light of the aforementioned fear of societal reaction: sexual minority individuals must not only contemplate the consequences of speaking out as a victim, but must also consider the potential stigma due to their deviance from sexual norms in largely heteronormative societies.

### **Limitations & Future Directions**

While many studies have been conducted on the lifestyles and social environments of sexual minorities and their effects on mental health, many of the studies are conducted in a spatially restricted fashion, resulting in the possibility that their conclusions are location-dependent. For instance, a critique of Green’s (2008) study of social hierarchies within the Torontonion gay community could be made based on the spatial restrictions of his study, which only considered Toronto. The high status attributed to young, white, muscular, cisgender men in the gay enclave is a standard possibly confined to Toronto, as this form of social stratification may not exist in other parts of the world with smaller white populations, such as Asia.

It also stands that very few of the studies discussed here examine large populations. Revisiting Schilit, Lie and Montagne’s (1990) study, for example, we find that their observations on batterers and victims in lesbian relationships were drawn from a sample of only 104 lesbians. Thus, the conclusions drawn from a limited sample cannot necessarily be said to be representative of larger lesbian populations. Building from this, heterogeneity within sexual minority communities is often overlooked in studies. While the experiences of different groups (lesbians, gays, bisexuals, transgendered, and queer) may be similar in terms of stigma, distinct social stratifications may exist within them, as in the case of white male for the Torontonion gay community in Green’s study (Green, 2008). Closer examination may reveal new sources of stigma from within such structures.

Nevertheless, a deeper issue is reflected: the perceived stigma surrounding sexual minorities is significant enough to deter individuals from admitting to a sexual minority status (or “coming out”). A dilemma for future studies in this area is therefore the

apparent necessity of using indirect means to broach the topic of minority status (e.g. asking participants more about their partners rather than asking them to admit to being a sexual minority). But perhaps more importantly, efforts to study sexual minorities should be associated with efforts to eliminate the associated stigma. I conclude that future directions for state-led research to improve the mental and general health of sexual minorities should begin with the following areas, some of which have already been proven effective: (i) devoting more attention to sexual minority status and health in censuses and national surveys; (ii) mirroring the policies of legitimization of sexual minorities, such as those seen in Norway; (iii) endorsing social campaigns to educate on the acceptance of sexual minorities.

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## **African Refugees in Canada and the “Healthy Immigrant Effect”: Trauma, Boundaries and their Link to Health Access**

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With time, Canadian immigrants have become more diverse and increasingly emigrate from countries outside of Europe (StatsCan, 2011). Today, over 20% of Canada’s population was born outside of the nation (StatsCan, 2011). Most of these immigrants have settled in large metropolitan areas in Ontario, Quebec and British Columbia. However, the highest proportions of immigrants have chosen to settle in the GTA (StatsCan, 2011). The purpose of immigration varies greatly. As a result, the pool of immigrants entering a given country will occupy a variety of immigration classes. Health geographer Bruce Newbold, describes three major immigrant classes: economic class immigrants, family class immigrants and refugees (Newbold, 2009). The fundamental differences between these three classes are based on the purpose of migration. Economic immigrants pursue increased economic opportunities while family class immigrants migrate to reunite with family members living in the host country. Finally, refugees immigrate to escape persecution from their home country, and thus to gain protection and safety.

Regardless of their class, researchers have found that upon arrival, immigrants have better health than their native-born Canadian counterparts. Within the immigrant population, though, the refugee class has the lowest health status. After a short period of time resettling, the health statuses of immigrants converge with that of the Canadian population before falling below it. This entire process is referred to as the “healthy immigrant effect.”

The “healthy immigrant effect” indicates that Canada’s immigrant population faces unequal health provisions after resettlement. Refugees in particular, end up with the lowest health statuses (Newbold, 2009). Due to health and medical geographers’ interest in promoting health equality amongst all

citizens, the issue of the “healthy immigrant effect” is of particular importance to the field of health geography. Hence, this paper aims to address the factors that contribute to the “healthy immigrant effect” amongst refugees in Canada. More specifically, it seeks to answer questions about potential barriers that African refugees, who make up a large portion of the refugees arriving in Canada, face in this country that would contribute to their decreased health statuses. This research is critical to understanding the way social determinants of health have resulted in the inequitable distribution amongst African refugees, other immigrants and native-born Canadians and as a result, has much to offer to the study of health and medical geography.

### Context

According to the Canadian Immigration and Refugee Protection Act, a refugee as defined by the Convention relating to the Status of Refugees is:

A person who, by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, (a) is outside each of their countries of nationality and is unable or, by reason of that fear, unwilling to avail themselves of the protection of each of those countries; or (b) not having a country of nationality, is outside the country of their former habitual residence and is unable or, by reason of that fear, unwilling to return to that country (Ministry of Justice, 2014).

Refugee experiences of migration differ greatly from those of other immigrants. The movement of refugees is, by default, “involuntary, hasty and often traumatic in nature” (Rousseau, Mekki-Berrada & Moreau, 2001, p. 40). As a result, the pre-migration period for refugees is unstable, dangerous and can lack adequate planning. Before arriving in the host country, refugees are by definition, in search of safety and protection from violent or repressive conditions in their home countries. They are frequently forced to separate from their families and adapt to huge changes in their social-political worlds. Thus they arrive in Canada having already experienced traumas

related to war, violence, persecution or suffering in their homeland. The experience of trauma that refugees carry with them positions this population at a higher risk for a series of mental and physical illnesses.

While refugees in general have traumatic pre-migration experiences, Rousseau, Mekki-Berrada and Moreau (2001) claim that African refugees are particularly likely to have witnessed acts of violence, had family members executed, been physically or sexually harassed, been imprisoned and/or tortured (p. 44). In addition, many African refugees are displaced into internment camps in Africa before resettling in Canada. At refugee or internment camps, refugees may have been exposed to disease, malnutrition, water shortages, and sexual and gender-based violence, negatively affecting their mental and physical health before arriving to Canada (Brujin, 2009).

Having already experienced social, political and economic losses, many of which are truly horrendous, refugees arrive in Canada hoping for a better future. Beyond safety and protection, refugees often wish to rebuild their lost lives in the host country. Many hope to reunite with their families, build economic stability and create successful futures for a chance to reconstruct their shattered lives. This positive approach to starting a new life in the host country may well have the capacity to reduce the negative impact of pre-migration experiences on mental health. However, refugees are forced to create a new life in a new social environment. They must use a “dual frame of reference” (Simich, Hamilton & Baya, 2006, p. 497) where they must learn to understand the world using a new societal lens while still maintaining their previous cultural understandings. Inevitably, many refugees will face difficulties in bridging expectations of both the old and new societies. Potential difficulties refugees face include discrimination, poverty, language barriers, reduced government support and deskilling.<sup>1</sup> If the difficulties prove to be obstacles that hinder their chances of success, refugee health status greatly declines. In other words, refugees’ pre-migratory trauma, in

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<sup>1</sup> Deskilling in this paper refers to the process in which immigrants are forced to work in jobs below their skill and educational levels, including the unrecognition of credentials obtained outside of Canada.

addition to new barriers that prevent them from recreating a better life in Canada, put refugees, including African refugees, at higher risk of poor health outcomes.

The literature reviewed in this paper has been collected using a series of journal databases. Keywords in the database search included: “health”, “refugee”, “African”, “poverty”, “trauma” and “Canada”. I also included “Black” to broaden the search results and include the particularly racialized experiences of black Africans. Other sources were used to provide more up to date refugee and immigration statistics.

### **Themes in the Literature**

After conducting a literature review, a number of themes explaining the “immigrant effect” in refugee populations emerged. While many health barriers discussed in the literature affected Canadian refugees more generally, a few barriers were particularly salient with regard to black African refugees. The primary obstacles outlined are: poverty related to deskilling and underemployment, limited social support and family reunification, racial and religious discrimination, language and a limitation of access to government-funded services that is linked to neoliberal policies of restructuring and cultural beliefs.

#### **I) Poverty, Deskilling and Un(der)employment**

Canadian refugees often struggle to integrate economically and frequently inhabit socio-economically underprivileged neighbourhoods. More generally speaking, refugees are more likely than the country’s native population and other immigrant groups “to be of marginal socioeconomic status.” (Beiser, 2003, p. 535) Socioeconomic status has been found to be a good social predictor of health outcomes in individuals. Low income is correlated directly to reduced access to healthcare services. In addition, Wu et al. (2003) note that low socioeconomic status “predicts the level of exposure to psychosocial and environmental health risks” (p. 428).

While refugees are generally more likely to live in poverty, Africans are amongst the worst economically disadvantaged refugee populations in Canada. According to one study examining the financial state of Sudanese refugees, 75% of the refugees had reported that even with additional financial

support from the government, they still did not have enough money to meet basic subsistence levels (Simich, Hamilton & Baya, 2006, p. 428). In fact, nearly 67% of African refugee respondents had experienced “food insecurities” in the preceding 12 months (Simich, Hamilton & Baya, 2006, p. 432). This is three times the percentage found in the general Canadian population.

The literature suggests that these poverty levels are not limited to the Sudanese community but are shared across African refugee populations in Canada. A large proportion of African refugees are dependent on social assistance in the form of welfare or child benefit. Among Somali and Ethiopian refugees, the largest African refugee populations in Canada, the average gross income was only \$1350 per month, making them one of the poorest refugee populations in Toronto (Danso, 2002, p. 6). In addition to paying for food and rent, African refugees have pointed to “transnational obligations” and the need to pay off government travel loans as furthering economic hardships and contributing to a downward progression into poverty (Simich, Hamilton & Baya, 2006, p. 437).

The low socioeconomic status of African refugees as a group is linked to the high unemployment and underemployment rate that the population experiences (Danso, 2002; Fenta, Hyman & Noh, 2004; Simich, Hamilton & Baya, 2006). Unemployment, more generally, is linked to poor health outcomes such as reduced mental health, increased risk for cardiovascular disease and premature mortality (Dean & Wilson, 2009, p. 187). In a study by Danso (2002) the interviewed Somali and Ethiopian refugee samples experienced a 38% unemployment rate and a 69% underemployment rate (p. 6), while a 48% unemployment rate was found amongst Sudanese refugees (Simich Hamilton & Baya, 2006, p. 429). However, contrary to popular biases about the ties between education level and socioeconomic success among refugees, employment levels were not reflective of African refugee educational achievements. African refugees were comparatively highly educated before arriving to Canada. According to a study by Rousseau, Mekki and Moureau (2001), 49% of African refugee participants had completed university degrees, 30% had

completed vocational studies while only 8% had an elementary education or less (p. 45). Fenta, Hyman and Noh (2007) found that about 68% of Sudanese refugees had more than a high school education (p. 365). African refugees even had higher levels of education than other refugee populations, but encountered extreme difficulty gaining employment as a result of deskilling and discrimination. Their educational credentials were de-evaluated or completely unrecognized by Canadian employers. In addition, many employers demanded Canadian work experience, forcing refugees to “work irregular, low-paying survival jobs that are below their skill and experience levels” (Simich, Hamilton & Baya, 2006, p. 430). As a result of both deskilling and their economic responsibilities, African refugees have reported high mental stress and frustration. Highly educated refugees were particularly unhappy or depressed as a result of unemployment and underemployment. According to Simich, Hamilton and Baya (2006), African refugees experiencing economic difficulties “were between 2.6 and 3.9 times as likely to experience loss of sleep, constant strain, unhappiness and depression and bad memories” as those who did not experience these problems (p. 418). The inability to rebuild an economically stable life therefore appears to further amplify the effects of trauma among African refugees. Not being able to recreate success in their host country results in a loss of hope and uncertainty for their futures (Danso, 2002).

### **II) Social Support and Family Reunification**

Separation from family members is considered to be a normal part of the migration process that refugees undertake (Rousseau, Mekki-Berrada & Moreau, 2001, p. 40). Family and other social support networks act as a protective shield against illness, specifically mental illnesses. This is particularly true for individuals who have gone through traumatic experiences, such as refugees. The lack of nearby family members, friends and “like ethnic communities” are strong predictors of mental health problems among refugees as they are forced to remember the traumatic experiences that led to their family separation (Simich, Hamilton & Baya, 2006, p. 437). However, only 23% of African refugees arrived in Canada with extended family members (Rousseau, Mekki-Berrada & Moreau, 2001, p.

46). Compared to refugees of other origins, African refugees “were more likely to live alone and be single upon arrival to Canada” (Rousseau, Mekki-Berrada & Moreau, 2001, p. 45). In general, black Canadians had fewer social support networks than other Canadians. Amongst African refugees, this was particularly true. African refugees experienced certain difficulties when they attempted to reunite with their families. On average, it took 17 months for African refugees to be reunited with their spouses and 42 months to be reunited with their children less than 18 years of age (Rousseau, Mekki-Berrada & Moreau, 2001, p. 49). Reunification with children over 18 years took even longer because, as mentioned earlier, African refugees often live in poverty, and refugees needed to provide evidence that they could financially support the older children. The emotional distress and anxiety resulting from this gruelling period of family separation can translate into poor financial and mental health outcomes for the African refugees.

Although African refugees are socially isolated in the period surrounding their immediate arrival to Canada, communities with a large African immigrant/refugee presence exist. This creates spaces for strong social relationships and support networks to develop within the African refugee population. However, as a result of their marginal position in Canadian society, which causes many African refugees to occupy lower socioeconomic neighbourhoods, the benefits of these social support are often confounded by the negative effects of living in poverty-ridden areas.

### **III) Discrimination: Racial and Religious**

Wu et al. (2003) discuss how “racial/ ethnic health differences are embedded in patterns of racial/ethnic discrimination” (p. 428). Refugees of a visible minority background are more likely to experience racial or ethnic discrimination that would prevent them from equally accessing resources such as employment and housing. Black African refugees in particular are subjected to significant racial discrimination in Canada. This may reflect anti-black sentiments from periods of slavery and racial segregation practices in North America. In Danso’s (2001) study of Ethiopian and Somali refugees, many believed that black Africans would never be

accepted nor would they ever be viewed as equal to white members of Canadian society. Racism is a very real experience for African refugees. In fact, 53% of African refugees had attributed employment problems to institutional and individual levels of discrimination (Danso, 2002, p. 7). Furthermore, 17% of Somali and Ethiopian refugees had pointed to “general racism” (e.g. racial profiling, racial slurs) as being the primary obstacle they faced in Canada (Danso, 2002, p. 10).

While racial discrimination is a common theme that appears in general refugee and health literature, religious discrimination was also a recurring theme amongst African refugees. Many African refugees, and more specifically Muslim African refugees, reported high rates of religious discrimination (Danso, 2002). Muslim women in Danso’s study reported mistreatment and even employment refusals due to dressing in accordance with religious beliefs. With recent discussions of legalizing the ban of religious symbols in Quebec, these concerns may become more apparent over the next few years. Experiences of discrimination affect the social and psychological well-being of individuals as a whole. However, the multilayered levels of discrimination that African refugees face, in addition to their past experiences of trauma, can have a severe effect on mental and physical health.

