



Health Perspectives

Undergraduate Health Studies Journal
Volume XI | March 2020
University of Toronto

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CONTENTS

SARAH WAKEFIELD	v	Foreword
OMAR FARHAT	vii	A Note from the Editors
MAYA OAKES		
MIHOJANA JHUMI	1	The Role of Colonization and Discrimination in Shaping the Inequitable Health Experiences of First Nations, Métis and Inuit Peoples of Canada
VICTORIA TAN	6	Neoliberalism as a Driver for Racial Disparities in Health
NAVDEEP KAUR GORAYA	12	Hurricane Harvey: The Impact of Climate change on Human Health
KAITLYN LEM	18	Antidepressants are Anti-Effective
ARIEL BANNER	25	Voices Unheard: Ungagging the global and Gendered Inequities of the Global Gag Rule
GABRIELLA EKMEKJIAN	29	Social Isolation of Seniors in Canada
ROBIN NATALIE TONBAZIAN	38	The Ontario Basic Income Pilot: A Universal Basic Income Model Could Improve the Health of Canadians
RAGSHICA SOTHEESWARAN	43	Political Economy and Intersectional Analysis of the 2014-2016 Ebola Outbreak

Director's Foreword

As the Director of the Health Studies Program at University College, it is my pleasure to introduce *Health Perspectives: Volume XI*, of the Undergraduate Health Studies Journal at the University of Toronto. Started in 2009, *Health Perspectives* has given undergraduate students an opportunity to participate in both writing for a peer-reviewed journal, and being part of the student-led editorial process.

This year's edition of *Health Perspectives* consists of eight papers: all written, edited, and published by student contributors. These papers focus on a wide range of health issues and determinants of health, in both Canadian and international contexts. They therefore illustrate our students' broad range of interests in relation to health and health care. The papers 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. The Health Studies program focuses on developing a critical understanding of health: it is therefore exciting to me that the articles in this collection all look beneath the surface for underlying, structural causes of ill health, with the ultimate goal of improving the health of individuals and populations around the world.

I want to thank Omar Farhat and Maya Oakes, this year's Co-Editor-in-Chiefs; Yousef Safer, Nammal Khan, and Sophia DiNicolò (Senior Editors); Matilda Dipieri and Madeline Cuillerier (Junior Editors); Serena Thapar (Layout Editor); as well as the Peer Review team, consisting of Meron Gidey, Thomas Hall, Serena Thapar, and Mariam Zaidi. They are responsible for the continuing high quality of this publication!

I sincerely hope you enjoy reading this edition of *Health Perspectives, Volume XI*.



SARAH WAKEFIELD

Director | Health Studies Program
University of Toronto

A Note from the Editors

We are thrilled to present you the 2020 edition of the Undergraduate Health Studies Journal, *Health Perspectives: Volume XI*. Founded in 2009, the Health Perspectives Journal has provided opportunities for many University of Toronto undergraduates to publish original work, and for Health Studies students to gain first-hand experience in editing and publishing as members of the Editorial Staff. This journal reflects a multifaceted approach to understanding and analyzing health through a multidisciplinary lens, and reflects the fundamental nature of the Health Studies program, which explores health across the social sciences, sciences and humanities.

Health Perspectives: Volume XI features the work of eight student authors, drawn from varying disciplines. Each article is presented from a unique vantage point and sheds light on significant health topics, ranging from the impacts of Colonization in shaping the health experiences of Indigenous Canadians to the Ontario Basic Income Pilot Project. Though the content of each article is different, each author challenges the conventional biomedical definition of health—that is, the absence or presence of disease—by demonstrating how social, cultural, economic and political factors shape health and well-being. To our authors and those who submitted their work for consideration: thank you for sharing your writing with us and contributing to a dialogue that fosters a holistic sense of health and well-being. Without you, all this volume would not have been possible.

We are so grateful for the support of Dr. Sarah Wakefield, the Health Studies Director, as well as the Health Studies Students' Union. To our diligent and thorough editorial staff: thank you for dedicating your time and energy to making Volume XI a tremendous success and our strongest publication to date!

And finally, to our readers: we hope that *Health Perspectives: Volume XI* presents you with another collection of fresh ideas and creative approaches to examining today's health issues that help shape your own understanding of health and well-being.

Yours in health,



OMAR FARHAT

Co-Editor in Chief | Health Perspectives 2020
President | Health Studies Student Union



MAYA OAKES

Co-Editor in Chief | Health Perspectives 2020

The Role of Colonization and Discrimination in Shaping the Inequitable Health Experiences of First Nations, Métis and Inuit Peoples of Canada

MIHOJANA JHUMI

Introduction

Free health care and education, high life-expectancy, plentiful job opportunities, ethnic diversity, freedom, and social justice are some of the various assets that constitute Canada as one of the most efficient and peaceful nations to live in. A study commissioned by the Organisation for Economic Co-operation and Development in 2011 ranked Canada 9th from 31 countries for empowering and enabling its citizens to live a free, self-determined and socially inclusive life (CBC, 2011). However, under the guise of such economic developments, the Canadian Indigenous population has been living in the recurring cycle of unjust and impoverished circumstances since the onset of European imperialism. According to Statistics Canada (2017), over 80% of Indigenous reserves had median incomes below the poverty line, average employment rates less than half of non-Aboriginals, as well as markedly higher incidences of crime, suicides, obesity, food insecurity and morbidity compared to the rest of the country (Gionet & Roshanafshar, 2015). In order to comprehend the stark disparities in affordability and access to adequate healthcare between Canadian Aboriginals & non-Aboriginals, this commentary will investigate the extensive role of colonization and discrimination as some of the most prominent social determinants responsible for the inequitable living conditions experienced by the First Nations, Métis, and Inuit populations.

The Underlying Causes and the Burden of Health Disparities

Much of contemporary research on health care is governed by reductionist approaches, such as biomedical techniques that aim to primarily treat and eradicate illnesses. While this may be a temporary solution to halt physical suffering, many fail to recognize the underlying historical factors from which societal injustices have and continue to stem from (Adelson, 2005). One such factor is colonization; the subjugation, assimilation and invasion of an area and its population. European colonization on Indigenous lands is accountable for the institutional inequity and the subsequent health discrepancies persisting among Indigenous peoples (Gionet & Roshanafshar, 2015). The dispossession of Aboriginal lands was legalized through the Indian Act in 1876 and the Scrip Program, which resulted in 98% loss of original lands from the First Nations and 83% loss of Red River Lots from the Métis Nation (Czyzewski, 2011). The Indian Act was enacted through the establishment of substandard reserve systems and residential schools to forcefully allocate families and communities to unfamiliar lands, exploitation of economic practices & services that were accustomed to Indigenous traditions and the withdrawal of their rights on natural resources (Richmond & Cook, 2016).

The rise of capitalism and international economic relations have led to major advancements in various industrial infrastructures in Canada, including the field of medicine. In fact, in 2017 Canada was ranked 9th among 11 of the world's affluent nations for its notable health-care system (Simpson et al., 2017). Yet, despite being governed by the same federal regime, the burden of chronic illnesses within Canadian Indigenous populations remain strikingly complementary to those of third-world countries. Recent findings from Statistics Canada reported 56% of First Nations and 55% of Métis populations being diagnosed with one or more chronic conditions, compared with the 48% of non-Aboriginal counterparts (Gionet & Roshanafshar, 2015). In addition, reports from 2007-2010 by The Canadian Community Health Survey (CCHS) indicate that 83% of non-Aboriginal citizens have a regular medical doctor, compared with 44% of Inuit populations who lack competent hospital services in close proximity to residential areas. Research conducted by CCHS also found that the First Nations, Métis and Inuit Peoples had extensively high rates of smoking, alcoholism and obesity. Although many regard the assimilation of Aboriginals as a discord of the past, much of Canada's current Indigenous health policies are rooted in the preconceived relationships between the imperialist government and its ignorance in considering the basic needs of those colonized.

Prior to colonialism, Native populations relied on natural and local ecosystems. They cultivated rivers to grow vegetation, developed their own organic medication and pursued healthy, active lives through practices like hunting, fishing, and harvesting for centuries. Their physical and spiritual connectedness to nature enabled them to nurture a deep cognitive and holistic apprehension for their communities and the well-being of their people (Kirmayer, 2004). Due to lower population density and the increased availability of a variety of resources, the prevalence of diabetes, cardiovascular and infectious diseases were also very limited (Young, 2003). Unfortunately, the rights and privileges of the Indigenous peoples were eventually forsaken to favour the interests of the colonists. According to the political economy and post-colonial theories of sociology by Karl Marx and Friedrich Engels, the debilitation of the First Nation's ways of life is a direct result of class-based power relations where injustice augments from competing economic interests to benefit those in power (Warwick-Booth et al., 2012). Privation of the fundamental basic human rights such as shelter, adequate healthcare, self-identity, land, ability to maintain economic stability and traditional subsistence provoked dependence on cheaper, unhealthy sources of food, loss of financial & communal welfare, increased stress-levels & suicides and ultimately led to generations of chronic physical & mental illnesses that are still prevailing the current era (Czyzewski, 2011).

Impacts of Racial and Gender Discrimination

The ongoing cycle of poverty and inequity inflicted through colonial structures, such as seizure of Indigenous lands, inequitable treaties & dislocation of families have not only affected the health experiences but also inaugurated the frequency of illegal practices among and against Canadian Aboriginals. In 2013, investigations by the RCMP have discovered reports of 164 missing and over 1,017 murdered Indigenous females since the past 30 years (McDiarmid,

2017). Despite representing only 4% of Canada's population, according to the Canadian Centre of Justice Statistics, the Aboriginals make up about 18% of federal prisoners (Gionet & Roshanafshar, 2015). This is yet another example of embodied discrimination in which inequalities are apparent in disproportionate risk of physical violence, crimes and poor health outcomes. As mentioned earlier, the purpose of the colonizers was to assimilate Indigenous people as they were believed to be uncivilized or inferior to the settlers. Along with racial bigotry, the Indian Act has further reinforced gender discrimination whose impact still runs deep through present day familial practices and sexist government regulations (Alan & Smylie, 2015). For example, as per the Indian Act, an Indian woman's Aboriginal and treaty rights were dependent fully on the legal status of her husband. Moreover, Indigenous women who were married to non-Indigenous men not only lost their Indian status but also had their treaty and health benefits, the right to live on reserve, the right to inherit her family property, as well as the right to be buried on the reserve with her ancestors completely revoked (Adelson, 2005). The devastating effects of such patriarchal supremacy are evident in the constant recurrence of victimization of Aboriginal women even in the 21st century.

Generations of negligence, incarceration, abuse and bigoted attitudes have led to systematic marginalization of Aboriginals in both the justice and socio-economic platforms. Job discrimination continues to be a major contributor to poverty. For instance, the unemployment rate of Aboriginal populations was 14% in 2001, which was double the rate of unemployment in non-Aboriginal households (Mikkonen & Raphael, 2010). For Aboriginals living on-reserve, this figure was 28%, twice the rate of those living off-reserve. This may be due to the increased rates of illiteracy and high school dropouts, which, in turn, have resulted from insufficient access to higher educational facilities and lack of government initiatives in providing affordable education pathways. Canada's decision to vote against the United Nations Declaration of the Rights of Indigenous Peoples in 2007 that aimed to improve Aboriginal economic and social conditions, the right to attain the highest levels of health and the right to protect and conserve their environments, is indicative of the institutional racism reinforced by colonial practices, along with violation of Canada's Human Charter of Right and Freedom that promotes justice and protection for all its individuals. Although there have been immense political and economic developments throughout recent decades, the need for improvement is much greater. The continuous struggle for social and individual equity in the field of healthcare, education, legality and employment have to be addressed in order to break the cycle of oppression.