### **IV) Language Barriers**

Literature regarding the language barriers faced by African refugees depends on the nationality of the refugees in question. Congolese African refugees, for example, spoke English better than most of their refugee counterparts (Rousseau, Mekki-Berrada & Moreau, 2001, p. 44). As a result, they did not face many language barriers upon arrival to Canada. Similar results were found in nations that were colonized by Britain and maintained a British education system. However, refugees arriving from Ethiopia and Somalia reported language as being a strong barrier that affected their social mobility. They are “coming from linguistic backgrounds where English is neither the national language nor widely used in daily communication or social interaction” (Danso, 2002, p. 10). Similarly, with the recent “Arabization” of the Sudanese education system which led to advanced schooling taught in Arabic, Sudanese refugees under the age of 40 are less likely to

be proficient in English and more likely to face language barriers in Canada (Simich, Hamilton & Baya, 2006, p. 421). In other words, African refugees coming from countries where English is not necessary are more likely to have limited access to Canadian services, including social and healthcare services, than refugees from English speaking nations.

#### **V) Limited Access to Government Funded Services: Restructuring**

African refugee migration into Canada reached its peak during the mid and late 1990s. This coincided with the neoliberal-influenced restructuring of the Canadian political, economic, healthcare and immigration systems. As a result, government funding for social support and healthcare services was cut, which greatly affected the amount of affordable financial, social and health care support African refugees could receive (Steele et al., 2002, p. 120). During this time period, health services, language interpretation, culturally sensitive services, welfare and other forms of government-funded aids were being reduced. User fees for prescriptions were also implemented, and new policies were sponsored for refugees who required welfare support “[faced] an additional \$100 reduction in benefits if their relationship with their sponsor has deteriorated” (Steele et al., 2002, p. 122). As a result, African refugees were left to effectively acculturate into Canadian society and rebuild a stable and healthy life, while seriously lacking access to Canadian services.

Needless to say, African refugees reported that they felt neglected by the Canadian government. They did not receive much help in learning about the different health services provided in Canada, such as cancer screening (Redwood-Campbell et al., 2011, p. 232). They also received limited government-provided “financial and ... resettlement assistance” (Simich, Hamilton & Baya, 2006, p. 421). Furthermore, refugees receive healthcare through the “Federal Interim Health Program” upon arrival, which does not provide comprehensive healthcare coverage (Steele et al., 2002, p. 121). Recently, even this minimal health coverage has undergone drastic cuts. This means that African refugees are subjected to worse health

outcomes and social service quality in their initial period of resettlement.

### **VI) Cultural and Religious Beliefs**

The literature review revealed that spirituality played an important role in the lives of many African refugees. For example, Ethiopian refugees viewed mental health problems as having a spiritual source and, as a result, consulted religious leaders for emotional problems instead of medical practitioners (Fenta, Hyman & Noh, 2004, p. 353-354). Similarly, Somali participants tended to attribute healing and cancer risks to mediation by spirituality (Paisley et al., 2002, p. 140). African refugees were also less likely to report psychological symptoms to physicians (Fenta, Hyman & Noh, 2004, p. 351-352). Muslim African refugees also identified the importance of the physician's gender in their experience of healthcare (Redwood-Campbell et al., 2011, p. 232). Women were more comfortable seeking healthcare from female physicians and men were more comfortable with male physicians. This suggests that understanding the cultural and religious beliefs of different African refugees will allow for more culturally sensitive healthcare practices that would encourage healthcare utilization amongst marginalized communities.

### **Discussion**

While African refugees make up a large portion of Canada's refugee population, very little research exists examining the health status and barriers that they face in this country. Most of the research regarding African refugees tends to be about their experiences in the United States. This may be because of the apparent social inequalities that black people face in the United States and the country's strong history of African slavery or could also be explained by the relatively large African-American population in the United States. Wu et al. (2003) discuss how "blacks and Hispanics constitute one fourth of the general population and the vast majority of ethnic minorities in the United States" (p. 426). In comparison, Canada is more multicultural and it would seem that as a result, health research on the immigrant population is more fragmented. Furthermore, the Canadian immigrants are

predominantly from Asia. This is reflected in the areas of focus that health geographers take when studying the “immigrant effect.”

A major limitation in this literature review is that while “African refugees” are discussed, most of the literature pertains to Somali, Ethiopian, Sudanese and Congolese refugees. This limits the paper to the experience of black Africans in these regions and does not take into account West, North or Southern regions of Africa. However, Somali and Ethiopians refugees are Canada’s largest African refugee populations (Danso, 2002, p. 6), so the literature is focused on the groups most relevant within Canada. Furthermore, these populations represent the different religious backgrounds present in Africa, including Christianity, Islam and native religions. Therefore, while the results may not be representative of the experiences of *all* African refugees, it could be relatable to a large portion.

All of the literature pertaining to African refugees that was used in this review employed both qualitative and quantitative methods. This combined methodology increases the strength and contextual understanding of the data presented.

The publication dates of most of the literature on African refugee populations range between 2001 and 2006. This time period would have been very close to the aforementioned boom of resettlement of African refugee populations in Canada in the mid to late 1990’s. Most of these refugees would have been settled in Canada from 2-15 years at the time that this literature was published. The average number of years in Canada cited for the African refugee populations included in the literature ranged between 2 and 5 years. As a result, the low health status in both physical and mental health reported by African refugees in the literature supports the “immigrant effect” predictions discussed earlier in this review.

Many of the studies reviewed in this paper recruited African refugee participants by looking through phone books and contacting culturally-based community centers (Danso, 2002; Fenta, Hyman & Noh, 2004; Fenta, Hyman & Noh, 2007; Paisley et al., 2002; Rousseau, Mekki-Berrada & Moreau, 2001). While this method allowed for a large sample size, it excluded

individuals who may not have been socially involved in their ethnic communities. Furthermore, not all individuals have their names or contact information available through the Yellow Pages. This suggests that the samples of African refugees used in the literature were not as random as would be hoped, which limits the generalizability of the findings to some extent.

It is apparent that while all refugees face a series of social disadvantages upon arrival to Canada, African refugees experience an exacerbated form of some of these disadvantages. For example, while visible minorities are more likely to face forms of racism, black Africans report experiencing extreme forms of systemic racism, including racial profiling by police and unemployment issues. The timing of the wave of African refugee immigration to Canada discussed above also made it more likely that they would not receive adequate government-funded support, making them even more disproportionately likely to face economic and health disparities.

However, the literature also showed that the African refugees, like the refugee class in general, are not homogenous. Factors such as national and ethnic origin, gender, religious background and race all lead to different experiences within the African refugee community in Canada. Recognizing that refugees are not a homogenous group is the first step in addressing the unfair health disparities they face. Policies of restructuring need to be changed so that greater social assistance and government-funded services can be offered to help refugees integrate successfully into Canadian society. Culturally and religiously sensitive considerations must be made when developing healthcare programs and facilities, with the aim of being more inclusive of refugee populations. Most importantly, issues affecting employment among African refugees, and the general refugee population need to be carefully examined. Services that would help with increased employability, such as skill development workshops, refresher courses and more employer-provided job shadowing and placement opportunities, need to be considered in order to reduce the high rates of underemployment and poverty among refugees.

However, with the recent implementation of Bill C-24, it doesn't appear that Canada is moving in the right direction. According to the bill, formally known as the "Strengthening Canadian Citizenship Act," refugees, other immigrants, dual citizens and individuals eligible to obtain dual citizenship, can have their citizenship revoked by both a federal court judge and citizenship and immigration delegate/minister. In addition, the bill increases the cost of citizenship applications and expands the age bracket that is required to take the citizenship test, subsequently increasing the legal barriers African refugees will face upon arrival. More research regarding the effects of legal, social, political, economic and environmental barriers on African refugees' well-being needs to be conducted in order to promote successful integration and gain a better understanding of the "healthy immigrant effect" within this population.

### **Conclusion**

Refugees, and especially African refugees, are socially disadvantaged and marginalized communities within Canadian society. In order to understand the particularities of the social disadvantages experienced by these refugees, we need to understand both the context of collective trauma and the heterogeneity of the population. A series of changes to social, economic and health practices must be made so that African refugees and other immigrants can healthily integrate into Canadian society. Cuts to refugee health plans and further restrictions on Canadian citizenship does not promote such integration and increases the number of barriers faced to successfully settle down. The sociopolitical framework that will rise as a result of these legal changes will not only question Canada's reputation as open to immigration but may impact the political voice or the determinants of health for a variety of immigrants. Canada as a nation needs to view the future health of refugees, including African refugees, as being intrinsically linked to the future of this country.

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# In Defense of Bill 52: Legally and Ethically Providing Medical Aid in Dying

JERICO ESPINAS

In 2014, Quebec officially passed Bill 52: An Act respecting end-of-life care. According to the act's explanatory notes, Bill 52 is meant to protect "the right of everyone to end-of-life care that is appropriate to their needs," in particular outlining ways in which the healthcare system is meant to respect a patient's wish to receive medical aid in dying (Parliament of Quebec, 2013). While the bill passed with a clear majority, some of the underlying bioethical principles of the bill can be contested. The justification of these principles is important. If, after all, the bill has an unjustifiable bioethical framework, then its application in Quebec's healthcare system will also be morally unjustifiable. In particular, this paper shall examine the general provisions of the act, the right respecting end-of-life care, and the requirements necessary to receive end-of-life care. First, this paper shall examine what exactly the law requires in order to respect this right to end-of-life care. Then, this paper shall examine these legal requirements using three different ethical frameworks: principlism, consequentialism, and deontology. Overall, the legal framework aligns with these ethical frameworks, allowing for the just application of Bill 52 and the respectful treatment of end-of-life patients. However, whether this bill will in fact be justly applied is also dependent on the social conditions of patients, which has not been adequately addressed by the act.

## Legal Requirements

Bill 52 covers different aspects of end-of-life care, including how the right to that care is to be respected, what institutions are obligated to provide care, and how advance directives are applied for end-of-life patients. For the purposes of this paper, three main chapters of Bill 52 shall be considered: Chapter I on general provisions, Chapter II on rights with respect to end-of-

life care, and Chapter IV Division II on medical aid in dying. This section will focus on the legal requirements of these three Chapters, drawing insight on the clauses' connections with legislation in order to examine closely its ethical framework.

Chapter I is important in addressing the main provisions of Bill 52. Clause 2 is particularly significant because it states three distinct principles. First, every act must respect the patient and recognize their rights and freedoms, creating a direct legal connection between end-of-life care and the Canadian Constitution, making a claim that this care can and should fall within constitutional limits. Second, patients must be treated fairly and compassionately, respecting in particular their dignity and autonomy. This principle outlines positive duties that both the physician and the healthcare system have towards the patient. These duties connect the act with other healthcare legislation, such as Quebec's Act Respecting Health Services and Social Services, which outline similar legal obligations that physicians have towards their patient (Parliament of Quebec, 1991). Thirdly, the healthcare team must maintain open communication with the patient throughout the entire end-of-life process. Similarly to the second principle, this creates positive obligations on the healthcare provider. This section can be in terms of how patients' end-of-life care should be accessed, creating more connections to healthcare legislation regarding transparency of information and informed consent (*Civil Code of Quebec*, CQLR c C-1991, 1991; Parliament of Quebec, 1991). Properly understood, then, the general provision for Bill 52 creates both legal that physicians and the healthcare system have to follow when performing end-of-life procedures, legislating a way of acting responsibly with the patient.

Chapter II is important in addressing the specific rights that patients have with respect to end-of-life care. Clause 5 affirms the right to receive end-of-life care if they meet certain requirements that are highlighted within the act. Notably, they may request this treatment at a healthcare institution, a hospice, or in their home, affording patients wide legislative access to this service. Clause 6 states two major conditions for

respecting the right to end-of-life care. Firstly, patients may refuse or withdraw life-sustaining treatment at any time. That is, refusing or withdrawing treatment does not require meeting certain requirements, but positively requesting end-of-life care does. This is legally significant because it gives greater respect for a patient's negative right to refuse treatment than their positive right to request particular care. Secondly, physicians must ensure that patients make a free and informed choice, requiring not only a lack of coercion but also an availability of information. This clause is connected to articles in the Civil Code of Quebec that require free and enlightened consent for all matters regarding bodily integrity (*Civil Code of Quebec*, CQLR c C-1991, 1991). Properly understood, this chapter not only grants the right to end-of-life care to all Canadians, but it also states provisions for physicians on how to treat rights-bearing patients.

Chapter IV clause 26 outlines the requirements necessary for a patient to receive medical aid in dying. Examining the particulars of Chapter IV Division II, four main requirements are provided that must be met in order for a patient to request medical aid in dying. Firstly, the patient must be able to give consent to the procedure. Secondly, the patient must be suffering from an incurable and serious illness. Thirdly, the patient must be suffering from an advanced state of irreversible decline in capability. Fourthly, the patient must be suffering from unbearable physical or psychological pain that cannot be relieved in a tolerable way. These requirements describe a very particular end-of-life patient. The first requirement means that the patient must be legally capable to give consent, either directly through substitute decision makers, or indirectly through advance directives and living wills. In the absence of the latter two options, an incapable patient cannot legally consent to the procedure even if they are suffering. The second requirement imposes a legal limitation on the kinds of disease that a patient must have to request medical aid in dying. Patients suffering from a curable disease whose treatment is difficult to administer cannot request medical aid in dying; these must be diseases with no cure. The

third requirement imposes further legal limitations, ensuring that patients request medical aid in dying because they are incapable of safely performing the procedure themselves. The fourth imposes a final legal limitation, emphasizing the patient's current state of mental and physical wellbeing. What is legally important here is that a high threshold of suffering must be met, better ensuring that the physician's aid is done to relieve suffering rather than to simply end life. While strict, these requirements are there to ensure that the principles outlined in Chapter I and in other healthcare legislation are upheld by this procedure.

Chapter I's provisions, Chapter II's rights, and Chapter IV Division II's conditions outline some of the legal requirements of Bill 52. I have examined some of the Bill's important legal requirements by either connecting them with, or connecting them to, other healthcare legislation. This examination is important because it helps guide what needs to be ethically addressed and what might require ethical justification.

### **Ethical Requirements**

The ethical requirements of the three chapters shall be discussed using three bioethical frameworks: principlism, consequentialism, and deontology. In particular, the important legal requirements shall be examined to understand Bill 52's underlying ethical justification.

Principlism is a bioethical framework that respects four main principles: autonomy, beneficence, non-maleficence, and justice (Sassower & Cutler, 2007). Upholding autonomy can be understood as respecting the patient's ability to rule their lives without controlling interferences or coercive limitations. Beneficence can be understood as a positive duty to perform procedures that benefit the patient. Non-maleficence can be understood as a negative duty to not perform procedures that harm the patient. Lastly, justice can be understood as the just distribution of healthcare resources to the population (Sassower & Cutter). Within this ethical framework, a healthcare system acts justly if it abides by these four ethical

principles. Properly understood, then, Bill 52 is justifiable because it is able to uphold these four principles.

Autonomy in the ethical sense is recognized positively in Bill 52. One way of positively recognizing autonomy is by accepting positive duties to promote their dignity and their ability to rule their own lives (Sassower & Cutler). Recognition of this positive ethical duty is seen throughout Bill 52. The general provision alone directly states that actions must respect the patient's dignity and autonomy. Ensuring that patients are able to autonomously wish for end-of-life procedures best recognizes this positive duty. This is done, for example, by making sure patients understand the information, as it is necessary in order for them to make their own informed decisions. Without it, the patient is not able to fully integrate the available choices into their life's goals, which limits rather than promotes their ability for self-rule.

The principle of beneficence and the corresponding principle of non-maleficence are also recognized in Bill 52. The principle of beneficence is clearly shown in the legal requirements necessary for end-of-life patients, where suffering is necessary to request the procedure. Legally, this ensures that the physician intends on alleviating suffering. Ethically, this ensures that the physician acts beneficently towards the patient. The principle of non-maleficence is more difficult to define. Some can claim that causing the patient's death is harm to the patient, and so medical aid in dying violates duties of non-maleficence (Sassower & Cutler). However, if we recognize that autonomy is also a principle that must be respected, then non-maleficence can be more broadly understood. An act only morally harms a patient if the patient did not consent to the act (Beauchamp, 1999; Kagan, 1998). After all, patients often undergo risky and painful procedures for their injuries. However, physicians do not violate duties of non-maleficence in those cases because patients consent to the procedure. The mere fact that one procedure causes pain and one procedure causes death should not be significant if the patient autonomously chose to do both. This broader understanding of non-maleficence is also recognized in the bill. As shown, autonomy

is continually required for physicians to undergo the procedure. Properly understood, these requirements acknowledge that physicians would be committing a terrible harm to the patient otherwise.

Lastly, the principle of justice is also recognized in Bill 52 by the equitable and easily accessible end-of-life care for all patients (Sassower & Cutter, 2007). It is important to note, then, that the bill does not discriminate against particular marginalized groups or demographics; the rights are afforded to all patients who meet the procedural requirements. This recognition of the right is also connected with institutional obligations to create clinical programs for end-of-life care, as in Chapter III. Importantly, these institutional obligations are enforced for a large number of healthcare institutions, palliative care hospices, and private care facilities. Overall, all patients should in principle have access to this type of procedure.

Bill 52 can also be understood using a consequentialist framework. A standard consequentialist theory states that what is morally right, and thus ethically justifiable, is the promotion of the most good for the greatest number of individuals. Further, common consequentialist theories state that human wellbeing is good, and so should be maximized (Kagan, 1998; Sullivan, 1999). Properly understood Bill 52 can be justified if it is able to provide the most wellbeing for the greatest number of patients. In many ways, Bill 52 does allow for the maximization of human wellbeing. Indeed, many believe that just being alive does not always trump being dead, some lived experiences can be so painful that the individual's wellbeing is negative. For example, an individual can be a prisoner of war and be made to suffer intense acts of torture. The torture occurs constantly and without relief, preventing the prisoner from experiencing any benefits of life. In these unfortunate cases, it can be both ethically defensible for such an individual to prefer death (Kagan; Sullivan). Diseases that fulfill the requirements for medical aid in dying are ones that are not only painful but also incurable. As such, the suffering being felt by the patient is both unbearable and constant. These suffering patients can be considered to have a negative level of

wellbeing. That is, having the patient's lived experience be connected to unbearable pain can reduce overall wellbeing. The patient may have some positive experiences, such as cultivating personal relationships, but as a whole, they are overshadowed by the magnitude and consistency of their suffering (Sassower & Cutter, 2007). Given that their wellbeing is consistently negative, the alleviation of their suffering through medical aid can be seen as a way to increase the wellbeing of the patient; similar to the prisoner, the peace of death is, on the whole, better than the constant pain of living. Stated differently, consequentialist calculations can justify medical aid in dying if the negative wellbeing of being alive is worse than being dead (Sullivan, 1999).

On the level of the individual patient, then, medical aid in dying can be ethically defended on consequentialist grounds. What becomes more problematic is justifying the broader practice of physician-assisted suicide. For some, allowing the healthcare system the ability to perform medical aid in dying will have more negative consequences to wellbeing (Sassower & Cutter, 2007; Sullivan, 1999). These opponents agree that in certain individual cases, there is more wellbeing in performing the end-of-life procedure. However, they argue that this fails to acknowledge the impact that this ability will have on other, similar patients who are suffering, but who do not want to die. The fear is that these patients will be coerced into accepting the procedure, either out of social pressures to conform to other end-of-life patients or out of economic pressure to alleviate hospital resources. Since these patients do not actually intend the procedure but rather are forced into it through coercion, performing medical aid in dying will seriously harm these patients. Since they do not have the freely given consent of the patient, the procedure is harm rather than a permitted action. Overall, the existence of these coerced procedures greatly affects consequentialist calculations. The harm inflicted on these coerced patients, they argue, is more than the pain alleviated from the suffering patients. A properly calculated analysis shows that giving physicians the ability to

do end-of-life procedures, such as medical aid in dying, is not morally defensible on consequentialist grounds.

Bill 52 properly considers both consequentialist arguments in its legislation. It acknowledges that the alleviation of suffering through death is a great benefit that physicians can give to end-of-life patients. Being able to provide this benefit to patients who are unable to commit suicide themselves is, after all, one of the main reasons behind this legislation. However, it treats seriously the second consequentialist argument that harm can be done to patients through coercion. This concern underlies many of the bill's restrictions and requirements. Without them, physicians are more likely to do harm to patients. The bill's emphasis on respecting the patient's autonomy throughout the process protects against the second consequentialist argument. If the bill is properly applied, then coercion is not present and the end-of-life procedure is an alleviation of suffering. Overall, the bill maximizes human wellbeing, and so can be justified using a consequentialist framework.

Deontology recognizes that our actions should be morally constrained by a number of different duties (Kagan, 1998). These duties can be general, such as a duty not to inflict harm on other individuals. These duties can also be very specific, and arise when there is a particular relationship between individuals. The special duty to uphold a promise, for example, only arises when a promise has been explicitly made between the maker and the receiver of the promise. These duties form morally binding obligations that constrain action. Failing to perform a duty is, under a deontological view, a serious moral offense (Kagan). For the purposes of this paper, patient-physician relationships shall be discussed. Properly understood, this relationship confers special duties to the physician to treat the patient in a particular way (Brody, 1992; Sassower & Cutter, 2007). Some of these special duties have already been addressed in other ethical frameworks. For example, the duties to respect patient autonomy, to benefit the patient, and to do no harm have all been addressed as bioethical principles that a healthcare system should uphold (Brody; Sassower & Cutter).

However, they can be understood as duties that physicians are morally obligated to uphold as well. The special duty that shall be covered is maintaining patient trust.

This special deontological duty is important because of its practical and ethical impacts (Sassower & Cutter, 2007). On a practical level, trust is necessary for the physician-patient relationship because it ensures an open and honest dialogue between the two individuals. This dialogue becomes particularly important when discussing prognosis and available procedures. On an ethical level, trust is necessary to treat each other respectfully as autonomous agents. An individual's life goals cannot be respected if, for example, the goals are considered to be false or unimportant by less trusting individuals. Notably, this duty can be understood both positively and negatively. A positive duty to maintain trust confers an obligation to cultivate trust with the patient. Having an open and accessible relationship, one where both individuals' views are accepted as equal, is one way of fulfilling this positive duty. A negative duty to maintain trust confers an obligation not to undermine the patient's trust. Ignoring a patient's wishes and imposing one's values is one way of failing this negative duty. Properly understood, the physician's special duty to maintain trust with the patient obligates them to treat the patient with a certain level of respect, acknowledging both their medical needs as well as their own personal goals and wishes.

Bill 52's legal framework is consistent with the physician's special duty to maintain the trust of patients. This consistency is most clearly shown in Chapter 1's provisions. Its four principles can connect the act with other legal legislation. However, its principles are also positive ways to ensure the trust of the patient by acknowledging the patient's freedoms, their sense of dignity, and their personal autonomy. Indeed, the legal emphasis on autonomy is also important for this bioethical framework because of the role autonomy plays in maintaining trust. Recognizing and ensuring autonomy by being open to the patient is necessary for trust. Properly considered, then, Bill 52's legal framework, which uses principled provisions and which emphasizes autonomy, can uphold this duty to maintain

trust. In these special duties, at least, the bill is defensible using a deontological framework.

### Application

The legal requirements of Bill 52 can be defended using three bioethical frameworks. In principle, then, the Bill is ethically justifiable. However, what is legally and ethically required may not be what is actually provided when the law is applied. For example, consider the education provided to marginalized communities, such as Aboriginals. Due to different social factors, such as the poor location of their communities, many marginalized communities do not receive the education they require (Preston, Pelletier & Pierce, 2011; Wilson & Cardwell, 2012). Importantly, this unjust and unequal access to education occurs despite having the same education legislation as other Canadians (Preston, Pelletier & Pierce, 2011; Wilson & Cardwell, 2012). Consequently, while a particular law can be the same for both marginalized and non-marginalized groups, its application for each group can be different. As such, a law's legal and ethical defensibility can be criticized depending on how it is applied to a particular group. Bill 52's application can be questioned because it does not guarantee that marginalized communities will also receive the same treatment as non-marginalized groups. In particular, while Chapter I's provisions outline an ethical set of principles for applying the legislation, it cannot guarantee that the procedure will in fact follow those principles.

Consider Chapter II's rights with respect to end-of-life care. Within this chapter is clause 6, which ensures that patients have the right to refuse life-sustaining treatment if that the patient is informed enough to make that decision (Parliament of Quebec, 2013). The law makes no prejudicial requirements that exclude marginalized communities. However, consider what is required in order for an individual to be informed. Under clause 6, the patient needs to be informed of their right to refuse treatment, what this decision procedurally entails, and other therapeutic possibilities that the patient can pursue. At the very least, a basic understanding of medical procedure is

necessary. However, not all individuals in marginalized communities are able to understand that information. Consider an elderly Aboriginal patient who grew up in a reserve and who did not receive a primary level education (Wilson & Cardwell, 2012). Due entirely on the patient's social background and her resultant lack of education, she is unable to exercise the same rights as other Canadians. It is important to emphasize that the content is not being criticized. Patients should be informed when making these decisions. However, the legislation does little to ensure that patients who are marginalized and require additional support just to exercise these rights are given the help they need.

Chapter IV's requirements for end-of-life care can also be criticized for not providing enough support for marginalized communities (Parliament of Quebec, 2013). The second requirement, for example, states that patients must suffer from serious and incurable disease. Legally, this should place a strict but equal restriction on the kinds of diseases that can request end-of-life care. No particular disabilities or demographics are prejudicially ignored by the law. However, this legislation still fails to consider suffering patients whose cures are religiously or culturally intolerable. For example, suppose the only cure for a serious illness that inflicts constant pain is a blood transfusion. A Jehovah's Witness cannot, under this law, request for end-of-life care because a cure is legally available for the patient. This prevents the patient from exercising their rights despite the procedure being available for all Canadians.

Overall, Bill 52 can legally and ethically be defended in principle. However, its application is far from ideal. Although its stated provisions strive to apply a respectful and equitable end-of-life procedure for all Canadians, it has the potential to disadvantage patients in marginalized and minority groups. These groups have particular healthcare needs due to their social factors, including clinical procedures that are sensitive to their patient's socioeconomic background or beliefs. The fact that the bill does not address ways to combat these systemic disadvantages is a fault that could lead to injustices, wherein patients do not in fact have access to these resources.

However, these faults should be recognized as empirical criticisms that require further study to not only show there are issues of accessibility but also to find effective ways to improve access. Legally and ethically, we can only appeal to the healthcare system and its physicians to act in accordance with the stated provisions of the law.

### **Conclusion**

Quebec's Act respecting end-of-life care attempts to provide end-of-life procedures that allow medical aid in dying. Three chapters of Bill 52 have been addressed in this essay and, overall, these chapters are legally consistent with other healthcare legislature in Quebec and Canada. These three chapters have also been ethically examined and a consistent ethical argument can be made to defend the bill's legal framework. Bill 52 provides a much-needed procedure for end-of-life patients that is both legally and ethically defensible. However, the legislation is imperfect, and leaves itself prone to systemic faults that disadvantage certain communities. Addressing these faults is an important political task because of its potential to unjustly harm these communities. Being good in principle is not enough. If the bill wants to maintain its status as a just piece of healthcare legislature, it needs to address the needs of these marginalized and minority communities.

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## Depression on the Backburner in India: An Intersectional Analysis

**ANTU HOSSAIN**

One of the most cautionary diseases that have become visible on the global stage are mental disorders. More specifically, the World Health Organization (WHO) has predicted that the global burden of disease will lie with depression, and it will be the second leading cause of disability after heart disease by 2020 (WHO, 2001). The literature and international agencies have placed a heavy emphasis on Western countries' experiences with depression because they are the greatest research funders of mental disorders. However, it is difficult to overlook the alarming depression rates in India. Depression affects 10% of the entire population at a given time, and one in every five suffer through depression at some point in their life (Chandrashekar, 2007). What is more unfortunate is that 15% of depressed persons end their life in suicide. Depression is an acute problem that has been on the back burner of India's agenda, and this is persistent because of the poor distribution of psychiatric attention in the population. There are 25,000 psychiatrists, 600 clinical psychologists, 500 psychiatric social workers, and 600 psychiatric nurses available for a country of 1.02 billion (Chandrashekar, 2007). The lack of caregiver professionals relative to the overwhelming population coupled with the great social stigma attached to mental health issues, has resulted in greater marginalization of vulnerable groups. Indian women face double the one-year prevalence rates of depression (9.5%) than men (5.8%) (Grover, Dutt, & Avasthi, 2010). Women are subject to multiple cultural, social, sexual, and structurally constructed identities. Much of the present literature has isolated these factors alone and then continues to explain how they contribute to oppression. Unfortunately, much of the research available positions women as a homogenous group and often fails to account for differences or how multiple factors are at play. Therefore, in the present

context it becomes important to explicitly position why women are more vulnerable to experiencing depression. The intersectional framework is a tool that can be used to create a critical landscape where the female gender is dissected with respect to patriarchy, caste level and poverty conditions.

### **Intersectional Framework**

Intersectionality originated in the work of African American feminist scholars (Collins, 1990; Crenshaw, 1989; Hooks, 1990) and is used to develop an analysis that frames how different dimensions of social inequality interact with each other and impact processes of oppression and domination. In this paper, the female gender will be analyzed as to how this identity interacts with social forces of patriarchy, being from the lower caste (*dalit*), and while living in poverty. The ultimate analysis is to apply how the intersectionality of these specific characteristics can increase depression prevalence. This approach is unique because it is not an additive approach (Hankivsky, 2012). It avoids looking at gender, race, or class as simple binaries (e.g. gender+ class+ race/ethnicity) and layers several simultaneous oppressions (Hankivsky, 2012). Intersectionality looks at a multi-level analysis that incorporates attention to power and social processes at both micro and macro levels (Dhmoon & Hankivsky, 2011). A daunting task may seem to be that intersectionality demands one to include all potential variables in a research design. This is false. Intersectionality encourages researchers to be explicit about which factors were addressed as prominent, and why other aspects were under-analyzed as a result (Hankivsky, 2012). The paper will first lay a solid foundation to help conceptualize some of the characteristics in question and their influences on each other, and then will segue into a multi-level synthesis that combines five aspects. Since the topic of this paper is concerned with gender, the analysis will attempt to de-center gender and thus allow space to determine salient interactions with other areas that include patriarchy, low caste, poverty, and their impact on depression.