Conclusion

European colonization in Canada is one of the most influential social determinants responsible for the deterioration of the Aboriginal ways of life and the persistent patterns of disparities within their economic, political, and societal interrelations. The Indian Act of 1876 imposed a legalized system of cultural genocide that relinquished the rights of Indigenous people to lead autonomous lifestyles. The Act rather forced them to surrender their ancestral properties, religious, medicinal & education schemes, their participation in foreign systems

of wage labour, and their Aboriginal statuses. The sources of disproportionate rates of chronic diseases, unhealthy life-style practices, criminal activities and pervasiveness of poverty can be traced back to the systematic and intrusive policies of imperialism that continue to favour unfair distribution of rights and services (Alan & Smylie, 2015). In order to tackle such inequitable practices within First Nations, Inuit and Métis health care systems, it is extremely crucial to eradicate financial and physical barriers through provisions of higher federal funds, fair & convenient allocation of resources, training healthcare professionals to accommodate Indigenous health frameworks in healing and diagnosis and investigation of how each population understands illnesses at a more experiential level. Innovative crime prevention policies, such as the First Nations Policing Policy that was established in 1992 to bring about social order and improve social security could be further promoted to support and work with vulnerable communities. In conclusion, to improve the contemporary context of Aboriginal health, distal determinants embedded within historical roots should be thoroughly examined and informed among all societal institutions. Although the repressive acts of colonization cannot be undone, the disparities in today's society can be amended if citizens, leaders and policy-makers from various different disciplines advocate for the prevention of gaps in education, employment & social services and implement holistic solutions that will serve for the well-being of all First Nations, Metis and Inuit populations.

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Neoliberalism as a Driver for Racial Disparities in Health

VICTORIA TAN

Neoliberalism became the dominant ideology in the early 1980s, driving policy changes throughout Canada and leading the nation through a period of rapid economic growth (Pinto, 2014). Neoliberalism favours minimal government interference in the economy and society which translates into the de-regulation of markets and privatization or elimination of social programs. This hands-off approach intends to encourage self-sufficiency and motivation in society to improve nations economically and socially (Siddiqi et al., 2013). As a result, individuals of poor social standing are believed to lack the entrepreneurialism and drive to improve their situation and seize the opportunities for upward social mobility (Raphael et al., 2010; Meredith & Tepperman, 2017). While neoliberalist policies enacted during the 1980s were conducive to Canada's increasing economic wealth, they have had health implications detrimental to racially marginalized communities. Resultantly, the neoliberal point of view has partly enabled the institutionalization of racism which occurs when the policies or actions of institutions limit the power of non-white individuals (e.g., those who do not identify as of European descent), relative to white individuals (e.g., those who identify as of European descent). Reductions in housing assistance, increasing criminalization, and unjust hiring practices are a sample of mechanisms through which neoliberal-driven institutional racism operates and undermines the social determinants of health of non-white groups. Hence, non-white individuals suffer worse health outcomes even when they exhibit neoliberal qualities of independence and self-motivation as institutional racism disadvantages them in multiple aspects of life. In this paper, I explore the enacted policies and resultant racial health disparities during Canada's neoliberal-dominant period and assert that neoliberalism creates and maintains the institutional racism that undermines the health of non-white racial groups.

One way neoliberalism has led to racial disparities in health through institutionalized racism is at the level of housing. Housing is a crucial determinant of health that has worsened for non-white individuals through Canada's neoliberalist Common-Sense Revolution (CSR) in the 1990s (Morgan, 2018). The CSR was the federal government's unsuccessful attempt at solving the nation's housing crisis by halting funding for affordable housing and placing trust in the growing markets instead (Hackworth & Moriah, 2006). As a result of the CSR, 17,000 planned affordable housing units in Ontario were not completed, and the number of Ontarians awaiting social housing exceeded 150,000 in 2000 (Hackworth, 2008). Hence, the CSR is an example of institutional racism as the halt on affordable housing had disproportionately affected non-white individuals who belonged to an estimated 60% of all social housing in 2000 (Haan, 2007). The CSR also intensified housing instability and homelessness rates, particularly among racialized groups (Peressini & McDonald, 2000; Pinto, 2014). Furthermore,

non-white individuals are at a greater risk of experiencing homelessness as 22% are estimated to be below the poverty line, compared to 11% for the general Canadian population (United Way of Toronto, 2004). Housing can also inform other determinants of health, such as income and education. For instance, while residential segregation is not enforced in Canada, housing patterns still suggest a division, particularly between non-white and white communities, as suggested by the overrepresentation of Black and South-East Asian Canadians in social housing complexes (Haan, 2007). Residential segregation is shown to be a major cause of poor nutrition and unequal opportunity for higher education and career advancement, where non-white groups are most affected (Williams & Sternthal, 2010; Williams & Collins, 2001; Acevedo-Garcia et al., 2003). As a result, non-white individuals are more likely to experience chronically high stress levels, leading to high blood pressure and increased risk of stroke, cognitive impairment, and heart disease (Massey, 2004). The quality of housing is also important as poor physical infrastructure and over-occupancy are associated with increased risk of respiratory and cardiovascular diseases (Jacobs, 2011). Moreover, areas in Toronto with poorer quality of housing and prominent segregation have higher rates of crime and violence (Wellesley Institute, 2012). Hence, while the CSR may not have had explicitly racist intentions, it is the lack of attention to race that contributes to institutional racism. Therefore, neoliberalism positions and maintains racialized communities into conditions of low housing stability and socioeconomic status, increasing racial disparities in health.

Canada's stricter anti-gang legislation that had emerged in the early 2000s is another neoliberal-driven policy change that disproportionately affects the health of non-white groups (Ormond, 2018). Neoliberalism emphasizes punishment and criminalization as solutions to preventing socioeconomic inequalities, violence, and social unrest, but these methods also maintain the status quo, keeping white people on top of the social ladder (Mariani, 2001; Evans & Davies, 2015; Sugarman, 2015). Canada's anti-gang legislation brought an increase in police presence and power to control gang violence in major cities. The result was increased targeting and incarceration of racially marginalized communities, without much analysis into the conditions that make racialized people susceptible to joining gangs in the first place (Ormond, 2018). For instance, the percentage of Black Canadians in prison has risen 70% in the last ten years and while this increase may not be attributable to the new anti-gang legislation alone, this increase in incarceration will still widen health disparities between races (Sapers, 2015). As well, both Black men and women in prison tend to report poorer health outcomes than white prisoners, including higher rates of suicide, cases of tuberculosis, and mental illness (Kouyoumdjian et al., 2016). Black and Muslim prisoners also tend to report higher rates of discrimination and violence from other prisoners and guards, leading to greater psychological trauma and stress (Penner, 2011; Martin et al., 2014; Slawson, 2017). Hence, while inhibiting gang activities could be effective in creating safer communities (Howell, 2010), a neoliberal approach essentially leads to the criminalization of a non-white racial status. As it currently stands, neoliberal ideologies favouring incarceration negatively impact non-white racial groups due to their susceptibility to entering the prison system and the subsequent detriment to their health.

Despite exhibiting neoliberal qualities of independence and self-sufficiency, non-white individuals face barriers in improving their standard of living, in addition to their likelihood of housing instability and incarceration. Finding and securing employment to improve their condition and social standing is consistent with neoliberal notions of individualism and entrepreneurship (Gough, 2002). However, racialized groups are met with barriers of discrimination and unfair hiring practices that limit their chances of employment, which can then lead to limited opportunities for upward social mobility and poorer health outcomes. For instance, a recent study found that when identical resumes were sent to employers in Canada with either typical Asian names or Anglo names, those with Asian names were 28% less likely to get a call back (Banjeree, 2018). A similar study found that applicants with traditionally Black names were 50% less likely to get a callback (Bertrand & Mullainathan, 2004; Pager & Shepherd, 2008). Unemployment is associated with low income, housing stability, and an increased likelihood of incarceration which altogether can lead to poor health outcomes such as malnutrition, obesity, and mental illness (Bambra et al., 2010; Schmitz, 2011). Hence, employment may not be as successful a mediator against housing and health status for non-whites as neoliberalism boasts (Meredith & Tepperman, 2017).

Non-white individuals can also suffer adverse health effects when accessing healthcare due to the lack of diversity amongst the physician workforce. Chen et. al (2005) found that non-white patients are more likely to report higher satisfaction during hospital visits with doctors of the same race or ethnicity. Additionally, when patients have more positive interactions with their healthcare providers, they are more likely to follow medical advice and even report better health outcomes (Blair et al., 2013). However, it was also found that from 1978 to 2008, 75% of all practicing medical doctors in North America were white (Castillo-Page, 2010). The lack of diversity in physicians may be attributable to unfair admission processes into North American medical schools and employment discrimination, which together prevent non-white individuals from becoming physicians (Reitz, 1995; Sullivan, 2004). Hence, the limitation of available physicians of colour may contribute to the health disparities between non-white and white patients. It is evident then, that even as non-white individuals comply with neoliberal ideology and attempt to seize employment opportunities, they are met with institutional racism that reduces their likelihood of securing employment. Employment discrimination impacts non-white individuals in their ability to improve their social conditions as well as their likelihood of receiving and following effective healthcare advice. Neoliberalism further compounds these effects by reducing the availability of housing assistance and increasing criminalization of non-white individuals. As a result, neoliberalism is detrimental to the health outcomes of non-white racial groups and aggravate racial health disparities.

To conclude, neoliberalism disadvantages non-white individuals through institutionalized racism, as seen in housing policies, incarceration rates, and discrimination in hiring practices. The varying social determinants of health between white and non-white groups can explain a multitude of instances of racial disparities in health. Neoliberal notions of determination and autonomy are

less effective for racialized groups as their ability to improve their living condition is hindered by neoliberal policies themselves. Thus, when looking for solutions to dampen health inequities, changes can be made at a policy-level to better reflect that health is not the fault of the individual but rather a result of broader, systemic forces. Still, it is important to note that even if new policy changes improve social housing, healthcare, or employment for non-white groups, institutional racism will be present so long as neoliberal ideals govern society's thinking. While this essay examines the intersection between neoliberalism and race, other social identities such as gender, and sexuality in addition to race, complexify how neoliberalism is experienced within Canadian society. Governments should thus be wary that neoliberal thinking will severely disadvantage those who are non-white and that the same policies can be felt differently across Canada's diverse social landscape. Overall, it is evident that neoliberal policies from the past and neoliberal ideology today enables and facilitates racial disparities in health.

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Hurricane Harvey: The Impact of Climate Change on Human Health

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The exacerbation of natural disasters by climate change is a major threat facing human health in the 21st century. In particular, the destruction caused by one Atlantic hurricane after another has become a recurring theme in news reports. This discussion focuses on the scientific literature on Hurricane Harvey to determine the immediate, intermediate, and long-term impacts of Atlantic hurricanes on human health. Immediate impacts include physical trauma and death; intermediate impacts include contamination, the spread of infectious disease, air pollution, and the inability to access medical care; and long-term impacts include mental illness. A discussion of how racial minorities, individuals with disabilities, and women are differentially impacted by Atlantic hurricanes is also provided. Ultimately, facing the threat of hurricanes must involve mitigation and adaptation strategies which acknowledge the role of climate change in worsening natural disasters, and the fact that marginalized populations are most at risk.