### **Patriarchy and Depression**

Patriarchy is defined as a set of social arrangements that privilege men, enabling them to dominate women as a group both structurally and ideologically (Walby, 1990). Despite emerging feminist ideals, the Indian society remains very patriarchal. As women continue to be oppressed, their psychosocial environment deteriorates, which can ultimately result in depression. Patriarchy should be considered from the dual perspective of men and women, and the types of identities this system constructs for both groups. The socially valued ideas in India of chastity and masculinity have a strong control on everyone's behaviour (Hurtado, 1998; Lindisfarne, 1998; Paternostro, 1998). For instance, hyper-masculine values are idealized in men to make them appealing to an ideal partner. On the other hand, chastity in women signifies a family's honour. These cultural values have become morally and ethically acceptable, as they have gained force through cultural participation. Thus, failing to meet these values creates a sense of shame along with a sense of "insufficiency and inadequacy" (Greenwald & Harder, 1998). Feelings of shame follow those who cannot live up to these high social pressures, making them internalize the shame, thus contributing to depression (Mahalingam & Jackson, 2007). Hypermasculinity as a dominating and accepted societal ideal reflects the discrimination that women face by men, and therefore, this societal endorsement lowers the mental health of women (Mahalingam & Jackson, 2007). Women in India are under constant pressure to prove their loyalty to their husband's family, uphold ideas of purity and piousness, and help the longevity of the family name by giving birth to sons. In some cases, women who fail to bear a son face the threat of their husbands marrying another woman. They internalize the blame society bears onto them and in effect, this leads to depression and further perpetuation of patriarchal influence. One community ethnographic interview translates the difficulties of family responsibility in bearing a son and depicts the unfortunate consequence of infanticide:

I had five children. I killed my third daughter. I could not stand the torture of my mother-in-law. She was complaining that I was giving birth to only girls. Family tree is not rooted yet. Perhaps we should find another wife for him. I was hating myself. Then my older sister told me that if you feed saline water the infant would die (Mahalingam & Jackson, 2007).

### **Kerala Case Study and Patriarchy**

The question now lies in how patriarchy remains such a salient cultural structure despite the globalization of values such as female empowerment and independence. Kerala, a state in southwest India is highlighted to have great public health indicators and is portrayed as an ideal region with an elevated status of women. However, this is not true. An indicator of gender development and empowerment is a region's mental health (Hapke, 2013). The Kerala Mental Health Survey indicates a higher incidence of mental stress and mental illness in its general population compared to national and international rates, and the rates are again higher for women (Hapke, 2013). Women are largely immobile in Kerala, where they are segregated in public areas from males and their interaction is disciplined. Their roles are tied to specific gendered identities related to domestication (Devika, 2002). Historically, it is around the early and mid-twentieth century that there was a movement to institutionalize the authority of a husband over wife and children. This was reinforced through forms of individualized property rights and a gender ideology, which emphasized women's domesticity and eliminated much of a woman's autonomy that existed under matriliney (Hapke, 2013). Such state practices have further entrenched patriarchy and have built upon the normative traditional views of women and the family to legitimize their own power. For example, even with the institution of marriage, it is deemed socially necessary for females to marry and leave their parental home for their husband's. Attached with many marriages are dowry deals, and this is more a "groom price" that displays the capital accumulation for the groom's families as well as a social and family status for women (Kodoth & Eapan, 2005). As one can

deduce, these deals put a heavy burden on the female's end and her family as it creates significant social and economic pressure. Thus it makes this socially necessary relationship one that is economically impossible, and causes psychosocial stressors and hardship, which are largely internalized by females.

The dowry price is more of a taxing problem for families with low income. However, women who are from high SES families also feel the influence of patriarchy. Females with higher education levels and relatively higher age for marriage in middle and upper class groups are a threat to the patriarchal system in place. The number one reason for violence within families is the failure of women to obey their husbands (Mitra & Singh, 2007). This forms a poor household environment where females are subject to greater domestic violence and verbal abuse, which are both pathways that can develop into depression. The fact that violence against women in the domestic sphere is so prevalent, can speak to the existence of deeply rooted patriarchal hierarchies. Any regressive backlash, such as further education or employment ability threatens this system and causes further reassertion of traditional norms and practices. Consequently, one can see how this affects women in different ways despite their social status (high income or low income) and thus leads to depression in many cases (Mitra & Singh, 2007).

### **Caste System and Depression**

The caste system practiced in India is one of the more undignified socio-cultural institutions in the world that breeds social inequity. It has divided the society horizontally and vertically, creating a monopoly of power. Resources are in the hands of upper-castes and the lower castes end up facing debilitating standards of living and disgraceful human rights (Mungekar, 2007). The Scheduled Castes (SC) and Scheduled Tribes (ST), also known as *dalits*, have been excluded from access to economic growth benefits since India gained national independence. These two groups constitute 27 percent of the total population, but are gravely deprived in many areas of

socio-economic development, such as literacy, education, employment, life-expectancy, nutrition and health (Thorat, 2009). This stratified structure is ingrained in the Indian economic, political and cultural context. Similar to patriarchy, it is a hierarchy that is connected to many other spheres of everyday individual experience and is reinforcing in nature. The analysis of a female's gender identity in a social hierarchical structure is critical to make explicit, along with the interplay of oppressive layers of patriarchy and caste background.

Women are subject to greater vulnerability if they are of lower caste. The SCs and STs have been subjected to different forms of violence, which center around the violation of their civil rights and the atrocities resulting from negative economic and political factors. They are faced with heavy social exclusion in public spaces. For instance, they are not allowed to enter temples, use public washrooms, roads, or share cremation grounds to mention a few (Das, 2013). The social clash extends to land ownership, employment wages, political involvement and violence. Women of the lower castes have been subject to atrocious violent acts by upper caste men. Of the total 168,000 crimes committed against SCs in different regions of India between 1997 and 2002, 5,641 were rapes against SC women (Das, 2013). The notions of purity and pollution and those of hierarchies become irrelevant from the point of the upper caste men who rape the SC/ST women, since their bodies are objectified (Das, 2013). Moreover, when the scheduled tribes and scheduled castes try to preserve their self-respect for honour of their women, they become irritants for the dominant and are subject to targeted violence. What is more distressing is the blatant insensitivity of the nation in response to the great violent acts against lower caste persons, particularly by political forums such as the Parliament and the State (Das, 2013).

### **Women, Poverty and Depression**

Poverty is paralleled with deprivation of resources, poor environment, and unequal power relations. Both identities, one being a woman, and the other of residing in a poverty-stricken

setting, are significant stressors which exacerbate one another. The gendered roles of Indian women add to their psychosocial stressors. For instance, most of the economic hardship and reports of distress involve females being responsible for child (and/or sibling) rearing starting from a young age (Kuruville & Jacob, 2007). In addition, women may have the double burden of working in the paid labour market to provide for their family's poor circumstance on top of their domestic duties. As such, depression can be associated with the core hopelessness experienced by poor educational and work prospects and the migration of husbands to urban areas for employment (Kuruville & Jacob, 2007). With only a female left running the household, there is even greater pressure and stigma associated with producing a son to help sustain the family in their economic hardships (Patel & Kleinman, 2003). Women are more likely to sacrifice their well-being for their family. This is a common conditioning that they have been subject to from childhood, such as in cases where greater medical attention will be given to their brothers. This type of devaluing of their medical needs carries over to their adulthood where their health is regarded as less important than their child's or husband's in the case that there are few funds for medical attention. In sum, women will forego certain goods and services in order to increase the amount available for others (Payne, 2000). Furthermore, depression during pregnancy is a common problem and is associated with a poor environment lacking in resources and high stress, and this includes indicators of socio-economic deprivation and problems with violence and loss of intimate relationships (Lovisi et al., 2005).

To summarize some of the effects of poverty, and more specifically in terms of class and how women are disproportionately burdened, a study by Gita Sen reveals the effects of class on social health inequities (Sen et al., 2009). Sen et al. (2009) separated groups of men and women into non-poor, poor and poorest and looked at their ability to seek treatment. Even though this is a broad model, it has the potential to be applied to mental health care treatment. The authors found that class does not make a difference in men and

the likelihood of non-treatment (Sen et al., 2009), but there is a drastic difference within women groups who are poor versus non-poor. This comparison only applies to the preliminary hurdle of accessing treatment, not the quality of treatment. The gender disparity is transparent in health inequity because the results show that the poor and poorest men are better off than non-poor women, and this is because non-poor women were closer to non-treatment akin to poor and poorest women (Sen et al., 2009). Therefore, one can see that through this model, class operates through gender. This research model shows that both class and gender are factors that must be studied in parallel and not in isolation, or there is the risk that their real oppressive consequences can be masked.

### **Combining Intersectionality: Low Caste, Poverty, Gender, Patriarchy and Depression**

The scope of literature on lower caste (*dalits*) women fails to employ an intersectional analysis for understanding depression among this group. There are two pieces of literature that do respect this theory, albeit not in explicit terms. It has been quoted time and again that the poor health of people from the *dalit* caste, their social exclusion and social stratification are due to the unequal distribution of power, income, goods and services. Historically and until present time, these *dalits* lead lives dictated by the ingrained caste system and which deprives them on various fronts; whether it be access to clean water, sanitation, nutrition, housing, education or employment. Ultimately, this is the consequence of ill fitted social policies and programs (Jiloha, 2007). Belonging to the lowest caste is inextricably linked to and is a proxy for poor socioeconomic status in India, and this can date back to family history and childhood development. A child born into the lowest caste family becomes aware of their low-caste status early in life. During the ages of 3-6 years, children experience heavy social exclusion and social stigma, and by 8 years of age, this aids in developing a non-resilient personality ill equipped with dealing with societal pressures (Jiloha, 2007). Moreover, children grow up with parents who are working in defiling

occupations and this leads to shame, anxiety and low self-esteem in regards to the family environment they grow up in, thus developing into low emotional stability (Jiloha, 2007). To elaborate, social stigma refers to a 'defect' in a person's social identity.

Moreover, females of the lower caste have been found to be more protein-calorie malnourished than males, and this has a deterring effect on their intellectual growth. As discussed earlier, *dalit* females face a great deal of discrimination and abuse. The resulting emotional despair becomes even more difficult to cope with when they are depleted of cognitive reserves (i.e. poor intellectual growth) from an early age. This little cognitive reserve makes them highly vulnerable mentally when dealing with consequences that lead to depression. To delve deeper into a multilevel critique of how a low caste (*dalit*) female's impoverished environment impacts her vulnerability to be depressed, there must be a segue into psycho-social stressors. Studies have revealed that low caste students have unrealistic motivation, personal inadequacies for failures, harsh and rigid self-evaluation and extreme anxiety for outcome of personal performance (Jiloha, 2007). Success is not as reinforcing as it should be, and failure is extremely discouraging. They experience a fear of failure because of the internalization of personal inadequacies, negative memories, alongside low perception of the self and heightened social anxiety (Jiloha, 2007). Even though this study did not particularly account for female students in the lower caste, one can extrapolate that based on the prominent patriarchy of the Indian landscape that female students do suffer even harsher mental health backlashes. This compounded stress can stem from the many cultural expectations, household duties and roles they need to fulfill.

A descriptive study conducted in Haryana, a northern Indian state, evaluated some of the factors that could contribute to the prevalence of depression in the region (Dhingra & Parle, 2011). Among women, stressful/forced marriage and low socioeconomic status are noted as the reasons for developing depressive illness (Dessislav, 2005). Women were largely

conflicted by marital and familial relationship problems and the death of loved ones (Dhingra & Parle, 2011). This speaks to the social burden and responsibility females carry because of their household roles as mother, wife, and daughter, all of which they must uphold properly. In general, "this study's findings demonstrate a high prevalence of depression among lower castes of the Hindu community with low socioeconomic status and particularly in female patients" (Dhingra & Parle, 2011). Unlike the first study (Jiloha, 2007), this study does not elaborate on how these multiple oppressions are at play with one another. However, the authors do credit intersectionality by explicitly problematizing these factors. In sum, it is concerning that it is rare of mental health research to take intersectionality theory into consideration within their analyses. There is hope that the aforementioned analysis in this paper is able to frame the reality of the multi-level interaction in a social and political context for lower caste (*dalit*), impoverished females in India, and their battle with the rising prevalence of depression.

### Suggestions

Future research should attempt to gain a more holistic picture of intersectionality theory in the Indian landscape by looking into ethnicity, religion, sexual orientation, geography, and age and how they interact with gender and mental health. Another aspect to position the intersectional framework is through urbanization. As more Indians are moving to the city for economic and educational reasons, there is a resulting change in the structure of the family unit. With a change in the family unit from an extended to a nuclear structure, there is a shift in family support networks and this loss is a stressor for depression. The literature puts a heavy focus on vulnerable populations, but there also needs to be an exploration of the agency, resiliency and resistance to domination by these persons (Hankivsky, 2012). Aside from looking at the extreme ends of poverty, there needs to be a focus on the dominant middle class and the factors that shape their identity. For instance, class identity formation and relationship to gender in

the middle class could be an area of great insight, and how it reinforces social status hierarchies such as patriarchy and caste. In reference to the changing landscape of Kerala (and in India largely) there are economic and cultural shifts, which result in tensions. It is important to be explicit of whether gender ideologies are being adopted or altered to the same degree in social practice across communities. Aggregate data can become problematic as it homogenizes groups and their actions. Various responses need to be teased separately and presented individually to uncover how specific determinants influence the larger economic and cultural context. The intersectional framework is a useful tool to develop inclusive and better quality policies. It frames complex problems of human life and social inequity in a manner that explicitly problematizes the many dimensions at play. This framework is an ideal approach for future research because it raises important questions, has the capacity to explore women's health, men's health, gender health and to debate hidden determinants. Lastly, the intersectionality approach equips policy makers to have evidence-based responses for changes to social and government programs which could change people's lives.

### Conclusion

In summary, depression is a product of multiple psychosocial stressors, the environment and social and structural processes which can become oppressive to the subject. Patriarchy is a dominant ideology in Indian society as it determines the gendered social roles that females and males fulfill. This assertive dominance leads to a gender-power relationship where females are made to be the inferior group. Feelings of shame are internalized and low self-esteem causes self-blame, and thus this oppressive social structure feeds into the male dominant culture and can lead to depression. Secondly, India's caste system has caused unjust alienation of those in the lower caste and has reproduced a social hierarchy. Within the lower *dalit* caste, females experience severe vulnerability since they are socially neglected, deprived of

resources purposefully and subject to violence by people from the upper caste. A lack of social support networks and the constant legitimisation by governing structures of discrimination in the public space has caused negative emotions and depression. Lastly, the poverty scale is tipped disproportionately in women's direction because of their poor socioeconomic situation combined with their many gendered social roles. They are automatically given a hefty responsibility to fulfill several duties (mother, wife and even labour worker at times), and this becomes mentally taxing, thus contributing to depression. As the argument in this paper unfolds, it becomes evident that gender, patriarchy, low caste and poverty are interlinked and influence each other strongly. The intersectionality framework allows researchers to question the origination of key determinants in a complex problem, such as mental health. It further problematizes and prioritizes these issues so that a foundation for health equity research can lead to application and change.

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## Canadian Extractivism in Latin America: Inequality as Foreign Policy

GAIL ROBSON

In a report detailing 10 years' worth of human rights abuses by mining companies, more than a third of the companies singled out as perpetrators were based in Canada (CCSRC, 2009). As a small economy in global terms, this statistic may be surprising, but it is not an anomaly; it is emblematic of the extent to which Canada has become a haven for mining companies and the lack of accountability placed on these corporations. This paper will explore theoretical conceptions of inequality and the history of free trade in Canada and Latin America to analyze the role of Canadian foreign policy in reinforcing a system of global inequality. I will focus on the mining industry in Latin America with Honduras as a case study, to argue that Canada's neoliberal and corporate-centric foreign policy is damaging to communities and antithetical to sustainable development. Extractivism—the focus of national policy on extraction of resources (Cite, this is a definition that is not common knowledge, it needs a source)—is a defining feature of not only Canadian trade and economic policies, but foreign aid and development programs as well. Canadian policies promote capital accumulation for the benefit of corporations and as such directly contribute to the resulting environmental degradation, devaluation of workers as units of production, undermining of social systems, and the concrete manifestations of disease, unregulated work conditions, violence, and rampant inequality.

There is a significant amount of literature connecting the conditions of income inequality and socioeconomic disparities to reduced health outcomes. Inequality destabilizes societies and as a consequence encourages corruption, undermines justice systems, and leads to higher mortality and more expensive health costs (Jong-sung & Khagram, 2005; Kaplan, 1996). Socioeconomic status has been referred to as the

“fundamental cause of disease,” as the primary determinant of an individual’s health status, and those countries with highest inequality have the worst health outcomes (Link & Phelan, 1995; Subramanian & Kawachi, 2003). England in the 19th century is a prime example of socioeconomic inequality, with the incredibly rich benefitting from the industrial revolution and the devastatingly poor suffering in workhouses with no labour laws or safety regulations (Engles, 1845).

Despite implementation of healthcare systems, unions, and regulations to combat this inequality in some parts of the world, the globalized economy has translated this fundamentally unequal system onto a global level. We still have women slaving over sewing machines—losing their eyesight without any health coverage, being sexually harassed with no hope of justice—but these women now work in Maquiladoras, or clothing factories, in Latin America for American and Canadian transnational corporations while their CEOs are living in New York City penthouses (Pineo, 2013).

Marxists and socialist political economists understand this inequality as a result of the capitalist relations of production. In a capitalist society, the class division is between those who own the tools and facilities of production-- the capitalists-- and those who work in these facilities to create product-- the proletariat (Howlett, Netherton & Ramesh, 1999). In the context of a globalized economy, this division often crosses country borders. Globalization and deregulating markets can lead to a form of “monopoly capitalism” in which multinational corporations come to dominate the economy, becoming so large that they themselves are able to draw in state support (Howlett, Netherton & Ramesh, 1999). The mining industry in Canada has created a system of monopoly capitalism, influencing Canadian foreign policy such that the Canadian government deploys its diplomatic and economic assets to promote extractivist neoliberal policies around the world.

Latin America has been a classic example of the clash between economic ideologies; this is seen in the devastating effects of the Structural Adjustment Programs in the 1980s to the ongoing capitalist Canadian and US policies pushed into

government documents on behalf of extractive industries. The constant quest for cheaper labour and higher profits leads to increasing labour exploitation through a “race to the bottom” for the lowest wages and least regulation (Veltmeyer, 2012). This creates dangerous conditions for the workers themselves, and often leads to backlash through grassroots socialist movements, but these are subdued by the sheer military and economic force of the multinational companies and the elites who benefit from this system of inequality (Veltmeyer, 2012).

To understand the context of this global inequality, one must first examine the history of trade and resource extraction in Canada and Latin America. As stated at the unveiling of Canada’s new global trade plan in 2013: “from the days of the courriers de bois and the Hudson’s Bay Company, Canada has been a trading nation” (Global Market Action Plan, 2013). This is true, though perhaps a simplified and sanitized version of Canada’s history.

The history of trade in Canada and Latin America follow a similar “origin story.” Both North and South America were “discovered” in the late 15th and early 16th century by European colonizers who exploited the land’s natural resources to trade back in Europe (Chasteen, 2001). The idea of the Americas being “discovered,” however, is very misleading. The indigenous people in the Americas at the time had established complex civilizations, including systems of agriculture, transportation, and social hierarchies (Mignolo, 2005). The European imperialists arrived in the New World looking for resources: gold, silver, timber, sugar, minerals—and they found them. Land was unceremoniously claimed from indigenous peoples from today’s Southern Chile to northern Quebec. The people themselves were displaced, enslaved, or murdered on a massive scale (Galeano, 1997). So complete was the eradication of these civilizations by the Europeans through military force, enslavement, and disease that in the early 1700s, about 200 years after the first arrival of the Spanish, explorers remarked on the “pristine” nature of Central America and its vast emptiness. Indeed, a country would look pristine if its cities were decimated and its population was reduced by up

to 90% in the span of a few hundred years (Devevan, 1992). The disregard for rights of indigenous people is a lasting injustice that can still be found in trade policies around the world today (Denevan, 1992).

Imperialism in this era was defined by European explorers claiming resources as their own, colonizing the land, and bringing these riches back to Europe (Chasteen, 2001). It was not until 1765 that colonies began to trade amongst themselves (Galeano, 1997). Before that point, all goods had to be brought directly to Spain. The law signed into effect by the Spanish Crown was one of the first “free trade” agreements. Colonies could trade with each other, widening the cycle of extraction and production—which at that time was dominated by wealthy land-owning capitalists in Latin American colonies and the transport of humans as slave labour from ports in Africa (Galeano, 1997).

The “Dominion of Canada” was officially founded in 1867; about 30 years after many countries in Latin America had fought for their independence from the colonizers of Spain, Portugal, and France. While technically “independent,” the power vacuum left in Latin America post-independence allowed an influx of US and British commercial projects (Chasteen, 2001). After serving primarily as exporters of primary goods to the US, Latin American governments shifted to state-led development policies of import-substitution industrialization after the market collapse of the Great Depression (Veltmeyer, 2012).

However, after constant attempts by the US to undermine socialist policies along with globalization and widespread financial crises, in the 1970s, inflation, corruption, and massive debt left Latin American economies vulnerable to collapse. It was then, in the late 1970s, the International Monetary Fund (IMF), World Bank, and US Treasury created the Washington Consensus— cementing the classical liberal philosophy of comparative advantage into a set of ten policies (Gore, 2000). In exchange for IMF loans, indebted countries had to adhere to these policies— slashing social spending, rejecting state intervention in the market, and effectively reverting to export-

based economies (Gore, 2000). These structural adjustment programs were a thundering success or utter failure depending on whom you ask. According to pro-market neoliberal economists like Milton Friedman, these projects, such as the so-called “Chilean Miracle”, were incredibly successful— (Richards, 1997). In Chile, Milton’s prescribed “shock therapy” of sudden and complete cuts to all social spending and government intervention brought the economy back into the global economic system exporting primary goods— but at the expense of massive inequality, rampant unemployment, political instability, and corruption (Richards, 1997). Neoliberalism proved most effective in re-instating class power over anything else. As Portes and Hoffman described, “Neoliberalism has proven more successful as a political than as an economic project” (2003). Neoliberal policies showed no evidence of their supposed “trickle-down” effects, and did not distribute wealth equally, rather they restored the concentration of wealth and power to the elites. These policies reinforced a system of comparative advantage and brought Latin American countries into the globalized production system as exporters of primary goods (Veltmeyer, 2012).

This emphasis on comparative advantage has persisted into modern international trade theory, especially as promoted by Canada (Howlett, Netherton & Ramesh, 1999). In the context of globalization, the capitalists and corporations that own vast amounts of resources don’t have to be anywhere near the resources and workers themselves. Unlike the conquistadors of the Spanish Empire who travelled across oceans to conquer and pillage the land, a more systematic form of imperialism, or “neo-imperialism” exists today through the normalization of capital accumulation in financial centres with little to no accountability to the workers and governments where the resources are being exploited (Klassen, 2009). This paradigm is founded on the ideas of extractivism— orienting markets around primary resource extraction. Extractivism is at the centre of Canadian foreign policy, which prioritizes corporations and capitalist ventures to advance Canadian interest— creating a concentrated pool of wealth in the headquarters of mining

corporations and the Toronto Stock Exchange but very little distributed throughout Canada, let alone across the globe (Veltmeyer, 2012).

Canadian development rhetoric centres on promoting economic growth in countries where resource extraction occurs— with the assumption that the investments from mining companies into local economies will stimulate development (Douglas & Kidornay, 2013). The ideology behind the 1980s Structural Adjustment Policies is still alive and well through Canadian influence in promoting deregulation and minimal government interference in the extractive industry. This development narrative has been criticized by many economists and development theorists including Escobar, a Colombian anthropologist who argued that “developmentalism” is buying into the modernization trajectory with the industrialized Western model as the final goal, or, as he describes it: “colonizing ourselves” (Escobar, 1995). He argues that since colonization, “developed” countries could only reach that stage through the exploitation of others— and as long as a country is being exploited, it will never get out of the “developing” category (Escobar, 1995). Both this model of development and the image of what makes a “developed” society are flawed.

While Canada leaves it to the “invisible hand” of the market to fairly distribute wealth in countries where resource extraction occurs, the government has no problem intervening for the sake of corporate interest back in Canada. Canada is a haven for mining corporations with over 75% of global mining companies headquartered in Toronto (Douglas & Kidornay, 2013). In 2011, \$439 billion was listed in mining projects in the Toronto Stock Exchange (TSX) and 90% of all global mining equity financing was done on the TSX in 2012 (Toronto Stock Exchange, 2012). The government provides support for mining companies both directly and indirectly, through leniency in investor speculation, tax incentives, corporate protection from legal responsibility for abuses outside Canadian borders, actively advocating on behalf of the industry, and engaging diplomatic and development support for mining projects (Deneault & Sacher, 2012).

Investor speculation allows companies to fabricate profit margins and encourage investment without any proof of profits, let alone proof of ethical practices (Deneault & Sacher, 2012). Other countries, including the US, have laws promoting investment transparency, but in Canada, market and social pressures are supposed to compel companies to adopt governance standards that will maximize their value (Rousseau, 2003). Tax incentives encourage investors to put shares in mining companies, through both federal and provincial programs. Up to 115% of the amount invested can be deducted, effectively supporting mining speculation by public funds (Deneault & Sacher, 2012). Any Canadian with money in retirement funds, RRSPs, pension funds or savings accounts is unwittingly contributing since most of these are almost entirely invested in the mining-heavy TSX (Deneault & Sacher, 2012).

The legal and political systems in Canada create a bubble of protection around mining companies. It is nearly impossible to hold companies accountable for abuses and crimes committed outside Canadian borders. The UN Committee on the Elimination of Racial Discrimination focused its 2007 recommendations on the suffering inflicted on indigenous people by the Canadian mining industry abroad. In the report, they noted “reports of adverse effects of economic activities connected with the exploitation of national resources in countries outside Canada by transnational corporations registered in Canada on the right to land, health, living environment and the way of life of indigenous people living in these regions.” They recommended that Canada “take appropriate legislative or administrative measures to prevent acts of transnational corporations registered in Canada which negatively impact on the enjoyment rights of indigenous peoples in territories outside Canada” and “explore ways to hold transnational corporations registered in Canada accountable for these acts” (CERD, 2007).

Despite this clear indictment of Canada’s role in regulating the extractive industry, there is still almost no access to recourse within Canada and it is up to a host country to provide justice— something that can be undermined by poverty, corruption, and elite-corporate collusion within the borders of

many countries. In fact, in 2014, Canada was the only country to raise objections to the United Nations Declaration on the Rights of Indigenous Peoples at the UN General Assembly in 2014 (Lum, 2014).

Canada's diplomatic, economic, and trade priorities were clearly laid out in the 2013 Global Markets Action Plan. This plan establishes Canada as a haven for the extractive industry. In its own words, the government "will entrench the concept of 'economic diplomacy' as the driving force behind the Government of Canada's trade promotion activities throughout its international diplomatic network." It goes further to claim that this new focus "represents a sea change in the way Canada's diplomatic assets are deployed around the world" and acts to ensure that "Canada's long-term economic success becomes one of our priority foreign policy objectives" (GMAP, 2013). The document goes further to affirm "all Government of Canada diplomatic assets are harnessed to support the pursuit of commercial success by Canadian investors in key foreign markets" (GMAP, 2013). As stated in the plan, Canada's diplomatic assets are hard at work promoting trade norms through international institutions like the World Bank and IMF (Douglas & Kindornay, 2013).

New global trade rules created with Canadian consultants promoted by these institutions no longer recognize Aboriginal peoples' right to the resources of their traditional lands. Moreover, the Canada-supported World Bank Group's Multilateral Investment Guarantee Agency actively supports mining companies by granting insurance guarantees to those companies with "business risks"—that is, those at risk of being involved in war, civil disturbance, or environmental disasters (Halifax Initiative, 2006).

The Global Markets Action Plan also references the importance of Canadian businesses working where "the corporate social responsibilities of Canadian companies gives them an advantage" (GMAP, 2013). Canada has been a champion of corporate social responsibility— or CSR— as outlined in the recent report "Doing Business the Canadian Way: A Strategy to Advance Corporate Social Responsibility in

Canada’s Extractive Sector Abroad” (DFADT, 2014). In 2011, a project was introduced which contributed Canadian development funds to mining CSR projects in partnership with Canadian NGOs in Peru, Ghana and Burkina Faso (Alonso, 2014). While socially responsible action on the part of companies is something to be praised, generally the corporations themselves fund CSR. Using government development and aid money in corporate projects reveals that Canada’s development agenda does not aim to benefit communities, rather, corporate profits. This also politicizes aid and makes it more difficult for grassroots organizations to oppose mining projects on their own terms. A critique of this approach stated that: “tying Canadian aid funding to mining projects strengthens the political forces in the recipient countries supportive of the extractive industry all the while weakening critical voices” (Engler, 2012). Thus, without grassroots action, it is very difficult to push for policy change at local, national, and regional levels.

The commitment to “ensure that all Government of Canada diplomatic assets are harnessed to support the pursuit of commercial success by Canadian investors in key foreign markets” set out in Canada’s Global Market Action Plan is very clearly illustrated by a case study of Canada’s role in Honduras. Honduras has been used for other countries’ capital accumulation and strategy for hundreds of years. Since independence from Spain, its economy has been dominated by British, American, and eventually Canadian commercial enterprises— from exploitative mining to a transportation system built to ferry goods straight out of the country (Escalera-Flexhaug, 2014). Honduras became the archetypal “banana republic”— its political, economic, and military structures were almost entirely controlled by monopolies of corporations exporting primary goods (Chasteen, 2001). From independence until the mid-1900s, Honduras was controlled by a series of US-backed presidents and private militias. Resistance through grassroots socialist movements eventually led to a massive, countrywide banana plantation strike in 1954 (Gordon & Webber, 2011). Throughout the 1970s, social organizations

became stronger and there were modest improvements in worker protection. However, during the Cold War, Honduras provided a strategic location for the US military, and the American government wanted to keep it under control (Shipley, 2013). During this time, fear of communism was at an all-time high and social organizations were seen as a threat to the strategic interests of the US. A brutal military battalion was created by the Honduran and US military to act as a death squad and stamp out any protest over social inequality or the ongoing US occupation (Gordon & Webber, 2011). This level of terror was a very concrete manifestation of the war over economic ideology at the time. Socialist groups were decimated and did not start to rebuild until the 1990s when the US loosened its grip on Latin America post-Cold War (Shipley, 2013). In 1998, Hurricane Mitch struck the country. Several thousands died and the existing infrastructure was destroyed, leaving Honduras with over \$3 billion in debt (Shipley, 2013). The Canadian government responded to this disaster by providing \$100 million in aid and a “long-term development plan” for reconstruction projects (Escalera-Flexhaug, 2014). This reconstruction plan came in the form of Canadian trade lawyers rewriting the Honduran General Mining Law and the introduction of over forty Canadian mining companies as investments. The new laws gave companies expansive land rights and tax breaks (Escalera-Flexhaug, 2014).