On August 25th, 2017, Hurricane Harvey made landfall on the coast of Texas near Rockport, devastating surrounding areas (Jonkman et al., 2018; Risser & Wehner, 2017). A Category 4 storm on the Saffir-Simpson scale, Harvey was characterized by winds travelling at speeds of 200 km/h and unprecedented amounts of rainfall, leading to significant wind and flood-related damage (Jonkman et al., 2018; Miller, 2019; Risser & Wehner, 2017). Thirteen million people were directly affected by the storm, requiring rescue from floodwaters and temporary housing; a number of Texans were injured or killed (Grineski et al., 2019; Smith et al., 2018). While a causal relationship between man-made climate change and extreme weather events cannot be established, scientists agree that rising atmospheric and ocean temperatures, as well as rising sea levels, contribute to more violent hurricanes (Miller, 2019; Butler, 2014). The mass devastation wrought by Hurricane Harvey emphasizes the sentiment implicit to the notion of planetary health: the health of human beings is inextricably linked to the health of the Earth-system itself (Whitmee et al., 2015). This discussion uses the case study of Hurricane Harvey to elucidate how climate-exacerbated Atlantic hurricanes negatively impact human health and how these impacts are socially stratified. Hurricane Harvey was selected in particular as the passage of two years since this disaster has allowed ample time for scientific research into the effects on health, which is not currently possible for more recent events such as Hurricane Dorian. First, an explanation of how climate change is thought to contribute to more violent hurricanes is provided. This is followed by a discussion of the immediate (physical trauma and death), intermediate (contamination, the spread of infectious disease, air pollution, and

inability to access medical care), and long-term (mental illness) impacts of these weather events on human health (Erickson et al., 2019).

It cannot be stated with certainty that climate change caused Hurricane Harvey, but scientists maintain that rising atmospheric and ocean temperatures, as well as rising sea levels, contribute to more devastating hurricanes (Miller, 2019; Butler, 2014). First, increases in atmospheric temperatures result in higher amounts and rates of rainfall during hurricanes (Miller, 2019). This phenomenon is explained by the Clausius-Clapeyron equation, which indicates that “warmer air holds more water vapour” (Miller, 2019). The Clausius-Clapeyron equation posits a 6-7% increase in atmospheric water vapour, for every 1°C of warming (Miller, 2019; Risser & Wehner, 2017). Hurricane Harvey has anecdotally been used as evidence for this phenomenon. Total rainfall in Texas during the storm set new records for the United States, with the highest level of rainfall in the area reaching 60.58 inches (Jonkman et al., 2018). In one analysis, scientists concluded that “human-induced climate change likely increased the chances of the observed precipitation accumulations during Hurricane Harvey [...] by a factor of at least 3.5” (Risser & Wehner, 2017). These scientists also observed an 18.8% increase in water vapour in the atmosphere before Hurricane Harvey, which is much larger than the percentages set by the Clausius-Clapeyron equation (Risser & Wehner, 2017). It is also important to note that rising atmospheric temperatures are causing hurricanes to move slower, increasing rainfall times and damage (Miller, 2019). This stalling can be attributed to the slowing of atmospheric circulation patterns due to climate change (Miller, 2019). Second, warming of the ocean provides more “heat content for hurricanes to use for fuel,” and causes storms to rapidly intensify (Miller, 2019). It is difficult, however, to determine the extent to which this was implicated during Hurricane Harvey. Third, rising sea levels are making storm surges worse, which increases the volume of water that can travel inland and cause flooding; storm surges were implicated in flooding during Harvey (Miller, 2019).

The violent nature of hurricanes and the related issue of flooding has immediate impacts on human health, resulting in physical trauma and death (Jonkman et al., 2018). There is inconsistency in the literature regarding the total number of deaths due to Hurricane Harvey, with numbers ranging anywhere between 70 to 93 fatalities (Jonkman et al., 2018; Constible, 2018). In their analysis breaking down the primary causes of death, Jonkman et al. (2018) cite 70 fatalities. Of these, 81% were from drowning in the floods created by unprecedented levels of rainfall (Jonkman et al., 2018). 6% of deaths were from electrocution (Jonkman et al., 2018). High winds can destabilize powerlines, throwing them into large aggregates of floodwater (Butler, 2014). Flooding in homes where outlets and electronics are not elevated also creates the potential for electrocution (Grineski et al., 2019). Finally, 4% of deaths occurred due to physical trauma from “car accidents or falling trees” (Jonkman et al., 2018). In this way, one can observe that the increased rainfall, more powerful winds, and slower moving hurricanes associated with climate change have immediate and devastating impacts on human health. The aftermath of a hurricane results in intermediate effects on health including contamination, the spread of infectious disease, air pollution, and the inability to access medical care (Erickson et al.,

2019). Damage to infrastructures such as wastewater treatment plants and petroleum manufacturing sites can result in land and water contamination (Constible, 2018; Erickson et al., 2019; Karaye et al., 2019). During Hurricane Harvey, over 40 wastewater treatment plants were damaged, causing gallons of sewage water to flow into surrounding areas (Constible, 2018).

In their 2018 paper, Yu et al. studied levels of *Escherichia coli* bacteria inside flooded homes in Houston, to determine the extent to which residents were exposed to fecal water 6 months post-Harvey. They found that indoor stagnant water contained higher levels of pathogenic bacteria than both Houston's streets and bayous (Yu et al., 2018). This has major implications for human health, increasing the potential for waterborne bacterial ear, eye, and gastrointestinal infections (Yu et al., 2018; Constible, 2018). In addition to contamination by sewage water, overcrowded temporary shelters play a large role in the spread of viral, bacterial, and fungal infections (Shukla et al., 2018). The Jonkman et al. (2018) group reported one death from infection through exposure to contaminated water. Hurricane Harvey also resulted in the release of chemicals such as benzene and toluene into the environment through the damage of petroleum storage tanks (Karaye et al., 2019). Exposure to these chemicals can result in conditions such as osteomalacia and dermatitis (Karaye et al., 2019).

Another intermediate impact of hurricanes on health is an increase in air pollution through mould growth and release of pollutants from industrial plants (Constible, 2018; Phillips, 2018). Not only does flooding exacerbate contamination issues, but it also fosters an environment in which mould can grow (Constible, 2018; Chow et al., 2019). This has serious implications for human health, as the presence of mould can lead to invasive mould infections (Chow et al., 2019). During Hurricane Harvey, approximately 8.3 million pounds of air pollutants were also released into the atmosphere (Phillips, 2018). This may explain why the most common problems cited following Hurricane Harvey included allergies and nose irritation (Grineski, 2019; Constible, 2018).

Finally, access to health care is affected and limited during hurricanes (Jonkman et al., 2019). 6% of deaths during Hurricane Harvey can be attributed to lack of medical treatment (Jonkman et al., 2018). In these cases, chronically ill individuals, such as those requiring dialysis, were unable to receive the medical attention they required in a timely manner (Jonkman et al., 2018). It is important to note that Texans were differentially impacted by the intermediate effects of Hurricane Harvey depending on their race/ethnicity, socio-economic status (SES), and gender, as well as whether they were disabled or not (Collins et al., 2012). The degree of flooding was greater in Hispanic, Black, and other racial/ethnic minority homes than in White homes (Collins et al., 2019).

The degree of flooding was also greater for individuals of low SES in comparison to high SES counterparts (Collins et al., 2019). Differential flooding leads to differential impacts on health, working to exacerbate pre-existing health conditions in these communities (Collins et al., 2019). Researchers also determined that individuals with disabilities, particularly those with ambulatory and cognitive disabilities, were more likely to live in areas affected by flooding during Hurricane Harvey (Chakraborty et al., 2018). Finally, women are more

affected by natural disasters than men (Babat, 2012). Although the literature on Hurricane Harvey is limited, it is known that following Hurricane Katrina, women were subject to more physical and sexual assault following the disaster (Babat, 2012).

Hurricanes also have long term impacts on the mental health of affected populations (Butler, 2014). A number of factors such as extent of flooding, displacement, relocation, and extent of hurricane exposure (damage to property, separation from family members, and financial burdens) are significantly associated with negative mental health outcomes such as anxiety, depression, and post-traumatic stress disorder (PTSD) (Schwartz et al., 2018; Grineski et al., 2019; Lamond et al., 2015). To determine the impacts of Hurricane Harvey on mental health, Schwartz et al. (2018) recruited a sample of 41 adults from the greater Houston area to complete a survey relating to “demographics, hurricane exposures, and physical/mental health” (Schwartz et al., 2018). Researchers found that PTSD symptoms manifested in 46% of participants, anxiety symptoms in 53.7%, and depression symptoms in 39% (Schwartz et al., 2018). Increased levels of hurricane and property-related exposure increased the likelihood of developing PTSD or anxiety; increased levels of displacement were associated with increased likelihood of PTSD and depression; and increased chemical/toxin exposure was associated with an increased likelihood of anxiety (Schwartz et al., 2018). To add another dimension to this, racial/ethnic minorities and individuals of low SES, low education, and older age all have a higher risk of PTSD following an extreme weather event such as Hurricane Harvey (Grineski et al., 2019). Increased intensity of hurricanes, exacerbated by man-made climate change, will inevitably increase mental health burdens and socially vulnerable populations will bear the brunt of this burden (Miller, 2019; Grineski et al., 2019).

Having discussed the impact of climate-exacerbated hurricanes on human health, it is important to consider adaptation and mitigation techniques and the benefits of such activities. Adaptation refers to “the attempt to adjust human and/or natural systems to actual or expected climate and its effects, in order to minimize harm” (Butler, 2014). On the other hand, mitigation involves the “abatement” of climate change and downstream effects (Butler, 2014). In this way, adaptation can be viewed as reactive, whereas mitigation can be viewed as proactive; a mixture of these two approaches is necessary to combat the threat of violent hurricanes (Butler, 2014). Researchers found that individuals with adaptive strategies in place had fewer health problems, lower levels of adverse mental health impacts, and greater resilience following

Hurricane Harvey compared to those that did not (Grineski et al., 2019). Adaptation takes place through various activities including general disaster preparation, installation of household drainage systems, the elevation of electric devices, and floodwalls (Grineski et al., 2019). Despite these strategies, Hurricane Harvey still resulted in \$190 billion in damage (Smith et al., 2018). This points to the need for proactive mitigation strategies which address reducing climate change as a whole in an attempt to abate the damage done by hurricanes (Miller, 2019). Mitigation must also involve recognizing the socially vulnerable populations which are most affected by these disasters.

Hurricanes have become increasingly salient topics of news discussion, with the names of different hurricanes reminding observers of the devastation each brought. Facing this threat to human life begins first and foremost with an acknowledgement of the implications of man-made climate change on the intensity of hurricanes (Miller, 2019). The continued warming of the Earth's atmosphere and oceans, as well as rising sea levels, are contributing to the creation of more intense and violent storms which are incompatible with human health and wellness (Miller, 2019). The impact of hurricanes on human health functions through a variety of immediate, intermediate, and long term pathways (Erickson et al., 2019). Permeating each of these pathways, are issues of social stratification and inequality, wherein the most vulnerable populations are most affected by natural disasters; true environmental justice and solutions must consider this fact (Collins et al., 2019; Babat, 2012; Chakraborty, 2018). Climate change must be approached with the appropriate urgency, and solutions must include both adaptation and mitigation (Butler, 2014). As the importance of countering climate change grows within the public consciousness, again and again we are reminded of our duty to commit to a level of planetary health which leaves the Earth-system in a place to provide future generations with happy and healthy lives.

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Antidepressants are Anti-Effective

KAITLYN LEM

This paper will argue that antidepressants, the current first-line treatment approach for depression, are ineffective on their own, and that holistic models of care would produce more long-lasting, consistent health outcomes. This can be accomplished through public policy changes that re-define how depression is considered. This argument will be supported with research on the lack of, or limited positive benefits of antidepressants when prescribed in isolation to treat depression. First, this paper will review how depression has historically been understood and treated. Next, it will show that the dominant simplistic biomedical model approach to treatment does not address the social determinants of depression. Then, this paper will consider the known evidence supporting a multi-modal approach to treatment achieved through public policy changes. It will also discuss the negative implications of a single model approach to mental health for the individual and the population. This paper will conclude by suggesting ways to broaden the current model to make treatment more effective by addressing root causes of depression on a population level.