In the early 2000s, citizens began to protest against the structural adjustment programs, austerity measures, and transnational corporations controlling the country’s resources (Escalera-Flexhaug, 2014). Manuel Zelaya, head of a national social movement in this fight, was elected president in 2006. Zelaya’s presidency was a significant break from the US-backed politicians who came before him. He raised the minimum wage, joined ALBA; the socialist Latin American group for economic integration, and was actively critical of the US anti-drug programs (Shipley, 2013). He also instated a moratorium on approving new mining concessions, something that, at this point in the 2000s, was very much against Canada’s trade interests. A month after this mining bill was drafted, on June

28, 2009, Zelaya was exiled from the country in a violent military coup (Shiple, 2013).

The coup was almost universally condemned, both internationally and within Honduras. Hundreds of thousands Hondurans took to the street in protest and these protests persisted for over 6 months. The coup government responded with brutal repression, state terror, and state control of the media (Shiple, 2013). Canada's response to these events was to support the coup government. Harper congratulated the new president and swiftly began negotiations for a brand new Canada-Honduras Free Trade Agreement. Even in the direct aftermath of the coup, Peter Kent, then Canada's Minister of State of Foreign Affairs for the Americas stated that "the coup was certainly an affront to the region, but there is a context in which these events happened.... There has to be an appreciation of the events that led up to the coup" (Lacey & Thompson, 2009). The rhetoric out of Ottawa was that Zelaya must have been responsible for the coup, and even went so far as to claim that Zelaya was "reckless" and "unhelpful" when he tried to return to the country of which he was still technically elected president (Rights Action, 2009; DFADT, 2009). While human rights organization criticized the non-transparent post-coup elections that were boycotted by 60% of the population, Canada accepted the legitimacy of the new government and lauded the elections as "free and fair" (Escalera-Flexhaug, 2014). Canadian support for this government came, of course, in offering the new president, Pepe Lobo, support to re-write the country's mining codes— scrapping Zelaya's tax and environmental regulations (Escalera-Flexhaug, 2014). These changes came in the wake of several public health and environmental crises from mines owned by Canadian corporations including a Goldcorp mine in San Martin where cyanide leaching had contaminated an extensive range of land and water systems. The re-written laws legalized dangerous open-pit mines— those at highest risk of leaching cyanide (Escalera-Flexhaug, 2014).

As of 2014, Canadian corporations control 90% of the mining in Honduras and have over \$600 million invested in the

industry (Escalera-Flexhaug, 2014). The government is not sending explorers to colonize Honduras or enslaving workers for corporate profit, but with this level of diplomatic and economic power, they do not have to. This systematic form of neo-imperialism is so engrained that it is written into the Honduran Constitution.

Human rights violations by mining companies are rarely, if ever, brought to justice. One of the few cases that was successfully brought to court in Canada was that of Angelica Choc, an indigenous Ecuadorian woman, against the mining company HudBay Minerals. Choc's husband, Adolfo Ich Chamán, a local anti-mining activist and community leader, was murdered by security forces at the Fenix mining project near the town of El Estor, Guatemala in 2009 (Choc V. HudBay, 2013). Choc and her lawyers in Toronto managed to bring the case to Canada after arguing that the system in Guatemala was not equipped to bring it to court, however her case was eventually rejected and at the appeal stated there was “no reasonable cause of action” (Deneault & Sacher, 2012). While there was no legal justice in this case for Angelica Choc, the fact that the case managed to come all the way to Canada was a significant step and means that these companies can potentially be held responsible for violations across Canada's borders.

Progress is slow and impeded at every level. In early December 2014, President Molina of Guatemala approved a law to increase taxes on transnational miners from 1% to 10%. Within days, Canadian companies including Tahoe Resources and Firestone Ventures, both listed in the Toronto Stock Exchange, have stated their intention to legally challenge the 2015 national budget, which includes this new rule (Jamasmie, 2014). These companies have the ability to legally challenge a government trying to balance its budget but the workers in Guatemala have no recourse to challenge the companies themselves for human rights violations. Each step towards more mining accountability and responsibility to the host country is a struggle against corporate influence with strong Canadian backing.

Both foreign and economic policy can be very abstract—working in the interest of economic growth, treating multinational corporations as concrete actors and interests, and engaging with “emerging” or “developing” markets like that in Honduras. In a critique of American policy during the Vietnam War, two Foreign Service officers, Lake and Morris, said that it “begins with a basic intellectual approach which views foreign policy as a lifeless, bloodless set of abstractions. “Nations”, “interests”, “influence”, “prestige”—all are disembodied and dehumanized terms which encourage easy inattention to the real people whose lives our decisions affect or even end” (1971). This reality check is essential, not just in armed conflict, but in the constant conflict between the livelihood of people around the world and a transnational “race to the bottom” for the highest corporate profit.

While the Canadian government and corporations do not actively promote human rights violations or the breaking of international norms— their activities still produce subtle and systematic changes that reinforce a system of inequality, whereby the dehumanized worker in Honduras earns very next to nothing while capital accumulates in the Canadian finance headquarters. Very little of what these corporations do is, in fact, illegal, and the government consistently acts to keep it that way. With this reality, those few opportunities that manage to bring the very real violations of health, life, and security of individuals around the world up against the abstract corporate interest of these mining companies, like the case of Angelica Choc, provide the most insights into the realities of a globalized capitalist system.

Effectively dealing with local corruption and providing assistance to “developing” countries around the world requires looking closely at the global levels of corruption in finance sectors and the active underdevelopment of those countries by the so called “developed” ones through policies, laws and norms coming out of financial and legal centers like Toronto and Ottawa.

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# Conflicts of Interest in Medicine and Scientific Research: An Overview

**ABDUL HOUR**

Conflicts of interest are a significant issue in medicine, scientific research and within academic institutions. By definition, a conflict of interest is when ties exist between medical and research professionals and industry that can influence the knowledge, attitude, and conduct of the professional to favour the industries they have ties with (Wazana, 2000). Conflicts of interest can have serious impacts on the integrity of research, the health of patients, and public trust. One of the most famous cases found is the type II diabetes drug, rosiglitazone (more commonly known as Avandia), that created a huge controversy due to its association with the risk of myocardial infarction (Nissen & Wolski, 2007; Rosen, 2007). Another significant example is the production of drugs to treat sexual dysfunction; the levels of production of such drugs is highly associated with ties between pharmaceutical industries and medical professionals (Moynihan, 2011). Conflicts of interest are often unavoidable and in order to manage them and limit their negative impact, guidelines and policies need to be further developed and enforced accordingly by scientific journals and institutions involved in conducting research or providing medical care and services.

## **Background**

Conflicts of interest can take many forms including medical and research professionals receiving gifts, free lunches, payment for their education, and other financial incentives to further their research and teaching (DeAngelis, 2000). Its definition varies across various scientific disciplines, including biology, medicine, chemistry, and physics among several others (Ancker & Flanagin, 2007). Money can seriously impact the research and publication process by creating biased, delayed or even suppressed publications (Ancker & Flanagin, 2007;

Bekelman et al., 2003). More specifically, financial ties with pharmaceutical industry are among the most noteworthy examples related to conflicts of interest. It is often found that industry-funded research results in more favourable results for the companies invested in them (Bekelman, MPhil, & Gross, 2003; DeAngelis, 2000; Perlis et al., 2005). The prescribing patterns of physicians may be influenced and consequently they may begin to favour and rapidly prefer to prescribe new drugs over generic ones (Wazana, 2000; Alkhateeb, Khanfar, & Clauson, 2009; Orlowski & Wateska, 1992). As a result, drug costs may increase. This is a significant issue that undermines the concept of public health, which seeks to promote health and prevent and control chronic and infectious diseases and injuries (Public Health Agency of Canada, 2011). Conflicts of interest in such relationships also go against the Declaration of Alma Ata (1978) and the Ottawa Charter for Health Promotion (1986) which promote the definition of health as a human right and the right for people to be involved in planning and implementing their health care (World Health Organization [WHO], 1978; WHO, 1986). This is significant because despite a knowledge imbalance that may exist between patients and their physicians, if physicians' behaviours, attitudes, and knowledge are compromised, as a result of their prescribing patterns, the inherent trust between patient and physician will be impacted and patients may not be able to make autonomous, informed decisions towards their health care.

Medicalization has also become a by-product of conflicts of interest. With the growing need to prevent disease and illness and early death, conditions that were once seen as common have been broadened and redefined at a rising rate (Moynihan, 2011). Conflicts of interest have been found in many of the panels used in the defining of diseases. The *Diagnostic and Statistical Manual of Mental Disorders* panels are a primary example of conflict of interest as evidenced by their ties to pharmaceutical companies that result in the widening of new definitions of disease as well as the inclusion of new disorders (Cosgrove & Krinsky, 2012). Rising rates of medicalization have become a crucial problem in that with new diseases,

almost anyone can be considered to have at least one disease and be prescribed permanent medication that may in fact be a detriment to their health rather than favourable toward it (Moynihan, 2011). Furthermore, with mental health issues in particular, over-medicalization can lead to risks of unnecessary testing and treatments and the stigma that typically accompanies many mental health diagnoses (Barbour et al., 2013).

Medicalization is typically fueled by conditions that are covered under health insurance and as a result there are rising concerns that over-medicalization contributes to increasing health costs (Conrad, Markie & Mehrotra, 2010; Mangosing, 2015). Reimbursement is of concern as some health insurance companies have elected to only consider certain illness (e.g., obesity) as reimbursable while refusing to cover other conditions such as infertility (Mangosing, 2015). In order to obtain a reimbursement or have certain medical services covered under insurance, they need to be defined as a medical problem and therefore, this can become an incentive to medicalize certain problems. Pharmaceutical industries are in the market for “selling sickness” and they have much to gain from over-medicalization because it will result in broader definitions of medical “illness” and the expansion of diagnostic categories (Barbour et al., 2013; Moynihan, 2009). They employ marketing strategies to increase the amount of people who think they have a certain condition requiring treatment and doctors play a role in how these strategies play out (Moynihan, 2009).

The Avandia controversy is a primary example of the effects that conflicts of interest can have on health. Rosiglitazone (commonly known as Avandia) was a drug developed in 2007 to help treat type II diabetes. A large risk of the drug was the potential for myocardial infarction (Nissen & Wolski, 2007). A prominent issue with the Avandia case was that it was “approved prematurely and for the wrong reasons by a weakened and underfunded government agency subjected to pressure from industry” (Rosen, 2007). Avandia caused a loss of public trust from patients in the drugs they were taking

and the physicians prescribing it to them (Misbin, 2007). Public trust is important for scientific research and medicine and the lack of it can be damaging to medicine itself and can lead to the halting and loss of support for new research and a fracturing of the patient/physician relationship (DeAngelis, 2000; Korenman, Berk, Wenger, & Lew, 1998).

### **Conflict of Interest: Opposing Views Surrounding the Issue**

While conflicts of interest are prominent today in scientific research and medicine, many researchers and physicians have claimed that it does not impact their decision making and professional conduct. Small gifts are believed to not have any impact on physicians' judgments toward a product (Dana & Loewenstein, 2003). However, several studies have conveyed that residents had generally optimistic attitudes toward industry gifts (Steinman, Shlipak, & McPhee, 2001). Medical residents thought that physicians were more likely to be influenced by pharmaceutical representatives (Sierles et al., 2005). Many residents considered interaction with pharmaceutical representatives to be equally appropriate for both residents and physicians, while some residents expressed disagreement and revealed a general approval of resident-industry interaction over faculty-industry ones (Steinman et al., 2005). However, studies show that even though they believed that accepting various types of gifts were inappropriate, residents actually received them (Sierles et al., 2005; Steinman et al., 2001). Many physicians and scientists justify their conflicts of interest due to the financial hardships they are under. Sah and Loewenstein (2010) reveal that the pressures associated with debt and minimal income led to the view by respondents that they were entitled to gifts from industry.

DeAngelis (2000) stresses the importance of realizing that a conflict of interest does not necessarily result in a different outcome. When being confronted about it, many physicians felt confident that their professionalism, ethics, education, intellect and scientific training would prevent them from being influenced by the institutions they interact with (Korenman et al., 1998; Mirza, 2004). It has also been revealed that ethical

views between scientists and the institutions they worked for differed in terms of fabrication, falsification, and plagiarism. They also differed in how their ethics affected their conduct and the ways they would punish such breaches of scientific integrity (Korenman et al., 1998).

### **Critical Evaluation of Opposing Views**

There was a consensus among studies from Korenman et al. (1998) and Mirza (2004) showing the degree of confidence physicians had with regards to their ethics, professionalism, and knowledge, as well as their ability to not let industry influence their behaviours and judgment (e.g., their prescribing patterns). Studies from Sierles et al. (2005) and Steinman et al. (2001) presented evidence that even though some medical residents perceived that gifts were inappropriate, they accepted them anyway. These studies also revealed that they were less susceptible than their colleagues to the influences of industry.

Dana and Loewenstein (2003) argue that the biasing effect of accepting gifts from industry being treated as a matter of deliberate choice is inconsistent with social science research. Through the review of basic social science research and inductive reasoning, the study demonstrates that judgments are subject to unconscious and unintentional self-serving bias even when trying to be objective. It is useful to view the topic from a social science perspective and attempt to explain why conflicts of interest exist when there are financial ties between physicians and industry. It also helps to point out how self-interest affects decision making and that self-serving bias appears to be unintentional.

Steinman et al. (2001) and Sierles et al. (2005) both study the attitudes that medical staffs have towards pharmaceutical industry interactions. Their studies show that residents generally have positive attitudes toward gifts from industry, believe themselves to be immune from their influence and describe behaviours inconsistent with their attitudes. In providing such contradicting attitudes among medical professionals, these sources provide a useful perspective to use when taking into account the effects that conflicts of interest

have on their behaviours and judgments. Both studies employed the use of qualitative research surveys to obtain results. Whereas both studies generally achieved decent response rates, the samples were not random and issues did exist in terms of the generalizability of the results. Another limitation of both studies include the reliance on self-reportings from respondents which may be subject to inaccuracy.

Korenman et al. (1998) addresses the growing scrutiny of the integrity of scientific research. It explores the differing beliefs of scientists and their institutional representatives on how they should respond to unethical acts (e.g., performance and reporting [i.e., fabrication, falsification, etc.], plagiarism, and conflicts of interest) and the appropriate punishments that should be enforced from such acts. This study employs a qualitative research approach in which surveys were mailed to respondents, asking them to indicate the degree to which the act in a scenario was ethical or unethical. The study provides somewhat of a contrast to the conflicts of interest between researchers and industry, and emphasizes the value of the researchers' ethics in their decision making. Some biases were present, as a result of the study being limited to a homogenous, funded group of basic scientists. This means that generalizations to other scientists could not necessarily be made and some ambiguities existed in the scenarios presented in the survey.