In ancient Greek medicine, it was believed that depression was caused by an excess of “black bile” in the body. It was treated with bloodletting, bathing, exercise, and diet change (Jackson, 2001). This method was predominantly a behavioural approach, focusing on the lifestyle changes of individuals (Jackson, 2001). In the Dark Ages, most medicine was under the control of the Christian Church and depression was attributed to a lack of devotion and faith (Siraisi, 2009). It was treated with atonement, prayer, and religious objects such as talismans (Foerschner, 2010). In the 19th and early 20th centuries, control of medicine moved out of the hands of the Christian church, and a broader range of theories were developed to explain depression (Foerschner, 2010). This resulted in the development of a variety of treatment methods including psychotherapy and lobotomies (Foerschner, 2010). However, it was not until the 1950’s that monoamine oxidase inhibitors (MOAI) became marketed as antidepressants (Ramachandrai et al., 2011). Monoamine oxidase inhibitors work by restricting the enzyme monoamine oxidase from breaking down serotonin, dopamine, and norepinephrine neurotransmitters in the brain (Ramachandrai et al., 2011). It was accidentally discovered as a treatment for depression when it was found to elicit euphoric symptoms in tuberculosis patients. However, the adverse side effects of MOAI consumption, such as hypertension and liver toxicity, resulted in them being slowly phased out as the first-line treatment for depression (Ramachandrai et al., 2011). This discovery facilitated the creation of treatments in response to the serotonin deficiency theory, which claims that a serotonin deficiency or imbalance is the cause of depression (Lacasse & Leo, 2015). Thus, modern antidepressants were developed in response to the serotonin deficiency theory. To this day, this theory is still the foundation of the dominant course of action in diagnosing and treating depression.

The serotonin deficiency theory is based on the biomedical model of health. The biomedical model views depression as the result of a biological abnormality and emphasizes pharmacological treatment in response (Deacon, 2013; Raphael et al., 2010). According to the biomedical model, the primary solution to depression is to increase serotonin levels in the brain. This approach is further endorsed by pharmaceutical companies who adopt the chemical imbalance theory to market selective serotonin reuptake inhibitor medications (SSRI) as a quick fix to treat depression (Kirsch, 2014; Lacasse et al., 2015). Currently, the biomedical model is the dominant approach for understanding and treating depression in Western medicine (Deacon, 2013). While this might appear to be a straightforward solution, analyses have shown that antidepressants can have adverse and undesired effects on the brain's serotonin levels: increasing, decreasing, or not changing them at all (Kirsch, 2014). Further, the consumption of antidepressants can result in weight gain, insomnia, sexual dysfunction, and withdrawal (Kirsch, 2014). The inconsistent results of antidepressants and array of adverse side effects illustrate the limitations of treating depression from an biomedical model in isolation from other forms of treatment. It is crucial to acknowledge the limits of the current paradigm in order to develop more efficacious, inclusive, and broader approaches to treatment to improve the mental health of the population.

Prior research by Irving Kirsch (2014) has shown that most and possibly all benefits of antidepressants are attributable to the placebo effect rather than the actual medication. The placebo effect takes place when a change or effect occurs in response to the administration of a neutral, "pseudo" substance, like a sugar pill, that contains no known health effects (Kaptchuk, & Miller, 2015). In administering placebos during an experiment or study, researchers are able to discount and control for any effects that occur to the individuals in that condition as being separate from the actual treatment effects of the drug being tested. In 1998, Kirsch and Sapirstein performed a meta-analysis of antidepressant medications and found a significant placebo effect and small drug effect (Kirsch & Sapirstein, 1998). 75% of the improvement in the treatment condition also occurred in people in the control group, meaning that SSRIs accounted for only about 25% of reported improvements (Kirsch & Sapirstein, 1998). In response to criticism regarding the veracity of this meta-analysis, Kirsch replicated his study in 2002 using the Food and Drug Administration's (FDA) information from pharmaceutical companies and their sponsored trials along with approved medications (Kirsch et al., 2002). Kirsch and his team uncovered numerous unpublished clinical trials on antidepressants that failed to find distinct and significant benefits of the drugs over placebos (Kirsch et al., 2002). They also found that the placebo effect can account for approximately 80% of the response to antidepressants (Kirsch et al., 2002). This data has been replicated in length, with different data sets, and the findings consistently show that the benefits of antidepressants are not clinically significant (Fountoulakis & Möller, 2011; Khin et al., 2011).

An argument can be presented that individuals with severe depression, compared with mild and moderate depression, may find increased benefit from antidepressants. A 2010 meta-analysis of the effects of antidepressants stratified

by depression severity found that the difference between antidepressants and placebos for patients with mild or moderate depressive symptoms was minimal or non-existent (Fournier et al., 2010). The efficacy of antidepressants in those with severe depression was significant over placebos (Fournier et al., 2010). When Kirsch et al. re-analyzed their 2008 data, they found that the drug-placebo differences for severely depressed patients was relatively small. Additionally, researchers theorized that it could be attributed to decreased placebo responsiveness rather than increased efficacy of the medication (Kirsch et al., 2008). This may occur if individuals in the placebo condition recognize that they were not given treatment (Kirsch, 2014). Further, participants who reported benefitting from antidepressants accounted for only about 11% of patients in the trial (Kirsch et al., 2008).

Although antidepressants can benefit those who suffer extreme symptoms of depression, there is sufficient research to show that SSRIs are completely inadequate to meet the care needs of patients with mild to moderate depression. The healthcare system and pharmaceutical companies inflate the effectiveness of antidepressants, exaggerating the range of benefits that antidepressants can produce in isolation as a quick unimodal solution (Fournier et al., 2010). In turn, the heavy emphasis on the genetic aspects of depression results in a disregard for potential alternative explanations, such as the social determinants of health.

The current simplistic biomedical approach to treatment does not address the social determinants of depression. Considering the social determinants allows one to look at the living conditions that individuals experience and how these factors contribute to and shape health. This is done by looking beyond the genetic factors that predispose people to illness and instead focusing on health as a combination of social and economic circumstances (Mikkonen, & Raphael, 2010). For example, in a review by the World Health Organization (WHO) (2014), it was found “that low socioeconomic status is systematically associated with increased rates of depression”. However, antidepressants alone cannot address the social determinants of depression such as income, race, social support, physical environment, and life circumstances (Allen et al., 2014). In a 2014 study, WHO researchers found a correlational link between a lack of social support and depressive symptoms, which was moderated by feelings of isolation and loneliness (Grundy et al., 2013). Additionally, these social determinants can intersect, allowing one individual to carry the burden of multiple determinants. For example, if an individual is of low socioeconomic status and lacks social support, they are more susceptible to depression than an individual who carries only one of these burdens (McLaughlin, 2011). Therefore, in treating depression with only antidepressants, all other factors that could contribute to an individual’s mental health status are neglected (World Health Organization, 2014). Solely using the biomedical approach to depression has led to a narrow scope of understanding and treatment methods.

The wide propagation of antidepressants and the chemical imbalance theory can lead people to perceive that antidepressants are the only, most credible, and effective treatment option (Kemp, Lickel, & Deacon, 2014). This

results in individuals selecting antidepressants alone as their preferred method of treatment and missing out on the benefits of additional treatments that address upstream factors (Williams et al., 2008). Neglecting the social determinants of depression results in not only ineffective and non-permanent action taken to treat depression, but also convinces people that pharmacotherapy is the best treatment option.

A possible solution could be to prescribe placebos. This strategy has not been implemented due to the ethical concerns surrounding withholding care which could potentially be beneficial (Bok, 1974). Hypothetically, providing a placebo would allow for the benefits of the placebo effect, without the adverse side effects of actual antidepressants. A potential source of the benefits of the placebo effect may lie in the decision to begin treatment, and taking agency to improve one's mental health (Kirsch, 2014; Snyder, 2004). As defining characteristics of depression include hopelessness and apparent loss of control, voluntarily deciding to begin taking antidepressant medication may restore a sense of hope and control in one's outcomes (Kirsch, 2014; Snyder, 2004). However, this may not work long-term. A study has shown that 89% of patients correctly guessed if they received the actual drug or not (Rabkin et al., 1986). This could result in decreased placebo effects and therefore make the placebo prescription ineffective. Despite the observed benefits from the placebo effect, the implications of prescribing medication with no actual treatment benefit and the possibility of extreme long-term side effects outweigh the temporary benefit of the placebo effect (Kirsch, 2014). Therefore, antidepressants in isolation are not an effective treatment method for depression, nor are they acceptable as a first-line treatment. Instead, other determining factors that contribute to an individual's mental state must be addressed in conjunction with the prescription of antidepressants, in order to holistically treat depression.

Both antidepressants and placebos treat symptoms at an individual level, but do not address causes of depression that cannot be linked to a biomedical risk, such as social and economic determinants. Like traditional antidepressants, placebos do not treat the socially-based, population level correlates of depression. A more proactive, long-term solution to accomplish this is to approach depression using a socio-ecological model approach. The socio-ecological approach addresses depression from hierarchical levels, with the higher levels encompassing those beneath them (Solar & Irwin, 2010). The highest of these levels is public policy change, with community, interpersonal, and individual levels below. Public policy changes, while not directly addressing the individual, are preventative and treatment measures that address the overarching social determinants that impact the population's health, which in turn address individual-level determinants (McLaughlin, 2011; Solar et al., 2010). It should be noted that all levels of the socio-ecological method work together to address the health inequities within the population that can cause depression (Solar et al., 2010). This includes the social, economic, and physical environments that contribute to depression. This should be addressed with policy changes to improve the distribution of wealth and health coverage and increase the number of safe social spaces for all populations. These interventions are horizontal in their benefits and address not just the social determinants of depression, but also

impact a variety of health outcomes including population level well-being and life satisfaction.

Policy level interventions as a means of addressing depression are widespread in their benefits of improving health and reducing inequities within the population. In a study on the effects of public policy change, researchers measured the benefits of added income and preferential employment on the mental health of Aboriginal children (Costello, Compton, & Keeler, 2005). Results showed that with the implementation of this policy, Aboriginal children's risk for psychiatric symptoms decreased and became comparable to those of children who had never experienced poverty (Costello et al., 2005). This shows the impacts of addressing depression with social determinants for treatment as well as prevention. By supplementing the incomes of an at-risk population, this intervention was able to increase the accessibility and affordability of health services and address the inequities of depression risk experienced by this population group. This policy change is an example of the effectiveness of the socio-ecological model in addressing the social determinants of depression, and consequently improving the health of the population through treatment and prevention measures.

The circumstances that lead to an individual's current state of health are not simply biomedical. As a result, antidepressants as the first line treatment for depression do not account for or treat the multitude of factors that can contribute to someone's depression. The WHO states "good mental health is integral to human health and well-being" (WHO, 2014). Thus, to improve the health of the individual, the community, and the population, it is critical to address and discuss the ineffectiveness of antidepressants. Alternate solutions must be hypothesized in order to improve the health of populations. The first-line treatment for depression must be transitioned from pharmacological to a more holistic, inclusive, and diverse approach. A collaboration between the biomedical and socio-ecological models would address the health inequities of depression on all levels. This must be done through public policy change, which through addressing the overarching social determinants of depression, can improve the health of the population and individual. Only through policy level change can depression begin to be addressed, treated and prevented adequately.

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Voices Unheard: Ungagging the Global and Gender Inequities of the Global Gag Rule

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The Mexico City Policy or the Global Gag Rule (GGR) is an antiabortion policy in the United States (U.S.) that restricts aid to any foreign health organization that counsels, refers or performs abortions. This policy has worked to limit the functioning of many health organizations globally as the U.S. is one of the leading foreign aid suppliers, sending roughly \$9.5 billion a year in foreign aid (Starrs, 2017). The GGR predominantly affects pregnant women who wish to terminate their pregnancy, as access to abortion services becomes limited. This policy brief highlights the global, political, and economic inequities caused by the GGR and the violation of sexual and reproductive rights of women. It is a call to action for policymakers of the United Nations General Assembly to encourage global partners to collaborate on a funding reserve for health organizations to relieve the reliance on US foreign aid and create stricter regulations around the protection of sexual and reproductive rights.