The opposing views presented show the ambiguity of conflicts of interest in medicine and scientific research. However, the justifications for and denial of the existence of conflicts of interest needs to be backed up with further credible evidence to make the results more plausible.

### **Presentation and Defense of Author's Position**

Conflicts of interest in scientific research and medicine are inevitable. Researchers need money to fund their research and teachings. Physicians often need new and more effective drugs to administer to their patients and, due to the amount of decreasing reimbursements, they may seek to change their practice patterns to overcome such reductions (Schofferman,

2006). The increased competition among scientific fields and issues with the systemic method of compensation for doctors and scientists is another factor to consider. A scientist's livelihood is based on his or her ability to publish compelling research. They, as well as physicians, may begin seeking money from outside sources such as drug companies due to problems in the way they are compensated. For these reasons, it is highly likely that ties between industry and physicians and scientists exist (Schneider, 2010). Conflicts of interest may be unavoidable and this does not necessarily mean that there is something dishonest about it or that it takes away from the significance of the work being done. However, a lack of disclosure and transparency of these conflicts of interest can lead to a decrease in the value and quality of research and medicinal practices, as well as damage to scientific integrity and the reputations of individuals involved (Schneider, 2010). New guidelines for managing conflicts of interest must be developed and existing conflict of interest policies need to be enforced. Many institutions lack adequate management and reinforcement of policies in this area and some may lack such policies altogether and, thus, endanger the integrity of the research conducted by their employees and impact the trust of the public in science and medicine.

There are several proposals of ways to manage conflicts of interest. Input from lay people in the debates of medical labelling may reduce the impact that conflicts of interest may have among expert panels for the issue of medicalization. Including a wider range of professionals from all different fields, both medical and non-medical, may also be beneficial. In the Avandia controversy, studies showed that a new paradigm was needed to target problems with the trial design, approval process and labelling of type 2 diabetes drugs (Misbin, 2007). This will help minimize the conflicts of interest among professionals approving the drug. The study conducted by Ancker and Flanagin (2007) on the prevalence of conflict of interest policies in peer-reviewed journals, also demonstrated that scientific journals can promote ethical publication practices through the implementation of conflict of interest policies.

### Conclusion

Conflicts of interest are often unavoidable by-products of ties between industry and physicians/scientists that can be detrimental to public health, medical ethics, and scientific integrity. As a result, there is a need for increased management of conflicts of interest by institutions that are involved in scientific research and the provision of medical care. Guidelines and policies need to be implemented and studied in order to evaluate their effectiveness at managing conflicts of interest. It is only through this that efforts can be made to maintain the quality of research/medicinal practices, scientific integrity and public trust.

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## Digesting Food Sovereignty

MARIAJOSÉ LÓPEZ MEJÍA & ROSEMARY COSTELLOE

The industrial food system has gained control over our eating habits. It has become increasingly evident that the diversity of fruits and vegetables in existence has been condensed in favour of standardized production. Intimate human connections to food have also been affected and diluted to the extent that, for millions of people, imagining food evokes only scattered visions of supermarket isles and a superficial ideal of produce that is aesthetically-pleasing above other more crucial considerations, such as obtaining food that is nutritious and not genetically-modified. According to Brewster Kneen, the result of such blatant disconnection is a *distancing* from our sources of food and nutrition (as cited in Knezevic, 2012, p. 249). Further, Wendell Berry (1990) argues that another outcome of this distancing is the development of an industrial eater, “who does not know that eating is an agricultural act, who no longer knows or imagines the connections between eating and the land, and who is therefore necessarily passive and uncritical” (p. 1). Specifically, this disengagement with food can deteriorate our understanding of nature, and the processes that bring food to our tables.

The development of the *Pedagogy of Food* in academia has spurred a politicization of the questioning of food practices and the production of food. It encourages the eater to both resist the industrial food system, and re-establish connections to the land (Sumner & Cook, 2009, p. 42). In fact, using food as a pedagogical tool can ignite and guide the industrial eater in two ways. First, by retracing historical processes of food production and consumption, the *Pedagogy of Food* can help us to reimagine food as an act dependent on the environment. Secondly, through the deconstruction and exposure of inequities within the industrial food system, the examination of food can become a vehicle for advancing social justice and challenging dominant structures of power (Flowers & Swan,

2012, p. 423). In essence, food becomes, as suggested by Belasco et al. (2011), an “edible dynamic”, that permits us to confront the inequities that permeate the world using food as a unifying and digestible road for political inquiry (p. 302).

Using the *Pedagogy of Food* as a guiding framework for this article, I will examine the realities of food insecurity among many Indigenous groups in order to convey an urgency to draw connections between Indigenous health crises and the lack of access to nutritious and culturally appropriate food. In this paper, I contend the dominant discourse that positions poor diet as a matter of choice among some Indigenous communities. Instead I suggest that poor diet choices are a direct consequence of food insecurity, in conjunction with *nutrition transition*. The *nutrition transition* experienced by Indigenous peoples is a direct consequence of colonization, and it has been perpetuated by the corporate spatial colonization of food as well as environmental deterioration. To end, I discuss the importance of Indigenous resistance strategies in challenging food insecurity, with an emphasis on those involving the *Food Sovereignty* movement and Indigenous Knowledge. Although this paper focuses primarily on the experiences of Indigenous groups in Canada, I also draw from observations and academic material gathered during a recent experiential learning trip in Belize, which reference the like situation faced by Maya Indigenous people.

### **Explaining the Indigenous Nutritional Transition**

The health of Indigenous peoples across Canada is significantly worse than that of settler populations. Certain health problems that they experience, such as anemia, dental caries, obesity, heart disease and diabetes are directly related to diet (Willows, 2005, p. 32). The dominant explanation for this maintains that the detrimental health conditions of Indigenous populations are attributable to a *nutrition transition*. Debbie Martin (2012) explains that the concept *nutrition transition* represent the intersection of social determinants of health and lifestyle factors; it implicates dominant discourse that links chronic health conditions with poor dietary *choices*

within a larger social model that affects food availability. These social factors, such as the impact of race and gender on income and spatial location, shift what may appear as dietary *choices* into inescapable dietary *realities*. In short, the type of food needed to ensure good health is simply unavailable to some of the communities considered most at-risk for chronic health conditions related to diet (p. 209).

*Nutrition transition* is a lived reality for many Indigenous communities, and it is a symptom of more pervasive food insecurity. While most Canadians make choices about the food they consume, Indigenous populations, particularly in the north, have great difficulty accessing food that is nutritious, healthy and economical (Food Secure Canada, 2011, p. 5). Barriers to nutritious and culturally appropriate food have emerged out of historically constructed inequities, which both affect Indigenous food security and severely undermine Indigenous health.

According to the United Nations Food and Agriculture Organization (FAO), food security “exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life” (FAO, 2003, p. 28). To this end, in the 1990s the international community prioritized food security by increasing the power of international trade institutions; imposing the neo-liberalization of agricultural production across the globe; and promoting the existence of food products at competitive prices that would allow personal purchasing power to be maximized (Desmarais, 2012, p. 361). The Canadian government has endorsed this definition of food security and also favours the international trade mechanisms oriented towards it. Yet, food insecurity is pressing in Canada, with Indigenous families “over-represented among those experiencing hunger” (Willows, 2005, p. 36).

Indigenous peoples living in spaces that are both remote and rural, as well as urban, experience hunger and malnutrition; not as a matter of choice, but because they live in a society that lacks understanding of their need to “hunt, trap, fish or otherwise harvest from the environment for sustenance” (Food Secure Canada, 2011, p. 5). These methods of food

procurement are important to the maintenance of Indigenous cultural traditions, and are thus intricately connected to Indigenous conceptualizations of culturally appropriate food. It is crucial to emphasize that the nutritional condition currently experienced by many Indigenous communities has not always been the case. Indigenous Nations have developed carefully nuanced uses for many diverse foods, such as berries, potatoes, herbs and medicines and have maintained a strong relationship with the land for their subsistence (p. 5). Unfortunately, this relationship has been eroded by colonial interventions and by the denial of Indigenous rights and treaties. Before colonial settlement, Indigenous communities, from both cultural and nutritional perspectives, valued certain agricultural practices such as the growing of corn, squash and beans. In the Great Lakes region, the Ojibwe and the Assiniboin actively harvested wild rice, which, rich in carbohydrates, was crucial to sustaining their communities living in a cold northern climate (Hurt, 1987, p. 38). Numerous factors associated with the Canadian state's Indigenous assimilation project, including the residential school system and displacement of Indigenous peoples from a nomadic lifestyle to static habitation on reserves, has limited their ability to continue these important agricultural practices. For example, on the Six Nations reserve in Northern Ontario, the availability of lyed corn, a fundamental ingredient in traditional Haudenosaunee Corn Soup, is currently very limited, as only one family in the community has retained the teachings needed to complete the lying process. Haudenosaunee Corn Soup is a household staple, and while corn itself remains available to Six Nations residents, it is important to draw connections between the smothering of its culturally significant preparation to the reserve's historical encounters with the Indian Act. It must be noted that at least three generations of Six Nations families were affected by enrollment in the Mohawk Institute Residential School (K. Parker, personal correspondence, February 2015).

Unfortunately, the contemporary Western diet has replaced the traditional foods of many Indigenous populations with market foods that lack nutritional value. As a result, traditional

Indigenous food systems have been eroded, and their food insecurity solidified (Willows, 2005, p. 32). An assessment of how the “massive land loss, genocide, epidemics, and ecocide” has undermined Indigenous diets is important in developing an understanding the forced nature of Indigenous dietary transitions (Olsen, 2002, p. 4). When examined from this perspective, it is very clear that the *nutrition transition* is an effect of colonization, a process that has rendered Indigenous populations vulnerable to a disproportionate “burden of disease and illness compared to other Canadians” (Martin, 2002, p. 210; Skinner, 2013, p. 33). When properly contextualized, the *nutrition transition* explains food insecurity and the role it plays as a social determinant of health. Thus, developing an understanding of *nutrition transition* that accounts for the displacement of Indigenous peoples, their loss of territories and their limited means “to access traditional country foods such as moose, caribou, seal meat, or wild geese” that has resulted is more reflective of Indigenous dietary realities (Food Secure Canada, 2011, p. 5).

Although Indigenous Nations have distinct languages, cultures and food systems, many have developed a similar a worldview that is underlined by the way in which they relate to the land for sustenance and spiritual guidance (Morrison, 2013, p. 126). Hence, the sensation of disconnection from the land due to relocation also evoke great cultural trauma (Olson, 2002, p. 1). The Euro-centric concept of *terra nullius* that informed colonial conquest, or the belief that “discovered” lands were underutilized, was widely used to “justify the appropriation, development, and exploitation of Indigenous lands” by colonial settlers and their governments (Martin, 2012, p. 216). Such injustices have yet to be rectified, as this view continues to prevent the Indigenous groups from accessing their traditional territories. Many Indigenous peoples that were forced onto reserves to absorb European values lost not only their traditional languages and cultural practices, but also traditions surrounding food that were viewed with suspicion by European settlers (Food Secure Canada, 2011, p. 4). In Canada, Indigenous land claims are very diverse, with

some also intertwined with claims to the rights to engage in specific activities that were previously practiced on the territories in question. For example, in addition to land claims, there are pending claims to “Aboriginal rights involving traditional activities of fishing, hunting, trapping, harvesting wild rice, and gathering” (Coates, 1992, p. 79). All of these are fundamental practices for the maintenance of a healthy and traditional Indigenous diet.

Another profound contributor to *nutrition transition* was the establishment of the residential school system, which attempted to “kill the Indian, save the man”. An overwhelming amount of the young residents of these “schools” endured physical and sexual abuse, and survivors were left traumatized. Many have resulting mental health issues and engage in substance abuse and other at-risk lifestyles to cope (Olson, 2002, p. 3). The intergenerational impacts of the residential school system have been witnessed through survivors’ lack of parenting skills; they were also unable to obtain traditional knowledge of food preparation due to separation from their families, reserves and natural living environments (p. 3). Malnutrition was also a very prevalent component within residential schools. Children were often served “minimal amounts of poor quality foods and refused any allowances for traditional foods in their diet” (Food Secure Canada, 2011, p. 5).

Such changes in food consumption have elicited severe impacts on Indigenous nutrition and health. For instance, as the Dogrib people, part of the Dene First Nations in the Northwest Territories, relocated from their bush settlements into towns and cities, they demonstrated a decreased ability to assimilate glucose, which has been connected to many “dietary changes and stress related hormones that inhibited insulin production and utilization” (Olsen, 2002, p. 4). Diabetes is a highly prevalent health issue in North America today, and evidently one of the hard-felt legacies of the imposition of a colonial diet on Indigenous peoples. Regrettably, settler-Canadian law continues to regulate and undermine the lives of Indigenous peoples through the Indian Act, which has exercised control

over all spheres of First Nations and Inuit life since 1876. This includes repressing their connections to food systems and traditional territories, without significant consultation to Indigenous priorities and needs (Food Secure Canada, 2011, p. 4).

### **Spatial Colonization of Indigenous Food Environments**

Household income and the cost of food are more potent factors for food selection than healthiness, taste, or nutritional value. As well, nutritious food is often unavailable among pervasively cheap and unhealthy food. With the destruction of Indigenous food systems and the deprivation of their access to traditional foods and lands, Indigenous peoples' methods of food procurement have dramatically changed. They face extreme hunger, living in food deserts. This has forced Indigenous peoples to enter into new patterns of consumption that predominantly include pseudo-foods, which are products "typically high in fat, sugar, and salt [that] often provide over-abundant calories" (Winson, 2012, p. 188). As a result of this substitution, the current diet of Indigenous peoples lacks vitamin A & D, fibre, iron, folacin, calcium and fruits and vegetables (Willows, 2005, p. 33). It is necessary to consider that due to the lack of access to ancestral lands for food sources, Indigenous peoples rely on store supplies to survive. An investigation of the eating habits of Cree children challenges the popular conceptualization that some Indigenous communities make a choice to eat poor, processed food diets. It found that even though the intake of store-bought food was predominant in their diets, the children studied expressed a preference for traditional food (p. 34).

The cost of purchasing market foods in northern communities is extremely high. In order to reach these communities, food must be transported by truck, ship and air (Skinner, 2013, p. 15). Hence, the availability of a variety of fresh and high quality products is limited. The concept of *spatial colonization* is useful in explaining how such a precarious food situation arises. According to Anthony Winson (2012), *spatial colonization* refers to "the power of food processors to place product in the most visible and effective selling spaces in

a food environment” (p. 193). In other words, the *spatial colonization of food* describes the power of corporate food retailers, entitled by national and transnational economic accords, to dictate consumers’ consumption patterns based on what is made available to them, and how the food is displayed on shelves. Indeed, the *choice* made on by residents on reserves to purchase pseudo-foods is determined by the pervasiveness of these types of products in their food environments, and a lack of other options.