Scope of the Problem

The breaking down of social services due to neoliberal globalization, along with the imposition of capitalist ideologies, from Western nations, has created a dependency of middle and low-income countries on U.S. foreign aid to provide needed health services. Global health organizations must receive the funding they need to keep people alive, healthy, and free from restrictions imposed by the U.S.. According to the International Women's Health Coalition, the GGR is harmful to the health of women, youth, marginalized communities, LGBTQ populations, those living in poverty, and religious minority groups as it increases barriers to "...a broad range of services...including comprehensive abortion care, contraceptive services, HIV/AIDS testing and treatment, screening for cervical cancer, breast cancer, prostate cancer, and support for survivors of gender-based violence" (Rios, 2019, p. 2). The GGR affects women and other populations seeking reproductive and sexual health services through the U.S. withholding aid to pay healthcare providers.

Global Political and Economic Inequities

The GGR has been reinstated and revoked many times since its inception in 1984 by Ronald Reagan at the Second International Conference on Population (Lo & Barry, 2017), and as such, the fluctuating nature of this policy has led to a precarious resource for many health organizations. When implemented, the GGR creates a barrier to aid. In South Africa, a non-governmental organization lost all US funding when they suggested that they perform abortions (Masbaso, 2019). Nationally, 54% of 260,000 abortions each year are performed illegally in South Africa, due to limited access to services and resources (Masbaso, 2019). According

to Birn et al. (2017), neoliberal globalization has led to inequities between individuals, groups, and entire countries. Furthermore, the creation of Structural Adjustment Programs by the World Bank has led to the imposition of neoliberal ideologies onto lower and middle-income countries, forcing them to open their trade markets, resulting in higher debt and higher rates of child mortality (Birn et al., 2017). The imperialistic nature of the GGR allows for the US to impose its patriarchal ideologies around the regulations of women's bodies onto other countries. By withholding aid from foreign health organizations that provide or refer to abortions, the US can dictate what can or cannot be done in particular health organizations. The GGR creates global gendered health inequities by forcing U.S. legislation on global organizations, negatively impacting women's health through restricting access to reproductive health care services.

Violation of Sexual and Reproductive Rights

A study concerning the effects of GGR in Sub-Saharan Africa over the years of 1995 to 2014, suggested there was an increase in abortions when GGR was in effect (corresponding with the lack of available modern contraceptives), however during that time the GGR was revoked, abortion rates decreased, and contraception use increased (Brooks et al., 2019). The restriction of sexual and reproductive health services directly violates sexual and reproductive rights as stated by the Declaration of Human Rights and negatively impacts the health of women and other minority groups who need access to sexual and reproductive education and services (UN, 2014). Individuals working in the healthcare service industry are also impacted as a reduction of funding limits their availability of work. According to the World Health Organization (WHO, n.d.), "An estimated 303,000 women around the world died due to complications of pregnancy and childbirth in 2015" with a large proportion of deaths taking place in Sub-Saharan Africa and other low and middle-income countries (WHO, n.d.). Women are dying from complications of childbirth due to a lack of professional maternal care and scarce contraceptive resources. Women's health and reproductive rights must be protected, through the availability of important services as women predominantly take on the unpaid labour of social reproduction, and as such are often the main caretakers for their family. If a woman dies due to complications with an abortion, the health and wellbeing of other family members, particularly children are greatly impacted (Lo & Barry, 2017).

Policy Recommendations

Global Sexual and Reproductive Health Funding Reserve

The coming together of multiple global partners and the pooling of money for a funding reserve dedicated to sexual and reproductive health for global health organizations may work to reduce the dependence of middle to low-income countries on direct foreign aid from the U.S. As Hawkes et al. (2017) suggest, the UN Agenda 2030 for Sustainable development encourages public and private partnerships such as a global public private partnership for health (GPPPH) to build on experience and resource strategies to improve efficiency and equity in global public health. If GPPPH can create a stable fund for sexual

and reproductive health, it would relieve the dependence global health organizations have on U.S. aid and work to fill in the gaps of funding for more access to sexual and reproductive health services. This fund would ensure that health organizations can allow for services such as the availability of contraceptives and abortions in middle to low-income countries, working towards the Sustainable Development Goal target 3.7 by 2030, which aims to ensure universal access to sexual and reproductive health-care services (WHO, n.d.). These services include family planning, information and education, and the integration of reproductive health into national strategies and programmes (WHO, n.d.). A disadvantage to this recommendation is the fact that, as Hawkes (2017) suggests, GPPPH invites more private actors, which may work to increase more privatization of healthcare, further increasing barriers to access. Although this may be of some concern, what is important is that funds be available for global health organizations that provide essential reproductive services.

Regulating and Upholding Sexual and Reproductive Rights

The Sustainable Development Goal 5: Gender Equality target 5.6 urges to “ensure universal access to sexual and reproductive health and reproductive rights” (United Nations, n.d., p.22). This is a call to action for the UN to ensure that the U.S. government upholds its endorsement of the International Conference on Population and Development (ICPD) Programme of Action that speaks to reproductive rights as human rights internationally (UN, 2014). Nations signing on to this programme pledged to protect reproductive rights without discrimination allowing for people to decide freely on the spacing and timing of their children (UN, 2014). Going one step further, the United Nations Human Rights Office of the High Commissioner (2014) suggests that Human Rights bodies should be included in the legislative process as they can bring about a human-rights based approach to their policy-making and advising . A regulatory body that seeks to inform and hold accountable global policies would work to ensure that policies like the GGR are not able to take effect and negatively impact populations. A disadvantage to this policy recommendation is that all governments have different laws and regulations, which may make it difficult for a human rights regulatory body to enforce free access to sexual and reproductive health services and resources without discrimination. Although this may be a barrier, the UN General Assembly must take action and hold the U.S. accountable for their imperialistic and human rights violations through the GGR policy.

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Social Isolation of Seniors in Canada

GABRIELLA EKMEKJIAN

Introduction

Humans are a fundamentally social species with the innate need to socialize, belong, and create social bonds (Cacioppo & Patrick, 2009). This innate drive for social interaction combined with the fear of social rejection and relationship dissolution has the power to shape health outcomes. The International Federation on Aging reports that “the number one emerging issue facing seniors in Canada is keeping older people socially connected and active” (International Federation on Aging, 2012, p. 71). Although seniors represent 15% of the Canadian population, 30% of those at risk of becoming isolated are seniors (Keefe et al., 2006). Many studies have demonstrated how, due to Canada’s rapidly aging population, social isolation has manifested into various health issues negatively impacting the wellbeing of seniors (Umberson & Karas Montez, 2010; Cacioppo & Patrick, 2009; Elmer, 2019). However, social isolation among seniors is generally framed as a narrow one-size fits all policy model excluding the needs and narratives of seniors from varying sub-populations and demographics such as Indigenous, LGBTQI2-S, and culturally diverse seniors.

Moreover, causes of isolation are interconnected and range from individual-level factors such as chronic illness, geographic location, limited transportation access, or death of a spouse, to broader societal factors including values associated with community cohesion and norms surrounding home-care (Menec et al., 2019). Since social isolation stems from existing issues, policy surrounding aging and senior isolation in Canada has primarily been framed as a symptom of other illnesses, including mental illness and disability rather than a systematic cause of illness and deterioration.

Central Features of Senior Social Isolation

The National Seniors Council of Canada defines social isolation as low quality and quantity of contact with others (The National Seniors Council [NSC], 2017). In this context, isolation includes few social contacts or social roles and the absence of mutually rewarding relationships (Keefe et al., 2006). In Canada, it is estimated that between 19-24% of adults aged 65 and older experience long-term isolation from others and their communities, wishing they could participate more in social activities (MacCourt, 2017). In Canada, this issue is often conceptualized as a subjective narrative and thus not given top priority on the Ontario policy agenda, as it is often viewed as a symptom of loneliness. Thus it is important to distinguish between loneliness and isolation.

Loneliness is defined as an experience of separation associated with the dissatisfaction of life and emotional distress (Sibley et al., 2016). Degrees of loneliness can vary as they are subjective evaluations of one’s social participation or isolation and thus can be viewed as having a U-shaped distribution against age (Sibley et al., 2016). Conversely, social isolation is an objective state that arises

due to a lack of social belongingness, encompassing multiple dimensions, including physical, psychological and temporal (Sibley et al., 2016). It is crucial to acknowledge that social isolation is not always linked or the sole cause of loneliness. Those who experience loneliness may not necessarily be socially isolated, as an individual may have access to resources combating loneliness but still feel socially isolated (Sibley et al., 2016).

A majority of interventions and initiatives targeted at reducing isolation amongst seniors often frame social isolation as an issue of loneliness, contending that if social interactions amongst seniors increases, then isolation will be ‘cured’ (Sibley et al., 2016). For instance, communal living initiatives such as Age-Friendly Communities (AFC’s) in Ontario are geared towards encouraging healthy aging through age-inclusive community living (Government of Ontario, 2019). However, such communal settings often leave seniors at a higher risk of being socially isolated (Sibley et al., 2016). For example, rates of social isolation among community-dwelling seniors or those in long-term care (LTC) is estimated to be as high as 43% (Sibley et al., 2016). Thus it is important to address social isolation in a manner that accounts for its multifaceted nature and ability to affect a wide array of senior sub-populations.

Key Demographics

The 2016 Canadian Census revealed that approximately 24.6% of the population aged 65 and over live alone (Statistics Canada, 2016). Of this proportion, 72% of men over 65 are married and living with a spouse compared to 45% of women (Statistics Canada, 2016). Moreover, 37% of women are widows resulting in almost half of the women over 75 living alone (Statistics Canada, 2016). Furthermore, though there are no firm statistics on LGBTQI2-S seniors, in 2014, 10% of Canadians aged 18-59 self-identified as members of the LGBTQI2-S senior community (Beaulieu, 2019). Combined with projected population growth rates, estimating that a quarter (25%) of the population in 2024 will be 65 and older, community groups report that LGBTQI2-S seniors fear aging and moving into LTC facilities (Beaulieu, 2019). This is primarily attributed to the fear of going “back into the closet” to avoid receiving inferior care and discrimination (Löf & Olaison, 2018). LGBTQI2-S seniors have experienced isolation due to their sexual orientation or gender identity throughout their lives, which exasperates the effects of isolation felt as they age (Löf & Olaison, 2018).

In addition, Indigenous seniors face countless barriers that may hinder their ability to socially participate in society such as, socio-economic disadvantages and geographical differences as some Indigenous seniors live in remote rural areas or reserves (NSC, 2017). Moreover, through historical oppressive practices such as residential schools, many Indigenous seniors experience intergenerational trauma, thus are highly apprehensive and unwilling to access health services (NSC, 2017). Therefore, LGBTQI2-S and Indigenous senior isolation are two-

tiered as they experienced isolation due to challenges in their past and continue to experience it as they age (Beatty, 2018).

Current Framing and How Senior Isolation is Perceived

Existing policy, such as the New Horizons for Seniors Program (NHSP) and the previous 2017 Aging with Confidence Action Plan for Seniors, present solutions including clinical interventions, therapeutic treatments, and community programs which promote social interaction of elderly adults (Employment and Social Development Canada [ESDC], 2018; Government of Ontario, 2017; Health Quality Ontario, 2008). Under the previous Liberal provincial government, the 2017 Aging with Confidence Action plan was spearheaded by Kathlyn Wynne, in an attempt to address the growing concern of social isolation among seniors. This policy inherently emphasized the shift of aging away from hospitals and specialized care supports to a model focusing entirely on home-care (Government of Ontario, 2017). Throughout this action plan, several novel resources were introduced that promoted self-directed care, independent living at home, and ways to mobilize existing social supports to ensure healthy aging (Government of Ontario, 2017). However, this narrow focus on self-directed care, in a sense, assumes that all seniors have social supports to mobilize or the ability to receive or provide themselves with 'self-directed care' (Government of Ontario, 2017). For example, a large portion of this policy's rhetoric discusses how new province-wide programs and resources will be launched, but does not provide instruction on how seniors will be able to access such programs (Government of Ontario, 2017). In addition, this action plan neglects to outline one general policy targeting social senior isolation, but rather reduces the problem into small sub-sections such as "increasing support for caregivers" and "helping people with dementia," placing the responsibility of healthy aging at the individual level rather than the governmental level (Government of Ontario, 2017).

At the federal level, the NHSP, which is still in place, frames social isolation and aging as a pan-Canadian deficit issue that can be addressed through community-based organizations funded through governmental grants (ESDC, 2018). Similar to the 2017 Aging with Confidence Action Plan, the NHSP adopts a self-directed care narrative encouraging individuals to participate in community care and volunteer programs, rather than burdening hospital and healthcare resources (ESDC, 2018). Seniors aged 65 and over are at a higher risk of developing chronic conditions, with over 77% having two or more chronic illnesses. Through this it is evident that seniors are more likely to be frequent users of healthcare services, placing an immense burden on healthcare resources (MacCourt, 2017). This echoes current rhetoric which frames social isolation and aging as a financial issue rather than a health issue. Such a broad framing of social isolation neglects to target the root causes of isolation, principally a lack of care, access, and diversity. It further fails to set out policies that encourage the provincial government to implement nationwide senior isolation programs ultimately resulting in this issue being nationally overlooked.

Economic and Political Dimensions

The current conservative government under Premier Doug Ford has re-engineered the healthcare system and is undertaking significant changes to address the costs of caring for the elderly (Crawley, 2019). The progressive conservative party is seeking to severely cut deficits and bureaucracies by \$6 billion, including the elimination of Local Health Integration Care Networks (LHIN), which work to oversee budgets and funding of LTC facilities and community health centres (Crawley, 2019). The LHINs will be substituted with five regional oversight bodies that aim to monitor healthcare spending by LTC facilities and hospitals (Crawley, 2019). In this sense, Ford is aiming to centralize healthcare, by creating one super-agency, Health Ontario, who's primary objective is to shift healthcare to patients' homes, in an attempt to cut healthcare spending and reduce the financial burden felt by hospitals.

Due to the severe lack of funding for capital expenditures in Ontario hospitals, an increase in overcrowding and hallway medicine has been documented (Government of Ontario, 2019). Through this narrative, though not explicitly stated on the current policy agenda, the conservative government has framed social isolation as an issue of hospital overcrowding (Government of Ontario, 2019). Ford states that by increasing spending for publicly funded home-care, a drastic reduction in hospital admissions will occur, thereby alleviating a large portion of the strain on hospital resources (Crawley, 2019). However, since one's home is seen as the setting in which the majority of isolation occurs, reforming healthcare to a model that promotes home-care, may further exacerbate social isolation among seniors (Luo et al., 2012). This transition is primarily premised on the neoliberalist notion that seniors prefer to age in place, with over 87% of seniors having expressed their desire to receive care in their homes (Canadian Association of Retired Persons [CARP], 2019). However, aging in place has a dark side. Evidence suggests that elderly adults who choose to age in their homes are more susceptible to mobility issues, social isolation, and depression (Luo et al., 2012; Sibley et al., 2016). When seniors remain at home they slowly watch their social circles dwindle, as loved ones pass or move away leaving them with no real support system (Luo et al., 2012; Sibley et al., 2016). This further contributes to senior isolation giving rise to a range of health issues negatively affecting seniors' quality of life (Sibley et al., 2016). Combined with the ever-growing list of delivery services and the fact that over 76% of seniors aged 75+ are currently receiving care at home, seniors are essentially imprisoned by their independence (Government of Ontario, 2017; CARP, 2019).

Should Premier Ford's healthcare reform transpire, this problem will dramatically increase, leading to the deregulation of both the home-care and aging sector. Ford's healthcare reform has commonly been framed as an initiative to privatize healthcare, which in turn, would exacerbate current home-care issues and create new challenges (Crawley, 2019; Walsh, 2019). Currently, home-care has difficulties pertaining to inconsistent quality of care, unpunctual caregivers, and most importantly, cultural and language barriers (Gray & Thomas, 2006). Hence, the shift towards privatized healthcare will only render home care

increasingly less accessible to seniors, especially when the majority outlive their pension plans.

Canada's life expectancy is increasing, with average life-spans rising to 80 years for men and 84 for women (Government of Canada, 2017). With this gradual growth, 'super' seniors are outliving their old age security (OAS) due to inflation and increases in the cost of living steadily rising over the past two decades (Government of Canada, 2017; Famularo & Skinner, 2018). As a result, 62% of adults aged 55-75 are worried about running out of money, as only 13% of seniors have a retirement plan in place (Government of Canada, 2017; Famularo & Skinner, 2018). Once seniors reach the age of 85, a majority will require some form of care, whether it be in-home LTC or entering a nursing facility (Canadian Association for Long Term Care [CALTC], 2018). However, LTC can be extremely expensive and could double in price should Canadian healthcare become privatized. This would not only prevent many seniors from accessing the care they require but would force them to age within their homes, ultimately increasing rates of social isolation (Government of Canada, 2017).

Re-Framing and Policy Recommendations

To circumvent the challenges social isolation presents a rigorous re-framing of existing policies is necessary to target the multifaceted reach of senior isolation. Current frameworks surrounding senior isolation are implemented into communities in a health promotion manner, primarily focusing on community engagement and education (ESDC, 2018; Government of Ontario, 2017). However, such broad framing is problematic as it reduces the complexities of senior isolation to one general obstacle that can be solved through one 'type' of intervention. Thus, re-framing social isolation as an economic determinant through a richer two-pronged approach which works to direct seniors out of hospital settings while providing resources tailored to senior sub-populations needs through culturally specific LTC facilities, would aid in reducing both hallway medicine and the overall burden on the Canadian healthcare system.

In addition to seniors having unique healthcare needs, they also have diverse cultural norms and views towards the caring of older adults. Many cultural backgrounds frown upon placing seniors into care, believing that informal caregivers such as friends, family, and neighbours should care for elders (CARP, 2019). This, however, could confine older adults to their homes, making them completely dependent on their informal caregivers, further putting them at risk for social isolation (Government of Ontario, 2017; CARP, 2019).

In Toronto, certain LTC facilities provide culturally specific care such as, the Yee Hong Centre located in Mississauga and Scarborough, which addresses Chinese, Japanese, and South Asian older adults cultural and linguistic needs (Yee Hong Centre, 2019; Cragg, 2017). Integrating elder adults' cultural backgrounds into LTC can aid in tailoring care to their specific needs and values. Moreover, this model could be extrapolated and applied to care for at-risk senior sub-populations such as LGBTQI2-S and Indigenous seniors. These two.

minority groups have experienced two-tiered isolation, either in the form of intergenerational trauma or isolation due to discrimination (ESDC, 2018). By providing tailored LTC several group-specific needs, which are often disregarded by the current one-dimensional care model, can be targeted and addressed by one intervention.

Cultural diversity among Canadians and those in LTC facilities is expected to increase dramatically over the next decade (Cragg, 2017; Ng et al., 2012). For example, in 2006, approximately 20% of Canada's total population was foreign-born however this figure is projected to surpass 28% by the year 2031 (Ng et al., 2012; CALTC, 2018). With this proportion in mind, LTC homes are increasingly faced with the challenge to recognize and support residents' unique cultural and ethnic beliefs (Cragg, 2017). As a result, in 2018, over 32, 835 Ontario seniors were on a waitlist to enter an LTC facility (CALTC, 2018). Those who are waitlisted, however, tend to occupy hospital beds for long periods placing immense strain on our healthcare system. Should the two-pronged approach be implemented, seniors would not only be diverted out of hospitals, diminishing the overall prevalence of hallway medicine but would reduce the burden on the healthcare system, both goals that Ford's reform seeks to address. Lastly, this approach will provide care specifically tailored to the cultural needs of seniors, allowing them a comfortable and safe community setting to age in allowing for a more personal approach to LTC.

Agenda Setting and Re-Framing Strategies

To ensure this policy is reflected on the current agenda, it is important to consider agenda setting and public promotion of culturally specific LTC. Through agenda setting, the pervasive issue of senior isolation will be made known to government officials, thereby assigning the issue to the political process and giving it impetus within the political stream. Advocating for seniors of differing demographics either through the media (agenda building) or public awareness of personal testimonies can further illustrate the multifaceted reach of this salient issue. By re-framing social isolation and its current narratives to an economic and cultural diversity issue, facilitating policy changes through a transparent process would be made easier. This would primarily be done through promoting culturally-based LTC through advertising, cultural history, and medical news streams.

Current research suggests that the lack of a clear governmental body that addresses senior isolation may be the principal reason that has allowed policy-makers to ignore the potential health implications of isolation for so long (Valtorta & Hanratty, 2012). Hence, for this issue to be taken seriously among policy-makers and politicians, focusing on risks to public health, renewing the research agenda, and broad-based community organization with a focus on cultural diversity are essential (Valtorta & Hanratty, 2012). Information and research must also focus on how these interventions will reach culturally isolated seniors through population-based strategies targeting high-risk individuals. Therefore, elements of agenda, awareness, and reframing require a systematic assessment of seniors needs and the implementation of a cross-disciplinary

approach that acknowledges the uniqueness of this issue to overcome public health barriers.

Conclusion

In conclusion, when addressing issues of senior social isolation, it is necessary to consider the wide reach this issue has and how its effects can manifest differently in various sub-populations of seniors. Thus, creating a policy to implement culturally specific LTC facilities is the first step in acknowledging the innate diverse nature of this issue. Since one's culture is ingrained within their identity, it can have substantial effects on healthcare practices, outcomes values, and beliefs (Cragg, 2017). With the addition of culturally specific LTC homes that cater to sub-populations, the cultural stigma surrounding home care will slowly diminish, the burden on informal caregivers will be alleviated, and seniors will be diverted out of hospitals, ultimately reducing rates of in-home isolation. Overall, senior isolation is a rampant issue in Canadian society that must be addressed through a two-pronged policy approach targeting the needs and cultural diversity of seniors. By doing so, Canada will be able to provide the care seniors deserve as they age, since after all, do they not deserve better?

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The Ontario Basic Income Pilot: How A Universal Basic Income Model Could Improve the Health of Canadians

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Introduction

Income is one of the most important social determinants of health, meaning the length and quality of one's life is closely linked to their bank account (Ruckert et al., 2017). For this reason, it is imperative that equitable income distribution policies be implemented to allow for fair health outcomes within a population. A popular model of income distribution piloted across the globe is Universal Basic Income (UBI), income provided unconditionally to citizens (Ruckert et al., 2017). In 2017, Kathleen Wynne announced the Ontario Basic Income Pilot with the goal of reducing poverty rates within the province (Kassam, 2017). This policy relates to health because of the income gradient present in health outcome measures (Bryant et al., 2010). Furthermore, the issue of income inequality relates to health as studies show that between two communities of equal mean levels of income, the community with less inequality will have better health incomes (Forget, 2013). The UBI model is important to healthcare as it aligns with the Canadian Government's plan of health promotion, the process of enabling citizens to have better control over their health by changing the environment individuals interact within (Epp, 1986). A universal basic income program can achieve this by increasing the absolute incomes of poor families while decreasing the level of inequality in a community (Forget, 2013), thus addressing the national government's challenge to improving health and reducing inequality (Epp, 1986). Evidence from previous universal basic income trials prove that policy reform would present beneficial effects to population health, including better birth outcomes and mental health. This essay shows how these health effects would be especially valuable in addressing health concerns specific to disadvantaged Canadian demographics. However, the cost of implementing such a program as well as the existing political climate within Canada are barriers to policy reform.