For example, the situation for residents of the Fort Albany Nation is dire in terms of food access. According Peetabeck Health Services community worker Gigi Veeraraghavan, in the Northern Store, which is Fort Albany’s only grocery store and major food supplier, a bag of apples can cost thirteen dollars and a bag of spinach as much as seven dollars and fifty cents (Bain, 2012). Fort Albany First Nation is located in the west coast of James Bay, Ontario on the south bank of the Albany River. This community is home to approximately eight hundred and fifty people and is governed by the Muskegowuk Tribal Council. As the reserve is very geographically remote, the Fort Albany community is only accessible by road for approximately six to eight weeks during the winter via an ice road; during the rest of the year the area can be accessed by plane (Skinner, 2013, p. 49). While northern Indigenous groups are forced to “pay exorbitant prices for basic nutritional foods” such as fresh produce, the cost of junk food remains the same as in southern Ontario (Food Secure Canada, 2011, p. 6). *Spatial colonization* is evident in this case, through the way in which corporate food suppliers dominate the availability of fresh food in the Northern Store, and therefore dictate the food preferences of Fort Albany residents in this area.

Similarly in the Yucatan Peninsula, which is the historical center of Maya culture, the spatial colonization of food is also very tangible. Leatherman and Goodman have termed the spatial colonization of food here the “Coca-colonization” of diets in the Yucatan (as cited in Bogin et al., 2014, p. 14). “Coca-colonization” refers to “the pervading presence of Coca-Colas, Pepsis, and an assortment of chips, cookies, candies, and

other high-sugar, high-fat snack foods” (p. 14). Tragically, these products, like in many other food markets, are replacing traditional Maya beverages. The pervasive ubiquity of Coca-Cola, one of the most powerful globalized food corporations, is evident in urban centers and remote areas alike. Advertisements:

Invite people to try high sugar, high caloric drinks. These drinks are only slightly more expensive than bottled water, which is often produced by the same companies that manufacture the soft drinks. Coca-Cola, Pepsi and other companies supply kiosks to sell their product. The companies supply refrigerators, tables, and chairs with their logos to small stores, cafes and even schools. The companies also pay for these outlets to be painted with their corporate colours and logos (p. 14).

The increased visibility of these products and their positioning as a replacement of traditional foods reflects neo-colonial attitudes of corporate imperialism that continue to endanger the food security, health and livelihood of Maya peoples living in the Yucatan (Winson, 2012, p. 193).

### **Environmental Determinants of Indigenous Food Security**

The modification of the environments that Indigenous groups inhabit is yet another force that works to restrict access to traditional foods. Deforestation, hydroelectric dams, land and water contamination and climate change continue to challenge the survival of plants and animals that contribute to traditional diets (Willows, 2005, p. 34). The relegation of Indigenous peoples to reserve territories has led to an inevitable exhaustion of resources within and surrounding these areas, which now pushes Indigenous populations to make longer and more expensive trips in order to find traditional food and game, further exacerbating existing issues of availability (Skinner, 2013, p. 35).

Indigenous communities in Canada have noticed dramatic changes to their traditional food systems, notably concerning the quality and quantity of wild game, which has been compromised by toxic chemicals. To illustrate, the Mohawk

community of Akwesasne has struggled with PCB contamination, which is known to cause severe hormone disruption in mammals. PCB is an organic chemical compound that has been cited in numerous pollutant contamination cases across the globe, and can have very harmful effects, ranging from cancerous tumours to neurological disorders (Simpson, 2003, p.130). Akwesasne Mohawk territory lies along the St. Lawrence River, spanning across what is now known as New York, Quebec and Ontario. Contamination of their water, land, fish and game animals has been noted, along with incidents of human breast milk contamination, due to chemical runoff from nearby General Motors, Reynolds and Domtar production plants (p.132). Another poignant example is that of the Grassy Narrows First Nation, which is north of Kenora, Ontario. They have been struggling against the effects of toxic waste dumping by the Reed Paper Plant into the nearby English-Wabigoon River since the 1960s. Soil sediment tests continues to report unsafe levels of methyl-mercury contamination, with a state of emergency being declared by the Grassy Narrows Band Council in August 2015 which notified residents of the complete exhaustion of safe drinking water resources in the territory (Free Grassy Narrows, 2015). Methyl-mercury contamination is also associated with neurological disorders and damage, among numerous other negative health impacts. The fish in Grassy Narrows, which is a staple food for both aforementioned Indigenous communities, has also been severely contaminated, affecting the health of residents and also subsistence and local economies (Simpson, 2003, p. 132-33). According to Toledo, following farming, fishing is the primary economic activity and food source of Indigenous groups that dwell in coastal areas, along the margins of rivers and on islands (Gonzales, 2013, p. 104).

A point that is often ignored regarding the position of Indigenous peoples within agriculture today is that at the global level, Indigenous farmers produce crops that feed at least seventy percent of the world's population (p. 103). While Indigenous farmers around the world subsidize government food prices and are important contributors to the global food

market, they unfairly find themselves being hit first by environmental changes that affect their harvest and fishing economies.

### **Indigenous Knowledge and Food Sovereignty**

While this article has emphasized that the food security of Indigenous peoples is in peril, it is necessary to highlight that these communities are not passive in the struggle for justice. Filiberto Penados emphasizes that Indigenous peoples are actors who are non-static and innovative thinkers (F. Penados, personal communication, May 2014). In this context, Indigenous groups around the world can be viewed as communities of practice, which act as sites of learning and spaces for cultural and knowledge production (Lave, 1991, p. 10). Specifically, Indigenous peoples:

Have forever had their own cosmology passed on from generation to generation. This cosmology speaks about the sacredness of the universe, of the indissoluble relationship between humanity, nature and the universe. These are principles that inform an Indigenous proposal for society and development, and from which arise a proposal that promotes sustainability, holism, and pluralism (Penados, 2007, p. 6).

This cosmology, or Indigenous Knowledge, takes into account the changes in biodiversity, species loss, sustainable management of resources, and the use of plants and animals for medicinal purposes, which allows Indigenous peoples to craft ways of living and responses that work to maintain sovereignty (Gonzales, 2013, p. 102). It is in their role as “ecological custodians”, that Indigenous peoples have responded to environmental stresses, such as climate change and food insecurity, with ecologically sound strategies (Harvey, 2009, p. 58). These ancient belief systems, traditional laws and principles rely on a network of Elders, spiritual leaders, healers, hunters, trappers, gatherers, fishermen and medicine people for successful maintenance (McGregor, 2013, p. 14). The transference of Traditional Knowledge continues to solidify Indigenous Nations as communities of practice, as it “has been handed down from generation to generation through

apprenticeship, ethical and cultural values and through rituals among other forms of transmission” (Harvey, 2009, p. 58).

The management of Indigenous food systems, which involves landforms, vegetation, watersheds, rivers, and climatic zones, culturally significant plants, animals and fungi species, is intrinsic to Indigenous Knowledge. Within these systems, food “has been primarily cultivated, taken care of, harvested, prepared, preserved, shared and/or traded within the boundaries of respective traditional territories based on values of interdependency, respect, humility, reciprocity and ecological sensibility” (Morrison, 2013, p. 126). Therefore, Indigenous food systems stand in stark opposition to the mechanistic, linear food production, distribution and consumption practices championed by the industrial food system (p. 126).

Contemporary Indigenous understandings of food self-reliance also differ substantially from dominant food security discourse. The standard of “food security”, which has gained international recognition and adherence, has been based on Anglo-, Euro-, America-centric ways of knowing and worldviews that were later mapped onto Indigenous lives. In essence, the concept of food security, and the international community’s strategies for reaching it has become a “globalized truth”, which neglects local and cultural experiences, and critically the embodied knowledge of Indigenous peoples throughout the world (Dei & Simmons, 2009, p. 17). Further, this imagining of food security that depends on industrialized forms of agriculture undermines small-scale and Indigenous farming operations. Its dependency on capital-intensive food and agrochemicals consistently threatens the health of farmers and labourers, alongside the health of the land that they work (Food Secure Canada, 2011, p. 7).

*Food Sovereignty* has evolved in multiple ways as a social justice-oriented counter-framework to international neo-liberal food security discourse. It crucially reflects and accounts for the concerns of Indigenous peoples in relation to food self-reliance (Desmarais, 2012, p. 365). Since 1996 La Via Campesina, a social movement of peasants, farm workers and Indigenous peoples around the world, has promoted a

differentiated agenda that opposes the liberalization of trade. Its proponents also oppose structural adjustment programs that create hunger and destroy local economies, as they perpetuate the denial of access to and control over land, water, seeds and natural resources, and enforce the use of pesticides (p. 367). Instead, *Food Sovereignty* proposes to address the inequities that cause food insecurity (p. 362). Indeed, encompassing a larger analysis of food forces and actors, *Food Sovereignty* describes the right to pursue:

Healthy and culturally appropriate food produced through ecologically sound and sustainable methods, and their right to define their own food and agriculture systems. It puts those who produce, distribute and consume food at the heart of food systems and policies rather than the demands of markets and corporations (Provost, 2013).

La Via Campesina's *Food Sovereignty* movement has become a vehicle for "problem-posing education as a humanist and liberating praxis [which allows] people subjected to domination... [to] fight for their emancipation" (Freire, 2000, p. 9). Indigenous principles such as localizing food production, working with nature, focusing on peoples and communities and valuing the work of food producers have been key in guiding the movement's framework (Desmarais, 2012, p. 369). Indigenous communities across the world have come together to stand on the international stage and demand food sovereignty through the United Nations Declaration of the Rights of Indigenous Peoples, adopted by the General Assembly in September 2007. The declaration set forward concrete provisions that reaffirmed their desire for *Food Sovereignty*, and the urgency of upholding their rights and relations to the environment and traditional territories. It rejected industrial capitalist farming practices that destroy diversity and natural genetic resources, and called for a reclamation of traditional diets as part of cultural identity (Food Secure Canada, 2011, p. 7).

This UN Declaration proved to further galvanize smaller grassroots initiatives aimed at combatting profound food insecurity. Coping strategies initiated by Indigenous

communities abound. These projects, which include partnerships with non-Indigenous peoples, draw from both traditional and contemporary food practices and mark the beginnings of a resurgence in Indigenous *Food Sovereignty*. Some communities have developed food-sharing strategies, such as community freezers, which promote a return to old norms of food reciprocity (Willows, 2005, p. 33). In Fort Albany, for example, community food champions began organizing a non-profit ‘alternative market’ in partnership with Toronto’s FoodShare in 2011, which sells fresh fruits and vegetables bi-weekly. The produce makes a seven hundred kilometer trip via truck from Toronto to Cochrane, then continues its northbound journey via train to Moosonee. It makes the last segment of the trip via plane. Once the food arrives in Fort Albany it can be purchased by community members at the market, which is set up in the school gym, a mere three days after its departure from Toronto (Bain, 2012). The market consistently sells out within thirty minutes of opening, and has received the approval of Fort Albany Elders who are also frequent clients.

The transport costs for this project are covered, in part, by the Nutrition North Canada subsidy. Chartering the food up north removes overhead costs and combats food desert conditions in Fort Albany by allowing for a fifty percent price reduction for the produce that is as fresh, and at times even fresher, than that sold in local grocery stores (Skinner, 2013, p. 125). Joseph LeBlanc, a community project co-ordinator with the Nishnawbe Aski Nation, shares the profound impact of the establishment of this market in the community:

To have a say in the food system in our community is to have control over what is sold...what's available at the Northern store and your budget determines what you buy to feed your family. The choices you make are not about what you want to eat (Bain, 2012).

While it is important to note that this initiative represents only one aspect of the Fort Albany community’s journey to self-sufficiency, it does allow community members to feel motivated and empowered as they control food prices, which indicates

that more macro-level food system change is possible (Skinner, 2013, p. 125). Their efforts provide a decisive challenge to the spatial colonization of food experienced by many Indigenous groups living in reserves across North America.

Another example can be found in Belize, where the Maya community of Toledo established a Learning Center in 2011 designed to “offer specialization in agriculture, eco-cultural tourism, agro-processing and sustainable use of resources” (Penados, 2007, p. 8). The Tumul K’in Centre of Learning draws on Indigenous concepts and fuses “Maya values, knowledge, and philosophy with contemporary science and technology” (p. 9). Mayan values form the core of the experiences and teachings provided by the Center; these emphasize respect for nature, community interdependence, cooperation, dialogue, consensus, and self-reliance. Students who have been failed by the traditional school system participate in a residential program where they learn conventional academic subjects, as well as engaging with Mayan language, history, arts, and agricultural practices with an emphasis on experiential learning (R. Alvarez, personal communication, May 2014). Students are also allowed to return to their villages to help with the planting season, and therefore the Center functions on a schedule that differs from the conventional school calendar. In Belize, where Indigenous groups have also suffered the consequences of colonialism, the Center is crucial to the preservation and validation of Indigenous Knowledge; decolonizing educational praxis; and to the maintenance of connections to the land, which are intrinsic to Indigenous identities and cosmologies, as well as Indigenous sovereignty. This unique project, which has been propelled by Mayan Elders and other holders of Traditional Knowledge, is congruent with the belief that a return to traditions, alongside the exposure of children to ancestral foods and food systems, enables students with an opportunity to combat the poverty and displacement of Indigenous communities (Food Secure Canada, 2011, p. 5). Indeed, this is an excellent example of resisting food insecurity through the promotion of *Food Sovereignty* via cultural education.

This article has taken up issues with the dominant, Euro-centric conceptualization of food security, and highlighted the intricacies and social determinants of health that create food deserts, and their impact on dietary choices for Indigenous populations. As evidenced in this discussion, the health problems associated with poor diet that are experienced by many Indigenous peoples “are historically rooted in colonialism and persist in neo-colonialist attitudes and policies today involving [Indigenous] health and culture” (Olson, 2002, p. 2). More specifically, a lack of access to traditional lands, the destruction of Indigenous social structures and family units, environmental degradation, neoliberal trade agendas and prolonged socio-economic vulnerability have forcefully and detrimentally impacted the capacity of Indigenous peoples to respond to their “own needs for healthy, culturally-adapted Indigenous foods” (Morrison, 2003, p. 127). To conclude, I have argued that the *nutrition transition* experienced by Indigenous peoples throughout the world must be contextualized within the disenfranchisement of their traditional food systems, which has resulted from colonial domination and corporate control of food availability. This disenfranchisement has been further perpetuated by the destruction of bountiful natural resources. Central within the discussion of Indigenous food security is conceptualizing *Food Sovereignty* as a precondition to authentic food security (Desmarais, 2012, p. 363).

It is very evident that Indigenous communities know their route to healing and achieving food security. They have a richness of Indigenous Knowledge, cosmologies, Elders and creative food strategies, which all play an essential role in the revitalization of traditional food systems. Lastly, I invite the reader to reflect on how traditional Indigenous ways of looking at and relating to the land may succour settler societies to maintain and respect the earth, which is the very soil that not only Indigenous peoples, but all peoples depend on to eat, and therefore to live. Considering that, according to Health Canada, First Nations peoples who live on reserves have a three to five times higher rate of diabetes than other Canadians, it is critical

to question how these reserve spaces in and of themselves are implicated in the well-being of those that live there. As the public eye prepares to interrogate the dietary choices that have led to these health crises, it is imperative to consider how the regulation and control of food supply throughout history, (especially the histories of colonial territories), have been utilized as an instrument of power to undermine those populations that pose a threat to nation-building projects, or have become an impediment to natural resource extraction and exploitation.

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