Background

Historically, Canada has piloted the Universal Basic Income model of income distribution twice. In 1974, Prime Minister Pierre Trudeau launched Mincome, a UBI trial located in Manitoba (Forget, 2011). The pilot's purpose was to determine if and how guaranteed income would cause disincentives to work amongst participants (Forget, 2011). The income security plan was met with opposition from the Canadian labour movement and was removed from the party's manifesto in 1979 (Forget, 2011). The model resurfaced in Canadian policy in 2017 when Premier Kathleen Wynne announced the Ontario Basic Income Pilot. The three-year pilot project launched in Hamilton, Thunder Bay, and Lindsay, including 4,000 participants aged 18-64 living on a low income (Hemmadi, 2018). Individual participants received \$16,989 annually while couples were given \$24,027, with 50% deductions applied on all earned income

(Hemmadi, 2018). Members of the pilot supported by the Ontario Disability Support Program had to withdraw to participate in UBI; however, they could receive up to an additional \$500 per month (Hemmadi, 2018). A year after the UBI's implementation, the province's political climate changed, resulting in the election of a Conservative majority government. The ramifications of this decision on income inequality in Ontario and the health of Canadians will be discussed later in this essay.

Income Distribution as a Means to Improve Birth Outcomes

Implementing a UBI model of income distribution in Canada could improve health by improving birth outcomes. The Gary Income Maintenance Experiment measured the effects of an expanded income support plan on the birth weight of babies born in “black female-headed ghetto families” in Gary, Indiana (Kats, 1973). The experiment weighed 404 infants at birth and concluded that participants receiving annual guaranteed income valued at \$3,300 or \$4,300 experienced a 0.3 to 1.2 pound increase in weight (Kehrer & Wolin, 1979). Improved weight was attributed to mothers having better access to food and healthier diets (Kehrer & Wolin, 1979). An individual's birth weight is an important indicator of their health, with low birth weight being linked to higher rates of morbidity during infancy and later life (Kehrer & Wolin, 1979).

Recognizing the correlation between income and birth outcomes is an important part of improving the health of Canadians. Similar to the group studied in the Gary Income Maintenance Experiment, Indigenous communities in Canada experience infant mortality rates that double their non-indigenous counterparts due to disproportionately low incomes (amongst other factors) (Sheppard, 2017). Furthermore, a ten year study found that 48% of the First Nations households surveyed struggle with food insecurity (Wright, 2019). The Canadian Government has identified reducing inequalities as a challenge to improving Canadian's health (Epp, 1986). By adopting the UBI model, a program with proven results of improving birth outcomes and access to food, the national government is both addressing its problem of inequality and simultaneously improving the health of Canadians.

Income Distribution as a Means to Improve Mental Health

A UBI model of income distribution could improve health in Canadians by bettering mental health. A cash transfer experiment was performed to identify the effects of a positive income shock on the mental health of school-aged girls in Malawi (Baird et al., 2013). The results showed that, compared to the control group, girls receiving this income experienced reduced psychological stress by 38% (Baird et al., 2013). The females reported to have increased leisure time, food consumption, and school attendance due to the effect of decreased stress (Baird et al., 2013). The effects did not continue once the program ended, suggesting a correlation between income and mental health (Baird et al., 2013).

Understanding this correlation is important to improving the health of Canadians. Similar to the group studied in Malawi (Baird et al., 2013), young Canadians report experiencing stress worse than that of older cohorts (Vuchnich & Chai, 2015). Each year these numbers are increasing which identifies that there are more stressors exerted onto younger generations (Vuchnich & Chai,

2015). Examples of stressors include belonging to a single-income household (Yoshikawa, 2012) or not being able to afford the lifestyle perpetuated as normal on social media (Dressler, 1996). The national government has identified improving people's capacity to cope with social determinants of health as a challenge to improving Canadian's health (Epp, 1986). Adopting the UBI model of income distribution has been shown to benefit the psychological stress of youth (Baird et al., 2013). Should the Canadian government choose to implement this model, problems of inequality and incapacity to cope with stress can diminish.

Understanding the Cost of Implementation

The cost of implementing a universal basic income program is hefty and this fact discourages voters and policy makers from developing policy reform. Germany's UBI proposal would cost about one billion euros in its first year, causing the national government to retract their efforts towards implementing such a program (Spermann, 2017). In comparison, Kathleen Wynne's Ontario Basic Income Pilot would cost \$43 billion to implement (Hemmadi, 2018). The issue of cost is especially important as UBI programs are funded by provincial and federal tax dollars. This means that investors (voters and policy makers) wish to see short-term economic rewards with these programs, but results may take time. Policy makers exacerbate this issue during election periods— voters are made to question where fewest of their tax dollars can be invested for the highest return. The UBI's cost is difficult to justify when its benefits arise much later, such as when youth affected by these programs enter the workforce and start contributing to the economy. Mincome was scrapped in 1979, the year Prime Minister Pierre Trudeau faced reelection (Forget, 2011). This trend is especially true in economically unstable times when gas is expensive and student loans are accumulating to the price of houses (Nova, 2018). Citizens seek immediate relief as opposed to long-term benefits.

Understanding the Existing Political Climate in Canada as a Limitation to Implementation

The political climate in Canada is individualistic due to the nation's structure as a liberal welfare state, limiting policy reform efforts. Ontario recently elected a conservative majority government, a decision that threatens the existence of an Ontario Basic Income Pilot. Premier Doug Ford's manifesto highlights the individualistic nature of Canadians today (Abedi, 2018). As an elect he promised to dismantle the UBI trial due to its cost (Kassam, 2018). As opposed to implementing social programs, which benefit Ontarians as a whole, he is promoting policies that are beneficial at the individual level. An example of this is how he plans to sacrifice Ontario's goal to combating climate change as outlined by Canada during the Paris Agreement to reduce gas prices (Benzie, 2018). The characteristics of few redistributive policies and low social expenditures are true of the liberal welfare state model (Nevarro, 2006). The liberal welfare state systematically supports income inequality within a nation. This differs from Finland, the first nation to test a Universal Basic Income model of income distribution at the national-scale (Koistinen & Perkiö, 2014). This decision-making was explained by pointing out that Nordic countries commit to universalism in social and welfare policies (Koistinen & Perkiö, 2014). This

compliments the concept of Social Democratic states addressing inequality through social programs (Nevarro, 2006). The existing political climate within the province and nation must change in order to support policies that benefit the population's health as a whole.

Conclusion

Implementing a universal basic income model of income distribution in Canada could improve health by bettering birth outcomes in Indigenous communities and mental health amongst Canadian youth. The model is especially useful in targeting the challenges the Canadian Government has identified to improving health. However, several limitations exist to the successful implementation of this policy reform including the costs associated with implementing this program, as well as the existing political climate in Canada. These two limitations must be addressed when moving forward with the UBI model of income distribution. In the coming years, more research must be conducted to understand the correlation between the Ontario Basic Income Pilot and the health of the Canadian population.

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Political Economy and Intersectional Analysis of the 2014-2016 Ebola Outbreaks

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Introduction

In 2014 an international public health emergency was declared by the World Health Organization (WHO) for the Ebola outbreak that affected West Africa (UN Women, 2014). Eight thousand seven hundred and four cases were reported, and 3589 deaths were confirmed since the outbreak began in 2014 (Jones et al., 2016). A common misconception is that the outbreak occurred around the time the emergency was announced, yet the first case of the fatal infectious disease was reported six months prior (Benton & Dionne, 2015). It is important to understand that previous historical factors and systems, with already existing structural inequalities enabled this to occur. An intersectional analysis using the political economy of health approach will be used to analyze the factors that have contributed and led to the failure of containment of the disease during the 2014 to 2016 Ebola outbreak in West Africa. This will be done by analyzing the impact of colonialism, imperialism, capitalism, neoliberalism, and health systems in West Africa by using previous literature findings. By reviewing previous literature, recommendations can be made to improve the structures and prevent such impacts from occurring again in the face of another infectious disease outbreak.

The events of the 2014 to 2016 Ebola outbreak that occurred in West Africa (mentioned as the Ebola outbreak), as well as the factors and structures that have contributed to the occurrences during this outbreak, will be analyzed. The population observed are from West African countries such as Sierra Leone, Liberia, Nigeria, Guinea, etc.

Conceptual Framework

Intersectional Analysis

Intersectionality was originally coined by Kimberle Crenshaw in 1989 (Hankivsky, 2014). It encourages the understanding that people are moulded by interactions that occur in various social locations and that these interactions are interrelated to systems and structures of power (Hankivsky, 2014). Intersectionality states that it is through these processes that oppression and privilege due to colonialism, patriarchy, imperialism etc. occurs (Hankivsky, 2014). By taking an intersectional lens, it must be understood that disparities do not occur due to single or distinct factors, but due to a combination of life experiences that are a result of power relations and social locations (Hankivsky, 2014). Intersectional analysis involves the understanding of social categories as interrelated and interacting fields that change over time and place (Hankivsky, 2014). An intersectional analysis will study what occurs when intersections meet, as well as their results (Hankivsky, 2014). This framework is used to study the case of Ebola in West Africa.

Political Economy Approach

The political economy approach considers the political, historical, economic, social and cultural aspects that contribute to ill health (Birn et al., 2017). It states that health and health care is political, as the distribution of power & resources, as well as the societal orders which protect them, influence factors at multiple levels over time which affects the health of individuals and populations (Birn et al., 2017). Key concepts of the political economy approach include colonialism, imperialism, capitalism, neoliberalism, social classes, redistribution policies. These concepts will be analyzed and addressed in the following paper. Political economy cannot be a theory, as when in isolation it does not directly depict the impact of health (Birn et al., 2017), hence political economy must be used with other frameworks such as the post-colonial feminist theory which looks at the influence of colonialism on people's life experiences today (Browne et al., 2007).

Description of the Issue

Hemorrhagic manifestations and fevers were key characterizations of Ebola (Fawole et al., 2016). An increase was seen in the number of cases and deaths from the Ebola virus disease in West Africa, which called for an international public health emergency in 2014 by the WHO (WHO, 2014; UN Women, 2014). The disease lacked treatments and vaccines, with already existing safety and efficacy statuses, and has a high mortality rate (Fawole et al., 2016). Due to this, in the event of an outbreak, such as the 2014 Ebola outbreak, an affected nation and its systems must be able to withstand the impacts of the infection. In the case of the West African countries such as Sierra Leone, Liberia, Nigeria, and Guinea, their structural inequalities and weak systems, such as a weak health care system, resulted in greater impacts of the outbreak on the residents of West Africa. The following sections will use the political economy theory to analyze the structures and factors that contributed to the failure of the containment of the disease. It is important to analyze these factors as they can provide ways forward to create a stronger system, better prepared in the face of another disease outbreak, similar to the 2014 Ebola outbreak.

Review of Literature

The literature involving broader structures and factors will be analyzed as to why Africans and West Africans were placed at risk. The factors will be narrowed down to become more specific in regards to the issue and causes of the Ebola outbreak in 2014 – 2016.

Colonialism

Colonialism is defined as a foreign power's domination over political, economic, social, and cultural systems over a prolonged period of time (Bell, 1991, as cited in Schaefer, 2015). This is done through the occupation of land with settlers from the ruling nation, as well as, economically exploiting the occupied nation by methods such as extracting its natural resources (English Oxford Dictionaries, n.d.). Multiple articles state that there were more difficulties when managing Ebola during the 2014-2016 outbreak due to the existing weak system, that became weaker when the disease occurred (Menendez et al., 2015; Benton &

Dionne, 2015; Davies & Bennett, 2016; Jones et al., 2016; Strong & Schwartz, 2016; Wilkin & Conteh, 2018; Yamanis et al., 2016).

One of the intersecting factors that contributed to the current weakened state of these Western African countries was colonialism. The Wilkin and Conteh (2018) article states how colonial history has left Sierra Leone with a socially, politically and economically undeveloped foundation to build their nation that was heavily politically divided. These power struggles were later translated into the inability to independently manage the Ebola outbreak on their own, resulting in the need for foreign aid (Wilkin & Conteh, 2018).

Colonialism is also highlighted in the article by Benton and Dionne (2015), where the colonial history of interconnected epidemics that also contributed to the weakening of systems. The interventions that were taken to manage illnesses such as smallpox and the Spanish flu under colonial rule included quarantines, house-to-house surveillance, fines for hiding the sick, as well as isolation (Benton & Dionne, 2015). Such interventions contributed to the already existing tensions and feelings of antagonism and mistrust between the ruling colonial government and its people (Benton & Dionne, 2015). These tensions and feelings of mistrust of the government have been translated to the current day, which was also seen during the outbreak .

Finally, an article by Levich (2015) highlights the colonial discourse regarding Ebola as being the “savage African disease”, that will occur at any-given time . The article states that these surviving colonial discourses in regards to Ebola were also mentioned during discussions of the 2014 – 2016 Ebola outbreak in the United States (Levich, 2015). Such discourses provided this notion of fear of intrusion, as mentioned by Levich (2015), and caused an increase of “Ebola panic” , yet there were no mentions on the colonial exploitations that caused the local responses to be insufficient at addressing the needs of the outbreak . The colonial discourses of the Ebola virus contributed to the increased panic seen in the Western countries (Levich, 2015; Nohrstedt & Baekkeskov, 2018). This, along with the local systems that were unable to keep up with the demands, such as the number of health care workers, during the outbreak caused the deployment of foreign aid workers. Colonialism allowed for the ruling countries, such as Britain and France, to take over and exploit the resources of the countries they occupied, such as Guinea, Sierra Leone, and Liberia (Benton & Dionne, 2015). They implemented their system and when colonization was deemed illegal, they left the countries, and took with them the economic and political stability that was required during the 2014 – 2016 Ebola outbreak. Many countries still suffer from poverty due to this today. Though colonial countries are not present in the form of colonialism in the West African countries today, they still have heavy influence on these regions.

Imperialism

In the previous section, it was shown how colonialism affected the economic and political structures of the West African countries that were affected in the 2014 – 2016 Ebola outbreak. The effects of colonialism had lasting effects, including the lack of trust on the government and its subsequent structures (Bentpn and Dionne, 2015). Similarly, though colonialism is illegal, it

is still present in the form of imperialism and is shown to have a great effect on the 2014 – 2016 Ebola outbreak that occurred in West Africa as well. Imperialism is defined to be when a state's influence is extended over to people of other territories (Collins Dictionary, n.d.). This influence of politics and economy can be done formally or informally.

In regard to the West Africa Ebola outbreak, there were multiple influences of international high-income countries in the form of foreign aid. Nohrstedt and Baekkeskov's (2018) article notes that when sending foreign healthcare workers, the high-income countries tended to send aid and workers to the countries they previously ruled during the colonial era, yet responses were often delayed (Benton & Dionne, 2015). For example, Britain focused its aid on Sierra Leone, while France focused on its former colony Guinea (Nohrstedt & Baekkeskov, 2018). In Benton and Dionne's article (2015), international humanitarian aid was seen as the main health provider in comparison to the public system, which was seen in Nigeria, Sierra Leone and Guinea. During the outbreaks, healthcare expenditures were also largely financed by international Non-Governmental Organizations (NGOs) instead of the government (Benton & Dionne, 2015).

The Wilkin and Conteh (2018) article states that Sierra Leone's post-war reconstruction was heavily influenced by foreign donors, such as the UN Mission in Sierra Leone. Great sums of money were given to the nation for reconstruction, yet this was dependent on the fact that the nation listened to the advice of these donors and adopted neoliberal policies that, according to the donors, would open up the economy (Wilkin & Conteh, 2018). It is such influences from foreign actors that encouraged the adaptation of neoliberalism, which also contributed to the weakening of systems during the 2014 – 2016 Ebola outbreak.

Capitalism & Neoliberalism

Capitalism is an economic system where the "free-market" determines distributions of services, prices, production, availability, as well as patterns of wages (Birn et al., 2017). Neoliberalism is the philosophy and practice that emphasises individualism and the free market (Collins Dictionary, n.d.).

In the Wilkin and Conteh (2018) article, they discuss the continued race for resource extraction that occurred in the post-colonial era, even after the departure of the colonial rulers. Elites and government parties are mentioned to speak in favour for the economic and geopolitical interests of the nation, such as Sierra Leone in this case, yet once in power the natural resources extracted and the economic gain from these operations are not placed into systems or structures such as public health care but are used for individuals' interests (Wilkin & Conteh, 2018). This can be seen during multiple successive governments in Sierra Leone, as they adapted neoliberal strategies of development, yet this has neither contributed to building stronger, more sustainable health systems nor has it aided in the alleviation of poverty (Wilkin & Conteh, 2018).

Similarly, Benton and Dionne's article (2015) discuss the Structural Adjustment Policies (SAPs) that were made by foreign financial institutions to support the economic development of countries, such as those affected by the Ebola outbreak. These policies came with conditions, similar to Sierra Leone's

case, where the Western African countries, including Sierra Leone, had to make cuts to their social services and government spending such as public health (Benton & Dionne, 2015). The conditions supported a neoliberal approach to governance, and as international companies held great power from their economic and politically dominant foreign roots, the countries involved found themselves in a difficult position to advocate for themselves.

Levich's article analyzes international aid and philanthropy, including the foreign aid work done by high-income countries. Levich (2015) discusses the system of Global Health Imperialism which explains how influential high-income countries are. These countries play a large role in determining what kind of care developing countries will provide to their people. For example, Levich (2015) states how wealthier countries feel threatened by health issues that supposedly originated from developing countries, and hence push for initiatives such as the use of militarization of healthcare. Additionally, Big Philanthropy in which corporations of high-income countries provide aid to developing countries, is beneficial to the Western transnational corporations as the health philanthropy is based on the philosophy of private institutions (Levich, 2015). This makes Big Philanthropy profitable to Western transnational corporations by using initiatives to strengthen themselves instead of the national health systems in the countries they provide aid to. Though seen to be done good intentions by high-income countries, it inevitably contributes to the weakening of the local health systems, preventing them from managing current and future outbreaks.

Health Systems

In the Benton and Dionne article (2015), it was noted that international NGOs were the main providers of health-care, as well as healthcare expenditures, but they lacked the motivation to develop comprehensive health systems with proper public health surveillance. This resulted in the creation of "vertical" programs that targeted specific groups, such as pregnant women or children, instead of creating holistic programs that were more efficient and effective in attempting to control or eradicate diseases (Benton & Dionne, 2015). It was also seen that there were fewer health care workers available in the care setting (Benton & Dionne, 2015; Nohrstedt & Baekkeskov, 2018).

The structures and factors that were previously mentioned heavily influenced the current status of the health systems of West African countries. Common effects include the delay in diagnosis amongst men and women (Yamanis et al., 2016), as well as health care services closing (Jones et al., 2016). In Sierra Leone, Liberia, and Guinea, maternity care and-or family planning services were halted, along with immunization services (Menendez et al., 2015). It was also commonly seen that there was a delay in care from healthcare providers, such as mothers receiving care in Sierra Leone, due to the fear of contracting the disease (Jones et al., 2016). Those who did not work in the healthcare field had to stay home in order to care for those who were ill, due to their social role, which resulted in their economic loss (Fawole et al., 2016). Due to the stigmatization and fear, originating from colonialism, as well as the lack of a supportive system, due to the neoliberal practices, businesses, especially women's businesses, were affected as well (Fawole et al., 2016).

Discussion & Critical Reflection

The review of literature described the various structures and factors that contributed to the weakened healthcare and social systems in West Africa during the 2014-2016 Ebola outbreak, that resulted in increased damages. By understanding the various intersecting factors, past and present, we can see the ways in which this particular outbreak has been influenced, and the context in which it originates from. It is important to remember that political economy is an interdisciplinary approach, which in isolation fails to show the direct impact that the political and economic structures have on health.

In order to prevent the mistakes made in the 2014 – 2016 Ebola outbreak from occurring again, and in order to increase the quality of health care and crisis response in the West African countries, changes must be made to the political and economic structures that influence their health. Though past events cannot be changed, current actions can be taken in order to learn from this history, and change the government systems so that they can be more sustainable and stronger in the face of another outbreak. To begin with, more research is required in terms of the analysis of the political-economic factors and the institutional cultures that influence health systems (Benton & Dionne, 2015; Nohrstedt & Baekkeskov, 2018). The importance of ensuring West African countries have robust, sustainable healthcare systems is also commonly highlighted (Benton & Dionne, 2015). For this, local governments must begin taking steps to strengthen their public health systems and more importantly international policies should be made and modified to prevent international corporations, NGOs and governments from exploiting a nation by using their current weakness against them. Partnerships are essential to creating and maintaining systems that affect public health and it can be seen that initiatives to address issues of health should not only be concerned with the individual's body but the histories and systems that contribute to their health. Hence, local and international organizations and institutions, such as local governments, WHO, World Bank and United Nations should work together to create policies and systems that support public health rather than diminish it. Another step would be to modify SAPs requirements to decrease public services such as social welfare and healthcare to instead encourage the adoption of such services. Institutions and organizations should provide increased training to caregivers and healthcare workers regarding fear, stigma and preparation for such events, so that in the occurrence of an outbreak health care services should not be halted. The neoliberal policies placed by the international organizations on the West African countries should be lifted, as preventing the government from allocating funds towards public services such as health and healthcare has done more damage than good (Benton & Dionne, 2015). The NGO's should be focused on strengthening the local health systems instead of finding profits for themselves (Levich, 2015). There will still be cases where there is a need for foreign health care workers, as paradigmatic change will not occur in these countries immediately, yet by learning from the mistakes made from the 2014 – 2016 Ebola outbreak, health organizations, governments and workers must respond quicker.

Conclusion

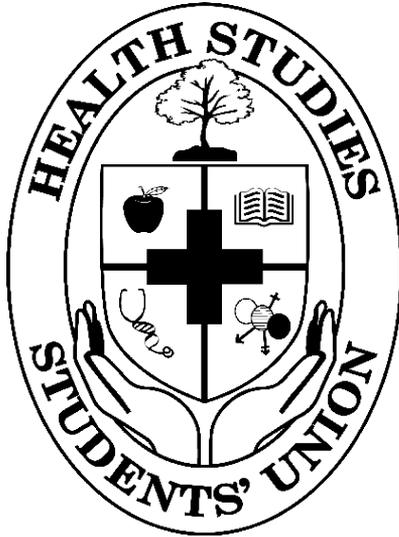
It is important to recognize that past historical events, and the existing systems that are a result of them, are great influencers of health. In terms of the Ebola outbreak in 2014-2016, the weakening of the West African countries, as well as the increased risk of obtaining Ebola, was seen as a result of colonialism, stigma, imperialism, and ideologies of neoliberalism. One's health is a result of multiple factors direct and indirect, which originate from during, and before one's lifetime. Health and health issues must be addressed with an intersectional approach that includes the involvement of multiple disciplines and fields that contribute to and influence people's health status. This is not only true for an individual, but also for entire populations. More research should be taken on the structural factors, and other interrelated factors that influence a population's health. Most importantly, more intersectional approaches should be taken when making health interventions, policies, and research. It must be accepted that health does not occur in a vacuum and that multiple factors influence it.

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